Bolton NHS Foundation Trust – Board Meeting 27 June 2019

Location: Boardroom Royal Bolton Hospital **Time: 0900**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09:00	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
09:05	4.	Minutes of meeting held 30 May 2019	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
09:15	7.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SUIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
09.20	8.	Quality Assurance Committee – Chair Report June 2019	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
	9.	Finance and Investment Committee – Chair Report June 2019	FC – Chair	Report	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
	10.	Workforce Assurance Committee – Chair Report	CEO	Report	CEO to provide a summary of assurance from Workforce Assurance Committee and escalate any items of concern to the Board
	11.	Urgent Care Delivery Board - Chair Report	CEO	Report	To receive a report on the Urgent Care Delivery Board
10.00	12.	Freedom to Speak up Annual Report	Tracey Garde	Report	To receive the Freedom to Speak Up Annual Report
	13.	Seven Day Services	Medical Director	Report	To receive a report on the seven day services
10.15	14.	Performance Report	All	Report	To discuss the metrics on the integrated performance report

Coffee

Governance					
11:15	15.	Patient Story		Verbal	For the Board to hear a recent patient story to bring the patient into the room (Press and public may be excluded to preserve confidentiality)
11.50	16.	Board Declarations	Trust Secretary	Report	To note
12.00	17.	Any other business			
Questions from Members of the Public					
	18.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted				
	Lunch and visits to wards and departments				

Meeting	Board of Directors Meeting – Part One
Time	09.00
Date	30 May 2019
Venue	Boardroom RBH

Present:-

Mrs D Hall	Chair	DW
Dr J Bene	Chief Executive	JB
Mrs T Armstrong-Child	Director of Nursing/Deputy Chief Executive	TAC
Mr A Thornton	Non-Executive Director	AT
Dr F Andrews	Medical Director	FA
Dr M Brown	Non-Executive Director	MB
Ms B Ismail	Non-Executive Director	BI
Mrs S Martin	Director of Strategic Transformation	SM
Mr J Mawrey	Director of Workforce	JM
Mr M North	Non-Executive Director	MN
Mr A Stuttard	Non-Executive Director	AS
Mrs A Walker	Director of Finance	AW
Mrs J Njoroge	Non-Executive Director	JN

In attendance:-

Mrs E Steel	Trust Secretary	ES
Ms R Ganz	Associate NED	RG
Mrs R Wheatcroft	Deputy COO	

Eight observers in attendance including members of the Shadow Board and Council of Governors

Apologies

Mr A Ennis (R Wheatcroft deputising)

Declarations of Interest

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

1. Patient Story

Mrs W attended to share her story of recent treatment for an infection around the site of her cardiac implant. MRs W spent two weeks as an inpatient and during that time was impressed with many aspects of her care, including the quality of cleaning and food. She had noted the posters promoting the ABC behaviours

and felt that all staff demonstrated these at all times with good contact and communication, a strong learning culture and good camaraderie – staff described as always smiling even at the end of a long shift.

In introducing her story Mrs W had explained about her role in setting up and chairing the Bolton ICD group and an action was agreed to look at ways to promote relevant support groups to patients.

Resolved: the Board thanked Mrs W for taking the time to share her story.

FT/19/31	PEIP to consider opportunities to promote support groups to patients	TAC

4. Minutes of The Board Of Directors Meetings held 25 April 2019

The minutes of the meetings held on 25 April 2019 were approved as a true and accurate reflection of the meeting.

5. Action Sheet

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

6. Matters Arising

There were no matters arising.

7. Chair's Report

The Chair welcomed attendees and observers and in her verbal update highlighted the following matters:

- At the meeting on May 23rd, the Council of Governors received an update on performance and a presentation on the implementation of EPR which is currently on plan. Feedback from Governors was very positive with recognition of the challenges and opportunities. Governors were encouraged to become more involved in the BOSCA assessments and training will be provided to Governors and NEDs who wish to participate in the inspections. Governors also approved the reappointment of Jackie Njoroge for a second three year term as a NED.
- The Start the Year conference on 20th May was well attended and provided a great opportunity for staff to engage on future plans for the Trust.
- Baroness Dido Harding has confirmed that she will be available to officially open the new urology unit in September 2019.
- Following the change of control of Bolton Council a meeting will be arranged to meet the new leadership team.

8. Chief Executive report

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

Two red complaints have been reported since the papers were published, these will be reflected in the June 2019 report.

For clarity, the Director of Nursing advised that the two maternity incidents had been reported on STEIS but in accordance with the new process would be investigated by HSIB rather than by the Trust.

Board members discussed the recent regulation 28 letter; the Chief Executive assured the Board that support is always available out of hours and at weekends.

Board Assurance Framework

The Board noted the updates to actions and controls to mitigate against the risks to the achievement of the strategic objectives.

Resolved: the board noted the CEO update.

9. Quality Assurance Committee Chair Report

Mr Thornton, the NED Chair of the QA Committee presented a summary of the meeting held on 15 May 2019. Key points for the Board to note were as follows:

- Terms of Reference updated with minor change to membership and the addition of a report from the Strategic Transformation Board
- Clinical Governance and Quality Committee Chair Report - No risks escalated but a number of amber areas within the chair report – these include the need for further audit on wrist bands and a further report on the Never Event Assurance Framework
- Pressure ulcers – quarterly update – good progress made although target to reduce by a further 15% not met – The committee agreed to continue receiving quarterly reports
- Radiology – plain film reporting - Further to the review of radiology reporting (reports previously submitted for MRI and CT) a written report was presented providing a level of assurance that although reporting on plain film X Rays is on average 1 week longer than the 14 day standard the impact on patient treatment has been minimal
- National Inpatient Survey - shows performance within the mid 60% of Trusts for the majority of areas. Some key themes for action using a QI approach have been identified including looking for ways to reduce noise at night, improving written information provided to patients and actions to reduce delays to discharge
- Sepsis – quality account priority - Update provided on the Quality account target, most actions achieved (detail within the draft Quality Account received in April 2019)
- Mortality Committee - Discussion focused on the increase in the three mortality indicators, the Medical Director advised that the CCG remain reluctant to change the way ambulatory care patients are coded and have advised that national changes will bring other Trust reporting in line with

Bolton. It was noted that although it is felt likely that the ACU coding has contributed to the increase in HSMR this was still taken very seriously and would continue to be a high priority for focus.

- Risk Management Committee – a new risk relating to the impact a recent power outage had on the data centre was escalated, at the time of discussing within Risk Management Committee additional short term protection was being considered to cover the six week period before the new data centre is available – until this time the data centre does remain vulnerable. Mr North advised that he had discussed the incident with the IT team and while it had previously been recognised as a potential risk the team had a business continuity plan but have recognised further learning from this incident.

Resolved: The Board noted the report from the Chair of the Quality Assurance Committee and Approved the revised Terms of Reference.

10. Finance and Investment Committee Chair Report

Mr Stuttard, the NED Chair of the Finance and Investment presented his report from the meeting held on 21 May 2019.

Key points for the Board to note were as follows:

- Month 1 Finance Report - The financial position to the end of April 2019 (Month 1), excluding PSF, is a deficit of £2.6m, against a deficit plan of £1.8m, an overall shortfall of £0.8m. The main reasons for the shortfall of £0.8m are an under recovery on income of £0.2m and an under performance on the ICIP of £0.4m. The ICIP target for the Trust is £15.6m but a number of risks are potentially starting to materialise. Mitigations are being identified. The risk associated with the ICIP is already recorded in the risk register at 16.
- The Committee discussed the Trust's aged debt with £1.9m over 60 days and significant amount over £500k over 240 days – a follow up report has been requested to understand the reasons for this and whether this debt can be recovered.
- Capital Planning 2019/20 - All NHS Trusts have received a letter from NHSE/I asking them to review their capital plans for this year as there is a current risk that nationally the capital expenditure limit will be exceeded. The Trust has submitted a response indicating that there are no proposals to reduce the capital plan although the profile of spend for the year has been revised.
- iFM financial update - The Committee received a report on the iFM financial position. It was noted that in 2018/19 iFM made a profit of £172k against an original target of £698k. There is no corporation tax payable on this profit as the company is able to take account of losses from previous years. In respect of 2019/20, iFM is forecasting a profit of £244k on turnover of £25.3m, which includes an ICIP of £1.4m. iFM have in place an ICIP tracker to ensure delivery of their schemes.
- ICIP Progress Report – As previously discussed, the ICIP Programme represents the major risk to the overall achievement of the Trust's Control Total and will be a theme throughout the year. The position at Month 1 was an actual achievement of £0.2m against a plan of £0.6m. A

comprehensive monitoring programme is in place, however a number of the schemes, in particular the system wide ideas, have still to be worked up. As previously reported, the bulk of the savings are in the second half of the year which is resulting in the significant risk to the overall achievement of the financial plans.

- The Committee received an update on new valuation techniques and while Committee members were assured that the Trust had followed guidance in line with national recommendations there was a potential £700k risk if the guidance were to be changed
- HMRC Contracted Out Services Review - The Committee were advised that following receipt of the Contracted Out Services (COS Heading 45) for the Trust, the submission of information requested has been made to HMRC within the timescale requested.
- GM Integrated Care System Financial Framework - The Director of Finance updated the Committee on the current position regarding the agreement of a System Wide Financial Control Total for Greater Manchester. Bolton FT is the only Trust currently with a surplus Control Total with the exception of the Christie. Meetings are taking place across Greater Manchester to ensure that the implications are fully understood and that there is equity across the system. Trust Boards will be asked to sign up to the ICS Control Total in due course.

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

11. Audit Committee Chair Report

Mrs Njoroge, Chair of the Audit Committee presented a combined report from the meetings held on 2nd and 23rd May 2019.

- Annual Report and Accounts – On 2nd May the Committee reviewed the draft accounts and report prior to considering the final documents for formal approval as agreed at the Board meeting on 25 April 2019. The Committee commended the work of the team in completing the mandatory returns.
- Internal Audit Reports – The Committee received a number of final reports from the internal auditor:

  The Mortality Framework review report was rated as medium risk with recommendations to improve on the learning from deaths processes. The Auditors recognised that progress has already been made and a number of good practices have been adopted.

  As previously discussed at Board, the review of Capital Projects was a high risk report identifying a number of ways in which the management of capital projects could be improved – iFM have responded to the report and made the recommended changes.

  The Governance and Committee effectiveness review looked at the IPM arrangements and concluded that there is a clear and structured process in place. Two low risk areas identified for potential improvement with regard to the action log and the format of meetings

  Data Security – the auditors reviewed a sample of data security standards ahead of the submission of the IG toolkit – a number of areas where

identified for further work before the submission – the Committee received the final IG submission by email and were assured that the recommendations had been addressed.

Internal Audit follow up and head of internal audit opinion – the Head of Internal Audit opinion for 2019/19 was "Generally Satisfactory for the FT and "improvement required" for iFM Bolton.

The follow up report provided assurance that the majority of recommendations made by internal audit had been addressed. Board members discussed the number of recommendations, it was agreed to share the follow up report with al Non Executives to provide assurance that although there reports generate a number of recommendations they are not disproportionate and action is taken

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

FT/19/32	Share internal audit follow up report with all Board members	ES

12. Workforce Assurance Committee Chair report

The Chief Executive presented her Chair's reports from the Workforce Assurance Committee meetings held on 26th April 2019 and 17th May 2019:

- The Committee received reports on recruitment performance and agency use and while it was noted that a number of positive actions had been taken there was concern that there did not appear to be a correlation between recruitment and a reduction in agency use. A further report has been requested to triangulate the details.
- Good progress has been made with regard to actions to reduce sickness absence – in time this should have an impact on the use of agency staff.
- The Committee received an update on the potential impact of changes to tax legislation in relation to pensions, this is a national issue but could have a significant impact on capacity – this has been added to the risk register and a paper will be provided for the June Board.
- Good progress has been made on spending the apprentice levy with the Trust now on track to ensure this money is appropriately invested in developing employees.
- The Health and Wellbeing report provided an update on plans to develop a more strategic approach to health and wellbeing including increased mental health support.
- The committee received a report on the development of training and roles for Physician Associates with recognition that roles will need to be created to ensure the Trust takes full benefit of this new role.
- Although significant work has been undertaken on job plans this remains a multifactorial issue – the impact of the pensions and tax changes discussed previously will also play into this, some consultants have already indicated a desire to reduce additional PAs and this may have an adverse impact on activity.

Board members discussed the use of agency staff, in particular responding to a

question posed as to whether after time the agency staff became culturally embedded in an area with use in relation to want rather than need. The Director of Nursing advised that this was an area of scrutiny at the IPM meeting, the Acute Adult Division in particular were able to articulate where agency use had been incurred and could demonstrate that this was linked to escalation areas. The Director of Workforce advised that the workforce and OD dashboard was being reviewed to aid clarity and ensure understanding of the factors influencing this expense.

13. Urgent Care Delivery Board

The Chief Executive presented the chair's report from the Urgent Care Delivery Board.

- The Urgent Care board received a presentation on palliative and end of life care and noted the good work and improved outcomes with more patients being cared for in their preferred place of death.
- A&E performance has continued to gradually improve and is currently at 86%. Performance was more of a challenge over the bank holiday weekends when escalation areas were opened.

Board members discussed the improved performance and reflected on the significant improvement in comparison to previous years. The management of holidays and potential surges was discussed with recognition that the system partnership has been effective in supporting the improvement.

Resolved: the board noted the Urgent Care Delivery Board Committee Chair report.

14. Integrated Performance Report

Board members reviewed the Integrated Performance Report considering the metrics within the report and focusing on areas in response to questions and as directed by the executive team. In discussing the metrics and responding to questions the following points were noted:

- In response to a question about learning from pressure ulcers attributed to a lapse in care, the Director of Nursing advised that the QA committee receive a quarterly update providing details of the themes. These themes are used to inform the forward plan; recent themes have been documentation and support stockings.
- The main factor identified as contributing to the reduced performance for clinical correspondence is reduced capacity with the medical secretary team. Performance has been discussed with divisions at IPM and the Workforce Assurance Committee have agreed an action to develop a flexible workforce to provide cover where required. No incidents have been reported as a result of the delay.
- Maternity indicators – Board members discussed the metrics for stillbirths, pre term births and intervention, reflecting on previous Board discussions, Board members recognised that the priority must always be the outcome for mother and baby. The Director of Nursing advised that NHSI would be

delivering a development session on data in August which would present a further opportunity to discuss and understand metrics and targets.

- In response to a question about the deterioration in RTT performance, the Deputy COO advised that work was underway with the CCG to fully understand recent surges in activity. The resignation of the single remaining dermatology consultant will create further capacity challenges which are being discussed with the CCG.

Resolved: the Board noted the integrated performance report

15. Declarations for the NHS Provider Licence

The Trust Secretary presented the declarations required for condition 6 and 7 of the provider licence.

Condition 6 – compliance with the conditions of the NHS Provider Licence, The NHS Act and the NHS constitution.

The Trust Secretary presented a summary of the evidence of compliance with the above conditions.

Board members noted the evidence and sources of assurance and agreed to confirm that in 2018/19, the Trust took all such precautions as were necessary to comply with the conditions of the Provider Licence and to have regard to the NHS Constitution.

Continuity of Services Condition 7

Board members were asked to consider their response to a statement confirming that the Trust would continue to have the required resources to provide Commissioner Requested Services (CRS)

Board members discussed the resources available and ongoing financial pressures. Whilst recognising that the financial challenge continues to be significant it was agreed that on the basis of the evidence previously presented in the Going Concern report, the recent audit opinion on the accounts and the credible financial performance in 2018/19 they would confirm an expectation that the Trust would continue to have the required resources.

Resolved: Board members approved the governance declarations for May 2019

16. Any other business

None

17. Questions from members of the public

No questions submitted

Date and Time of Next Meeting

27 June 2019

May 2019 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/19/27	25/04/2019	charitable funds	PEIP to follow up on location and availability of wheelchairs	TAC	Jun-19	verbal update
FT/19/33	30/05/2019	Workforce Assurance Committee	J Njoroge to provide further info to JM with regard to potential to spend above apprentice levy	JN/JM	Jun-19	verbal update
FT/19/28	25/04/2019	Ward visits	PEIP to follow up action to consider simplifying names of units for easier public understanding e.g. ACU	TAC	Jun-19	complete - update to QA committee
FT/19/32	30/05/2019	Audit Committee	Share internal audit follow up report with all Board members	ES	Jun-19	complete
FT/19/05	31/01/2019	Emergent organisms	Board development session from microbiology team	TAC	Jun-19	agenda item part two
FT/19/26	25/04/2019	system working	update on neighbourhood models	JB/SM	Jun-19	agenda item part two
FT/19/36	30/05/2019	Strategic options	work to continue with update to June meeting	SM	Jun-19	agenda item part two
FT/19/18	29/03/2019	Patient Story	FA to follow up on comparison of different chemo treatments	FA	Jul-19	follow up through QA Committee
FT/19/01	31/01/2019	Patient Story	February PEIP meeting to focus on provision of support for patients with hearing impairments - present back to Board in July 2019	TAC	Jul-19	
FT/19/29	25/04/2019	ICIP opportunities	future debate about business development opportunities	SM	Jul-19	
FT/19/31	30/05/2019	Patient Story	PEIP to consider opportunities to promote support groups to patients	TAC	Jul-19	
FT/19/34	30/05/2019	heatmap	review progress by reviewing with an earlier version	TAC	Jul-19	
FT/19/35	30/05/2019	iFM	Paper to outline future options to part two Board	ES	Jul-19	
FT/19/12	28/02/2019	Gender pay gap	include update on actions within Workforce and OD strategy to Board in September	JM	Sep-19	

Key

complete	agenda item	due	overdue	not due

NHS
Bolton
NHS Foundation Trust

Agenda Item No: 7

Meeting	Board of Directors

Date	26 June 2019

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

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	Dr J Bene Chief Executive

All information provided in this written report was correct at the close of play 20/06/19 a verbal update will be provided during the meeting if required

1. Awards and recognition

Internal

Employee of the Month – Samantha Pennington, Assistant Bed Manager, Patient Flow Team, Corporate Division

Sam was appointed to the role of Assistant Bed Manager in 2018 and has developed beyond expectation and is exceptional at her role. So much so, at times of pressure she has led a division under the supervision of a site manager or Head of Flow, covering days and nights. Sam has chosen to do this to ensure site manager has support and that patients are not delayed with their journey through the emergency department.

Sam is also supporting the training of two further assistant bed managers

Team of the Month – General Radiographers & PACS Team, Elective Division

During the power outage and subsequent 5 days, radiology had limited IT functionality, the general radiographers continued to image over 300 patients each day under contingency plans, keeping the workflow going and without causing delays to plain film images. They changed their normal practices and put new contingencies in place to make sure that all patients requiring plain film imaging received it in a timely manner, and that all clinicians had access to images and reports. They assisted clinicians in seeing images in x-ray rooms, delivered a preliminary report service and enabled clinicians to see reports on the CRIS workstations. All of this was done whilst continuing to image patients.

External

Gemma Faulkner - Lady Estelle Wolfson Emerging Leaders fellowship awarded by the Royal College of Surgeons

Pain team - shortlisted in the Team of the Year category, Nursing Times Awards for their Trust-wide pain education for healthcare assistants

Cancer Treatment

The Trust was ranked third in the country for performance against the 62 day cancer target.

The Ophthalmology team had five posters displayed at the recent Annual Scientific Conference of Royal College of Ophthalmologists help in Glasgow. One of the poster presentations (a service improvement report from the multi-centre Luminous Study) was shortlisted for and won the College's Sustainability Award

2. Stakeholders

2.1 Bolton

Update on Neighbourhood working to be provided in part two

2.2 North West Sector

Dates have been confirmed for Exec to Exec and Board to Board meetings with WWL NHSFT

2.3 NHSI (Regional)

Our Quarterly review meeting with NHSI took place on 30 May 2019, we were congratulated on the outcome of our CQC inspection and the improvement in A&E

performance and our strong staff survey results were recognised. We discussed our current challenges, particularly with regard to the 2019/20 control total

2.4 NHSI (National)

Baroness Dido Harding wrote to all NHS provider Chairs and Chief Executives to share the outcomes of an Advisory Group established to improve people practices. Chairs and CEOs have been asked to consider how Boards oversee investigations and disciplinary procedures with an explicit requirement that *"Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt."* The findings of the advisory group will be discussed within the Workforce Assurance Committee with an update to the Board through the WAC Chair report.

NHS Interim People Plan

The Trust welcomes the details of the Interim People Plan, which was published by NHS England/Improvement on 3rd June, 2019. The final plan is scheduled to be published in Autumn, 2019.

The plan is structured into the following themes, with each theme having a number of immediate actions that need to be taken to enable the people who work in the NHS to deliver the NHS Long Term Plan.

- Make the NHS the best place to work.
- Improve our leadership culture.
- Prioritise urgent action on nursing shortages.
- Develop a workforce to deliver 21st century care.
- Develop a new operating model for workforce.

The Trust's Workforce & Organisational Development Strategy is due to be reviewed in line with the Trust's wider organisational Strategy. Therefore details of the interim plan (and potentially final People plan) will be included within this review and any changes to the Workforce & Organisational Development Strategy will then subsequently be agreed by Board members.

Reportable Issues Log

Issues occurring between 23/05/19 and 20/06/19

3.1 Serious Incidents and Never events

One new SI was reported in month, this related to clinical care.

3.2 Red Complaints

Two red rated complaints have been received, both relate to concerns over missed opportunities to diagnose serious conditions with subsequent delay to starting treatment

3.3 Notable letters of thanks

All our wards and departments receive thank you cards and letters on a regular basis from grateful patients and quite often patients take the time to write a detailed letter of thanks to the Chief Executive or Director of Nursing. This month we received a lovely thank you letter from a family thanking us for support provided to their family in a number

of departments including E3, E5, obstetrics, neonatal, endoscopy, dermatology, ophthalmology, A&E and orthopaedics. The family included a donation of £700 for our charitable fund

3.4 Regulation 28 Reports

No new regulation 28 reports

3.5 Health and Safety Executive

The Health and Safety Executive will be undertaking a follow up visit in September 2019.

3.6 Whistleblowing

No concerns to escalate to board

3.7 Media Coverage

Positive

Benefits of proposed Bolton College of Medical Sciences

Coverage of oral health for Smile Week – Devonshire Road primary School

Trust best in GM, equal best in NW, equal third best in country for cancer waits

Neutral – Board members may be aware of recent media interest into cases of Listeria linked to an external catering company. The Good Food Chain company did supply products to Royal Bolton Hospital. On the advice of Public Health England, we immediately withdrew all products identified as being linked to the outbreak. We are not aware of any of our patients having been affected by this outbreak."

Negative – Trust in deficit after just one month

4 Board Assurance Framework

The Board Assurance Framework is currently being reviewed to align with the new five year strategy. As an interim the 2018 – 2020 BAF has been reviewed and updated.

	Trust Wide Objective	Lead	I	L		June 2019	April 2019	Jan 2019	Nov 2018	Sept 2018	Key Risks/issues	Key actions	Oversight
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	4	-	16	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	-	16	16	20	20	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 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	20	Urgent Care pressure and increased demand on Diagnostic and Elective work Late decisions in A/E Beds coming up late Lower discharges at weekends Staffing in key departments Changes in pension rules	Urgent Care programme plan SAFER ECIP support Enhanced pathways as part of the new streaming model	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability – delivery of control total surplus	DOF	4	4		16	16	16	16	20	Delivery of ICIPs In year cost pressures Agency cost pressures (links to workforce) Income/contracting risk Commissioning decisions Transformation funding Cash flow iFM performance System wide savings PSF risk	PMO and ICIP escalation meetings IPM Integrated Care partnership development Actions to address agency pressures PBR review Develop links with specialist commissioners Development of joint budgets within local system Review of costs and income iFM development including strategy and business plan System wide savings governance	F&I committee Board IPM Transformation Board ICIP escalation
5.4	Achieving sustainable services through collaboration within the NW sector	Dir Strat.	4	4		16	16	16	20	20	Estates and IT challenges Healthier Together/GM devolution	Ongoing discussions with WWL Involvement in theme three work Development of local care partnership	Board F&I

All information provided in this written report was correct at the close of play 20.06.19 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:	19 June 2019	Date of next meeting:	17 July 2019
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	D Hall, J Njoroge, J Bene, T Armstrong Child, A Ennis, F Andrews. Representation from the four clinical divisions	Quorate (Yes/No):	Yes
		Key Members not present:	M Brown, A Ennis, D Sankey

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story		The QA committee received a story outlining the care provided by the A&E team to an independent elderly lady following a fall resulting in a fractured wrist	Story and quality of care provided noted
Clinical Governance and Quality Committee Chair Report		No risks escalated but a red flagged in relation to compliance with NATSSIPs where the committee have agreed the development of a policy and the adoption of standard documentation The Committee received an update on nasogastric tube misplacement and the nutrition steering group report –	The QA Committee noted the actions requested by the Clinical Governance Committee QA Committee members agreed that an update on nutrition guidance would be presented to the Board in September
Elective Care divisional quality report		The Committee commended the report which provided a balance view of challenges and successes.	Although no incidents have been reported, an action was requested to provide further assurance that actions taken to increase MRI capacity do not have an impact on patient outcomes
Family care – divisional quality report		The Committee commended the report which provided a balance view of challenges and successes.	The QA Committee were assured that the actions taken in relation to the Saving Babies Lives Programme were having a positive impact
Medicines Optimisation update		The chief Pharmacist attended to provide his six monthly update focusing on actions taken to support the safe and effective use of medicines across the organisation	Action noted

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

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

Committee/Group Chair's Report

Learning from Deaths		The Medical Director provided details of the new learning from deaths process. 33 reviewers have now been trained to undertake reviews which in addition to the mandated cases for review will include a random sample and review where a patient's family/next of kin have expressed concerns	The Committee commended the report and process – follow up report to be provided in July and then a regular quarterly report
Falls quarterly update		Paper presented providing a summary of falls data which shows continued reduction in falls and an analysis of themes contributing to falls which will be addressed through a new action plan	Report noted
Bowel cancer screening report		Progress has been made in reducing waiting time however this is reliant on additional capacity some of which has been provided by eternal partners. The system remains fragile with limited resources across GM	The committee discussed the workforce challenge and agreed to continue to monitor – update requested in three months
Quality Dashboard		Noted the quality metrics, discussions focused on the mortality indicators which remain high	
CNST maternity incentive year two		The team provided a summary of evidence prepared for submission to CNST – currently two pieces of evidence still outstanding – the Committee were advised that these would be provided before the submission	Final report to QA Committee in July prior to seeking formal Board approval in July 2018
CQC insight report - overview		Challenges in relation to a number of metrics highlighted, Committee members discussed the use of the report and agreed a proactive response was required to seek assurance with regard to the actions being taken	Further action requested from the Clinical Governance Committee
SI reports		The Committee reviewed three final SI reports – two reports were approved for submission to the CCG. Committee members felt that further detail was required for the third report relating to a surgical never	

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

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Committee/Group Chair's Report

		event	
Patient Experience, Inclusion and Partnership Committee		No areas escalated, all agenda items rated as green	Report noted
Mortality Committee		The Committee are continuing to focus on the increased mortality indicators and the actions being taken in response to the mortality action plan	
Risk Management Committee		Bowel cancer screening risk discussed as per previous agenda item	
Strategy and Transformation Board		Updates received on the development of the new strategy, ICIP delivery and the OPD transformation programme	Report noted
IT and Information Committee		EPR implementation on schedule, Community mobile devices being rolled out	
Falls Steering Group		Reports noted	
Comments			
Risks Escalated – further assurance requested in relation to CQC insight report and in relation to the actions required following the surgical never event			

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

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	25th June 2019	Date of next meeting:	23rd July 2019
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Martin North, Annette Walker, Andy Ennis, Bilkis Ismail, Rachel Hurst, Andy Chilton, Catherine Hulme	Quorate (Yes/No):	Yes
		Key Members not present:	Jackie Bene

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
Month 2 Finance Report		Deputy Director of Finance (AC)	The financial position to the end of May 2019 (Month 2), excluding PSF, is a deficit of £4.6m, against a deficit plan of £2.3m, an overall shortfall of £2.3m. Taking PSF into account the deficit is £3.9m. The main reasons for the shortfall are: • ICIP off track by £1.0m • Income under plan by £0.7m • Expenditure run rate £1.6m worse than plan The Committee considered a range of scenarios looking at the impact in terms of the full year position which reflected best case, probable case and worst case outcomes. Of particular concern was in respect of the ICIP which showed schemes to the value of £8.8m categorised as red. This means that the schemes currently do not have a full plan and QIA in place to deliver the savings. Of this sum c£6.0m relates to system wide savings across the Health Economy. The Committee were advised that a system wide group has been established, but has not yet met, to consider this issue. However, this does constitute a major risk to the Trust's position. Capital spend/cash position/Better Payments Practice Code are all currently showing strong performance.	For noting.

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

Committee/Group Chair's Report

Financial Recovery Plan		Director of Finance	The Committee considered a comprehensive report from the Finance Director on the financial recovery plan as a consequence of the financial position at Month 2. The report set out a range of scenarios together with an extensive list of actions to bring the position back into balance. However, this is going to be a significant challenge for the Trust, particularly with regard to the system wide savings.	For assurance to the Board.
2019/20 Integrated Care Systems Finance Regime - Update		Director of Finance	The Committee received a paper on the 2019/20 Integrated Care System Finance Regime which had been considered at the Strategic Partnership Executive Board. The Committee's recommendation to the Board is to approve the proposed approach and this will be considered in part 2 of the Board.	For approval by the Board.
Overdue Debt		Head of Financial Services	One of the areas that the Committee is focusing on is the level of overdue debt. A report was received from the Head of Financial Services setting out an analysis of the aged debt. Particular focus was on overdue debts over 180 days which totalled c£1.0m. A range of actions are in place to chase up the debt and in some cases this is offset by monies owed by the Trust to the corresponding organisation. It was recognised that some of the debt may need to be written off and there is bad debt provision in the balance sheet for this purpose. The Committee will receive monthly updates on the progress in relation to payment of the debt.	For noting.
iFM Finance Paper		Director of Finance, iFM Bolton	The Committee received an update from the Director of Finance of iFM on the financial position of iFM. Overall iFM have reported a profit of £28.0k at the end of Month 2 against a target of £91.0k. They are projecting that taking into account the ICIP programme that they will be back on track from the end of Quarter 1.	For noting.
The Children and Young People's Integrated Health and Wellbeing Service (0-19/25 Services)		Director of Finance	An update was received on the financial aspects of this service. There are some financial risks associated with the service but assurance was given that these are all being dealt with.	For noting.

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Committee/Group Chair's Report

Annual Report of the Finance & Investment Committee		Deputy Director of Finance (RH)	The Committee agreed the Annual Report of the Finance & Investment Committee which will be presented to the Board in July for consideration and approval. The report considered performance against the 10 objectives for 2018/19 with 8 rated as green and 2 as amber. The Committee considered its objectives for 2019/20 for approval by the Board and have recommended 11 objectives on which assurance will be provided.	For approval by the Board in July 2019.
Annual Terms of Reference Review		Deputy Director of Finance (RH)	The Committee reviewed its Terms of Reference and have recommended some minor changes for consideration and approval by the Board.	For approval by the Board in July 2019.
Other updates		Director of Finance/ Chief Operating Officer	The Committee also received updates in respect of: • Capital & Revenue Investment Group. The main item considered by the Group was a report into the replacement of the site wide fire alarm and detection network equipment. A major piece of work is being undertaken to assess the requirements which is likely to result in significant financial cost of c£600k plus VAT over the next two years. • Digital Transformation Board.	For noting.

Risks escalated

The Committee considered the overall risk with regard to the financial position taking into account the financial recovery plan. The current risk rating is 16 and the Committee recommended no change at this point in time. However, this will be subject to review at Quarter 1 as the Committee took into account a number of actions that are expected to impact in Month 3.

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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:	21st June, 2019	Date of next meeting:	19th July, 2019
Chair:	J Bene	Parent Committee:	Trust Board
Members present/attendees:	T Armstrong-Child, F Andrews, J Mawrey, C Sheard, L Gammack , A Chilton and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce Equality – WRES (Race) and WDES (Disablity) Annual report		• The Committee considered the details of the WRES and WDES findings. It was noted that whilst improvement had been made in some areas significant work continues to be required. The Committee noted that there would be a focused discussion on inclusion at the next meeting and as such proposed actions moving forward would be agreed at this meeting. • For the first time the EDI findings were presented at Trust and Divisional level. Which the Trust noted is critical in developing Trustwide and local actions. • The Committee noted the focused work that had recently taken place by J Seddon on the Workforce Equality agenda.	**Actions agreed:-** • The Committee supported that the next meeting would be focused on the Workforce Inclusion. • The WRES and WDES reports will be presented to the Trust Board in August.
Workforce & OD Dashboard		• The Committee received the Integrated Workforce Performance Report. The report triangulated key workforce data to support informed discussions. • Detailed discussions took place regarding key workforce metrics such as Sickness, Headcount, Agency, Recruitment and turnover.	**Actions agreed:-** • Focused discussions at the next meeting on the reasons for headcount increase, and for this to be triangulated against non-core spend reductions (Agency, Overtime and Bank).

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Committee/Group Chair's Report

OD Metrics		• An update report was received on the enabling actions that are taking place to support in further driving up OD metrics.	**Actions agreed:-** • Report noted.
Bolton Workforce Locality / Integration		• An update report was received on the actions that are taking place to support workforce integration / collaboration agenda.	**Actions agreed:-** • Report noted
Guardian of SafeWorking (GOSW)report		• The Committee received an update from the GOSW (via the Medical Director). The Committee again noted their disappointment at the quality of the report and as such could take little assurance from the details of the paper.	**Actions agreed:-** • Deep Dive paper to come to August Committee setting out clearly the improvement actions that are being taken.
Interim People Plan		• Committee members were updated as to the details of the Interim People Plan for the NHS, which was published by NHS England/Improvement on 3rd June, 2019. The final plan is scheduled to be published in Autumn, 2019. • The Committee felt that all of the key themes within the plan were already covered in the Trust's Workforce & OD Strategy. The details of the Plan would though be included in the Trust's formal review of the WOD Strategy, which will take place in line with the Trust's Strategy.	**Actions agreed:-** • Report noted • Workforce & OD Strategy to be reviewed by Board in September/October and details included of the Interim People Plan to be included within this review.
Scholarship Nursing		• The Committee approved the development of a scholarship nursing programme. The programme would be piloted by offering an existing colleague within the Trust the opportunity to undertake study for their full nursing qualification on a funded basis. • Committee noted that the Executive team had fully considered the financial / operational / human resources implications in advance.	**Actions agreed:-** • Report noted • DoN&M and DoW to consider process for appointment and communication plan.

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

Committee/Group Chair's Report

Workforce Cost Improvement		• The Committee received an update on the work programmes related to Workforce within the Trust's Cost Improvement Programme. Specifically Medical Workforce (led by MD), Nursing & AHP Workforce (led by DoN&M) and other Workforce (led by DoW).	**Actions agreed:-** • Paper noted
Equality, Diversity and Inclusion Steering Group		• The Chairs report was noted	**Actions agreed:-** • Paper noted
Electronic Staff Record Steering Group		• The Chairs report was noted	**Actions agreed:-** • Paper noted
Education Governance Group		• The Chairs report was noted	**Actions agreed:-** • Paper noted
Risks escalated • Pensions and tax item. Discussion taking place in Part 2 Trust Board			
Recommendations to Trust Board • Full support of the Freedom to Speak Up Report has previously be given (last meeting) and this will be presented to this month's Trust Board			

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

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Urgent & Emergency Care Board	Report to:	Board of Directors
Date of Meeting:	11th June 2019	Date of next meeting:	9th July 2019
Chair:	Su Long	Parent Committee:	Board of Directors
Members Present:	All System representatives present	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Reducing Long LOS Delivery Plan	Amber	AE	• National and regional directive • Targets and trajectories agreed • ECIST feel we have SAFER well embedded but that there are still opportunities to improve especially around escalation of care and the management of patients with Mental Health needs	• Need to progress the reducing LOS work with partners especially GMMMH
Presentation around Housing Advice and Support Officer Role - Older People and DTOC	Green	Paul Cohen	• Good work in supporting older people with housing queries especially when wanting to relocate and downsize across Bolton • Helping identify rapid housing solutions to support patients with complex needs being discharged from hospital or IMC • Good work in finding housing solutions for the homeless	• Presentation noted • Considerable savings noted as well as better personal outcomes for the public • Seeking to expand the model of care
Care Home Transformation Scheme evaluation	Amber		• Most schemes with the exception of Immedicare to continue or be re-evaluated in 3 months if they were late to start • No immediate risk to urgent care performance	• Paper and actions noted
Comments Review of dashboard noted improving metrics regards attendances and admissions from care home sector.				
Risks escalated **None**				

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	Assured – no or minor impact on quality, operational or financial performance

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

Agenda Item No: 12

Meeting	Trust Board

Date	27 June 2019

Title	Freedom to Speak Up Annual Report

Executive Summary	This report provides an annual update on Freedom to Speak Up activity within the Trust during 2018–2019. Effective speaking up arrangements help to improve patient safety, staff experience and continuous improvement.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	The Trust Board is asked to note and discuss this paper. The paper has been previously reviewed (and commended) by the Workforce Assurance Committee

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

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	Tracey Garde, FTSU Guardian & Lisa Gammack, Head of OD	Presented by	Tracey Garde, FTSU Guardian James Mawrey Director of Workforce

1. Background

1.1 Effective speaking up arrangements help improve patient safety, staff experience and continuous improvement. This report provides an update from the Trust's newly appointed Freedom to Speak Up (FTSU) Guardian on FTSU activity for the period from 1 April 2018 to 31 March 2019.

1.2 During the period from 29 October 2018 to 31 March 2019 the Guardian role was performed by Tracey Garde (a Matron within Acute Adult Division) on a part-time secondment basis (0.4 WTE). Following a robust internal recruitment process Tracey was appointed to the Guardian role on a permanent basis (0.6 WTE) with effect from 15 April 2019.

1.3 The Guardian has recruited and trained a network of 13 FTSU Champions to strengthen the FTSU approach. The network is diverse in terms of the champions' gender, ethnic background, job roles and employing department. The Guardian intends to recruit additional champions in October 2019 during the National Speak Up Month which is a campaign led by the National Guardian's Office.

1.4 The FTSU approach is continually promoted via the Trust's normal internal communication channels. The Guardian also presents at the Trust's values based corporate induction programme. In addition the Guardian has delivered various presentations to staff groups and has visited numerous workplaces to promote the FTSU approach and raise awareness.

1.5 The Guardian continues to meet monthly with the Chief Executive and the Executive Director of Workforce and OD. At these meetings the Guardian provides an overview of the cases reported and the themes identified. The Chief Executive and Executive Director ensure that policies and procedures are being effectively implemented, help unblock any barriers that enable swift action to be taken to resolve cases and ensure that good practice and learning is shared across the organisation. The Non-Executive Director for FTSU has an open invitation to attend the monthly meetings.

2. FTSU Cases

2.1 During the period from 1 April 2018 to 31 March 2019 **16 cases** were reported through the FTSU route. This is significantly higher compared to a total of 3 cases that were reported in the previous year but below the average of 43 for Acute and Community Trusts in 2017/18.

2.2 Table 1 below shows the number of cases during 2018/19 broken down by each quarter. The Guardian formally reports the number of cases for each quarterly period to the National Guardian Office.

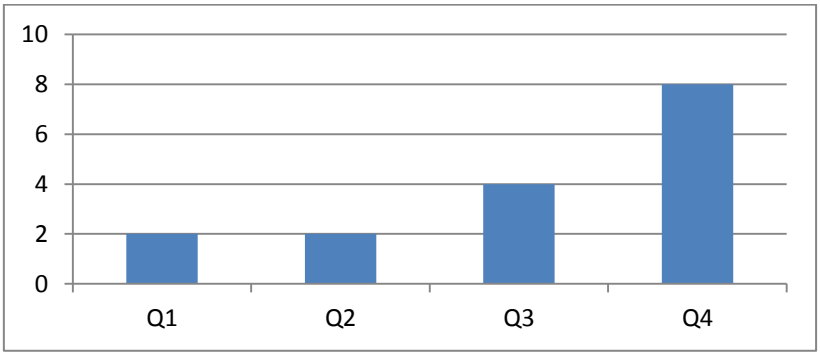


Table 1: 2018/19 breakdown of cases by quarterly reporting periods

2.3 In addition, table 1 shows that 75 % of cases (12 in total) reported during 2018/19 occurred since the introduction of the new strengthened approach in November 2018.

2.4 Table 2 below shows how Bolton FTSU activity compares with other Trusts in the sector. All Trusts are seeing an increase in staff speaking up which is a positive indicator of a speaking up culture. Colleagues will recall from the NHS Staff Survey that our staff generally feel able to speak up and that when they do then appropriate action is taken. (Bolton benchmarks positively in this area).

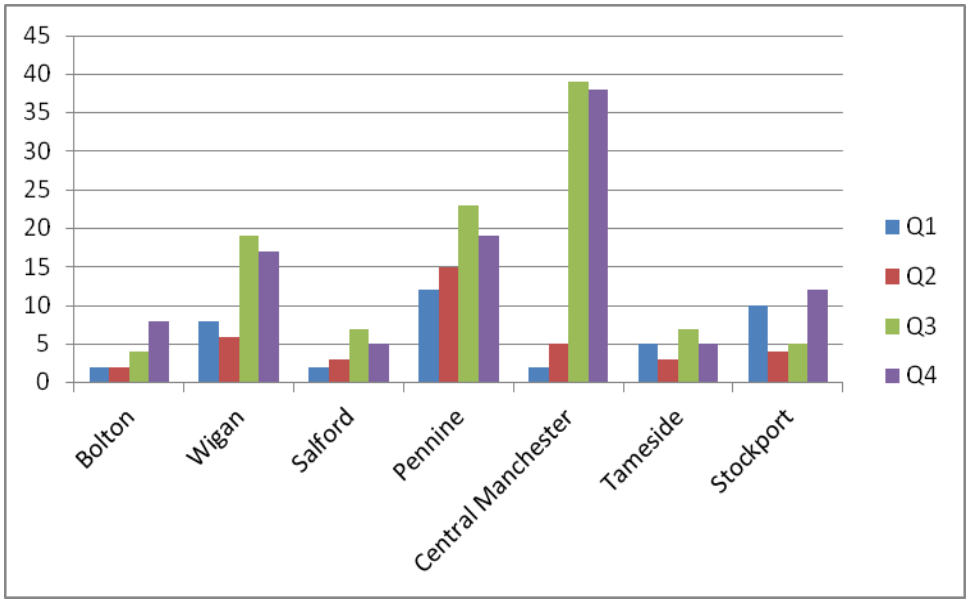


Table 2: Comparison of number of cases across sector

2.5 The cases in Bolton related to allegations of poor patient safety/quality and bullying/harassment as detailed in table 3 below. Some staff raised allegations relating to both which explains why the table below suggests there have been 18 cases when in reality there were 16.

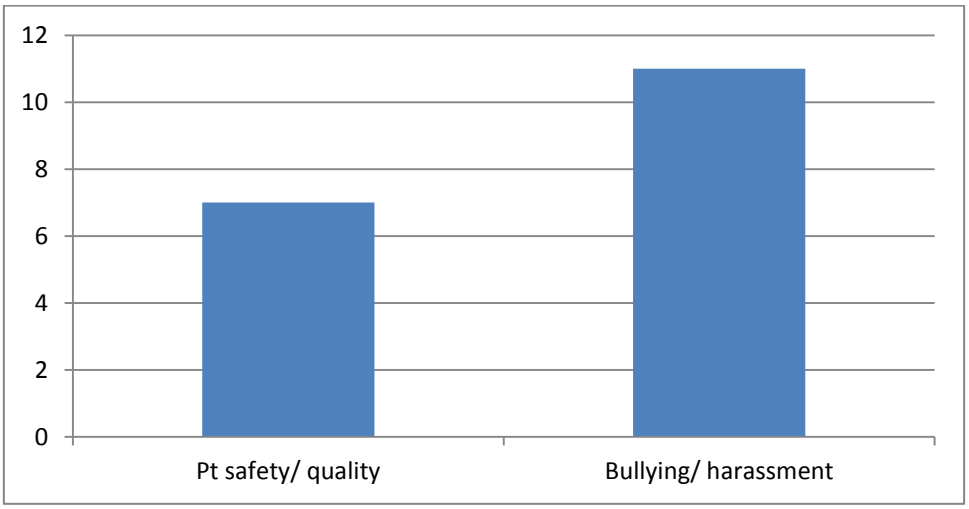


Table 3: 2018/19 breakdown of types of cases

2.6 Table 4 below provides a breakdown by Division of the number of cases raised by staff. 50% of the cases during 2018/19 were staff employed within the Adult Acute Division. It is likely that the significant increase in reporting is due to the fact that the new FTSU Guardian was employed within that division for a significant period of time and is therefore well known to staff. The 4 cases recorded as 'unknown' relate to 4 concerns raised with the previous FTSU Guardian. Unfortunately we do not have complete recording information relating to these cases. The one case recorded as 'other' was raised by an ex-employee who was previously employed in the Adult Acute Division.

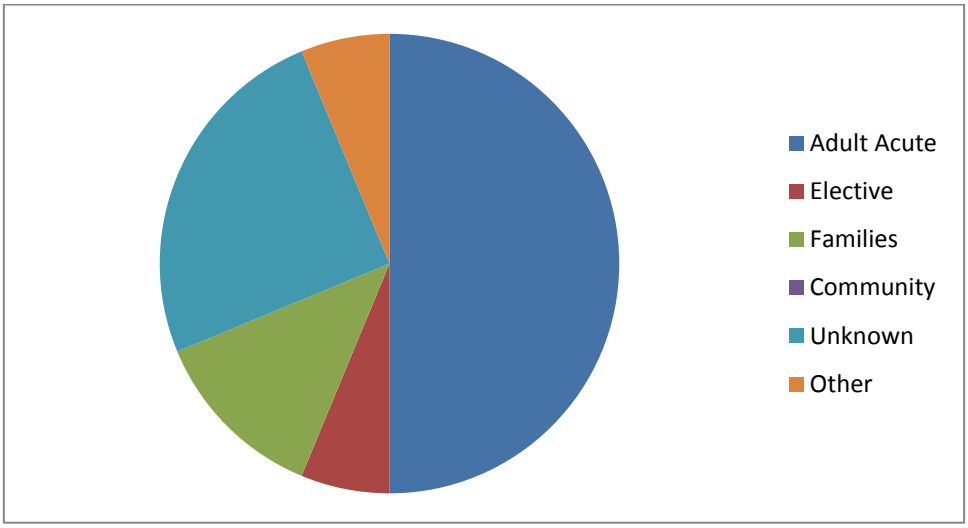


Table 4: 2018/19 Divisional breakdown of cases

2.7 Table 5 below provides a divisional breakdown of cases by theme. Some staff concerns related to patient safety/quality and bullying/harassment which explains why the table below suggests there have been 18 cases when in reality there were 16.

Division	Total Number of Concerns	Theme	
		Patient Safety / Quality	Elements of Bullying / Harassment
Adult Acute	8	2	5
Integrated Community Services	0	0	0
Elective	1	0	1
Families	2	2	1
Other	1	3	1
Unknown	4	0	3
Total	**16**	**7**	**11**

Table 5: 2018/19 Divisional breakdown of cases by theme

2.8 Of the 16 cases in 2018/19, action has been taken to resolve 15 cases, 1 case has been partially dealt with and remains under review. The Chief Executive and the Director of Workforce and OD are sighted on the progress being made in these cases.

2.9 The majority of cases have been raised by staff from a White British background. 2 members of staff from a BME background also raised concerns that related to racial issues.

2.10 The majority of cases (7 in total) have been raised by nursing staff either qualified/unqualified or student nurses.

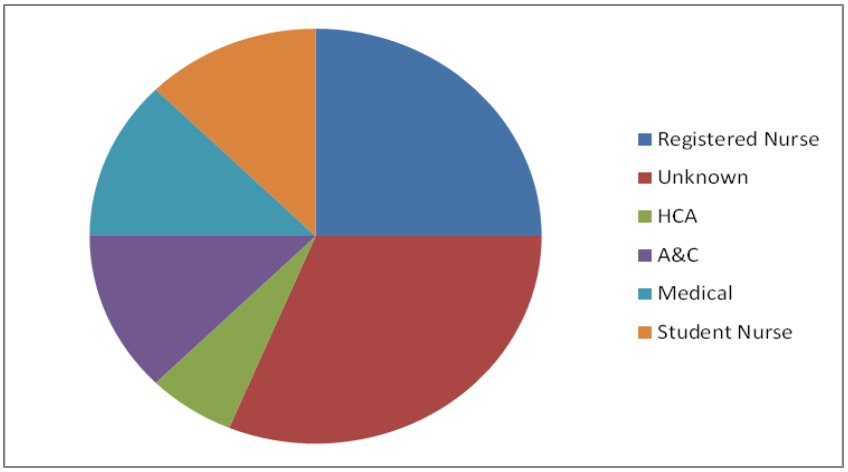


Table 6: 2018/2019 Breakdown by staff group

3. Conclusion

3.1 It is evident that the refreshed FTSU approach is having a positive impact. Through the concerns raised we are gaining new insights into our culture and how we can improve systems, approaches and our environment to make speaking up business as usual within this Trust.

3.2 The refreshed FTSU approach is new and evolving. To ensure staff are effectively supported to raise and resolve concerns we intend to further clarify roles and responsibilities of the Guardian, FTSU champions, HR colleagues, managers and staff side representatives and communicate this clearly to the workforce.

3.3 The FTSU cases have further highlighted that we need to do more to communicate to staff how we expect them to behave and what constitutes bullying and harassment. The new Unconscious Bias Training Programme, which will be rolled out across the Trust from June 2019 onwards, will be a significant step forward in helping to develop a more positive and inclusive workplace culture. In addition, the development of a Staff Deal and a refreshed articulation of how we expect managers and staff to behave will provide new tools to help tackle bullying and harassment. This along with a zero tolerance bullying campaign and behaviour skills training package will also help.

3.4 Furthermore, our 2018 NHS national staff survey results show that 11% of staff reported that they had suffered personally from bullying/ harassment from managers/ This is a 1% decrease compared to our 2017 results but the same level as our benchmarking group. Also in the 2018 national survey, 17% of staff reported personal experience of bullying/harassment from colleagues. This is 1% lower than our benchmarking group but 4% higher that our previous year's results. It further evidences that we need to do more to promote a positive culture to tackle bullying.

3.5 The FTSU cases relating to poor patient safety/quality have highlighted that we need to do more to create a culture where we learn from mistakes and we develop a more open and supportive environment which encourages continuous improvement. The work being undertaken around our Quality Improvement Strategy will support this. The staff survey also demonstrates that if staff are concerned about unsafe practice 95% of staff would know how to report it which equals the sector.

4. Recommendations

4.1 It is therefore recommended that the Trust Board:

- Note the contents of this report and consider whether any further actions are required.

NHS Bolton NHS Foundation Trust

Agenda Item No	

Meeting	Trust Board

Date	27th June 2019

Title	7 Day Services Report

Executive Summary	This paper describes the revised 7 day services Board Assurance framework and measures our performance against the 10 required standards as well as relevant actions still required. A copy of the required completed return for NHS Improvement is given as an appendix and requires approval from the chair of the board

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

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

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

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

Prepared by	Dr Francis Andrews, Medical Director	Presented by	Dr Francis Andrews, Medical Director

Introduction

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

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

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

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

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

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

The four priority standards

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

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

Evidence source 1 – consultant job plans

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

Evidence source 2 – local clinical audit

If a provider believes it has sufficient consultant presence to deliver the standard in theory, this should be evidenced by data from audits of delivery taken from patient case

notes or data taken from electronic patient records if these are able to provide this information.

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

Evidence source 3 – wider performance and experience measures

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

Current evidence for Bolton FT for standard 2:

Evidence	RAG	lead	Key points	Action
Consultant job plans		DMDs	Apart from critical care and obstetrics/gynaecology, Consultant job plans do not yet contain sufficient daily presence to support this standard in electives. Acute medicine close to compliance.	Previous modelling for a compliant 7DS has shown significant cost pressure. Review of previous modelling for each division by September 2019 for each directorate
Local audit (70 patients)		Clinical effectiveness	Audit completed	Need to breakdown data by speciality and feedback-end of June
Wider performance		Francis Andrews	-GMC survey 2018: Handover and supportive environment within range for all specialities except GP O&G -Weekend HSMR 'as expected'	Explore other metrics such as RCP guidance on safer staffing Complete by September 2019

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

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

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

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

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

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

Self-assessment of delivery of this standard should be based on a response to the Following question for each of the interventions:

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

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

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

			locally can provide this	

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

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

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

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

Evidence source 1 – consultant job plans

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

Evidence source 2 – systems to support ongoing review

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

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

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

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

Evidence source 3 – local clinical audit

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

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

Evidence source 4 – wider performance and experience measures

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

Evidence	RAG	lead	Key points	Action
Consultant job plans		DMDs	Critical care compliant and general paediatrics; acute medicine partially compliant, but no other speciality is	Need to look at medical and general surgical job plans as per standard 2 but also examine in these areas whether delegation is working in practice
Systems to support		DMDS	-NEWS scoring fully implemented -Board round system in place in acute medicine and paediatrics -no formal process to decide on whether to review except paediatrics	Implementation of board round review and process on who to review by October 2019 for each directorate
Local audit		CE	Audit completed	Need to breakdown data by speciality and feedback
Wider performance		Francis Andrews	-GMC survey 2018: Handover and supportive environment within range for all specialities except GP O&G -Weekend HSMR 'as expected'	Explore other metrics such as RCP guidance on safer staffing Complete by September 2019

Standards for continuous improvement

The standard and the relevant evidence required are detailed below

1 – Patient experience
Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends. Feedback from wider sources of patient experience, such as levels of complaints and local Healthwatch feedback directly related to quality of care on weekdays and at weekends
3 – Multidisciplinary team review
Assurance of written policies for MDT processes in all specialties with emergency admissions,

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

Assessment of compliance for continuous improvement

Standard	RAG	Lead	Key points	Action
1. Patient experience		Tracy Joynson	FFT: very little information on doctors, and mainly positive. No issue from Healthwatch and national in patient survey doesn't cover this.	To capture weekday/weekend category for PALS & complaints database
3. MDT review		Marie Forshaw Steve Simpson	-Adult discharge and transfer of care policy -Medicines policy covering medicines reconciliation	Further evidence for
4. Handover		DMDs	Fully compliant and audited for Obstetrics and gynaecology, critical care and acute medicine; SOP for general surgery, orthopaedics, general paediatrics,	Need to ensure handover regularly audited in all divisions and reported to MRG by September 2018. Medical Director to provide handover policy by October 2019.
7. Mental Health		RAID team	Fully compliant as confirmed with RAID team	None
9. Transfer to community, primary and social care		Rae Wheatcroft	Fully compliant as confirmed with operational services and pharmacy	None

10. Quality improvement		Francis Andrews	QI strategy which is monitored at Mortality reduction group; Learning from deaths looks at day of admission, monitoring of HSMR weekend and weekday mortality, readmissions monitored, length of stay monitored at IPM, Guardian of safe working report	Some metrics such as readmissions and length of stay and GOSW report need further analysis by weekend/weekday. September 2019

Conclusion

This paper has highlighted the new BAF process for 7 day services and provided evidence for Bolton FT. Regarding standards 5 and 6 we are compliant except for non-vascular interventional radiology. . Further work is required to explore different ways of consultant working and job plans and the potential to improve on consultant availability. Further assurance is required around board rounds, hand over; and wider evidence to support standards 2 and 8. A return has been completed in the format required by NHS Improvement; however no all the information detailed in this paper is required for this return

7 Day Hospital Services Self-Assessment

Organisation	**Bolton NHS Foundation Trust - Royal Bolton Hospital**
Year	**2019/20**
Period	**Spring/Summer**

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Our overall percentages for patients seen by a consultant within 14 hours were 54% during the weekdays and 57% at weekends. The admitting specialities captured in the randomised casenote review were as follows; Acute Medicine, Cardiology, Generaly Surgery, Geriatric Medicine, Paediatric Medicine, Trauma and Orthopaedics and Other (ENT & General Medicine). The overall (weekday + weekend) range of percentages, for patients seen within 14 hours - 44%-75% (mean 57%) Weekday percentages of patients seen by a consultant within 14 hours, broken down by specialty; Acute Medicine 58%, Cardiology 67%, Generally Surgery 56%, Geriatric Medicine 67%, Paediatric Medicine 40%, Trauma and Orthopaedics 57%, Other (ENT & General Medicine) 38%. Weekend percentages of patients seen by a consultant within 14 hours, broken down by specialty; Acute Medicine 60%, Cardiology 100%, Generally Surgery 38%, Geriatric Medicine 60%, Paediatric Medicine 75%, Trauma and Orthopaedics 50%, Other (ENT & General Medicine) 100%.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

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

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

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients requiring once daily review: There were 174 weekday once daily reviews required in the audit, 149 of these once daily reviews were completed (84%) narrowly missing the standard of 90%. There were 66 weekend once daily reviews required in the audit, 48 of these once daily reviews were completed (73%). Patients requiring twice daily review: There were 17 weekday twice daily reviews required in the audit, 15 of these twice daily reviews were completed (88%) narrowly missing the standard of 90%. There were 2 weekend twice daily reviews required in the audit both of these were completed (100%).	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

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

7DS and Urgent Network Clinical Services

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

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

Template completion notes

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

Integrated Summary Dashboard - May 2019

NHS Bolton NHS Foundation Trust

Executive Summary

Trust Objective	RAG Distribution	Total
Quality and Safety		
Harm Free Care		18
Infection Prevention and Control		10
Mortality		4
Patient Experience		16
Maternity		10
Operational Performance		
Access		11
Productivity		12
Cancer		7
Community		4
Workforce		
Sickness, Vacancy and Turnover		3
Organisational Development		6
Agency		3
Finance		
Finance		5
Use of Resources		
Model Hospital		22
Appendices		
Heat Maps		

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 significantly underperforming against the plan for the relevant period (latest, previous, year to date).
	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

NHS Bolton NHS Foundation Trust

Quality and Safety

Harm Free Care

Pressure Ulcers
The number of pressure ulcers in the hospital did not exceed the planned target for May. In the community, there were twelve Category 2 pressure ulcers, five over the target of seven in the month. There was a reduction in Category 3 pressure ulcers, bringing the number below target, and there were no Category 4 pressure ulcers in the month of May. The number of lapses in care was over trajectory, with five lapses in care in the hospital, and two lapses in the community.

Falls
Year to date performance during quarter 1 is within target. Quarter 4 falls update was presented to Quality Assurance Committee in June, which included a comprehensive work plan for the three identified high impact changes that it is anticipated, will support a further reduction in falls this year.

The first CQUIN audit for falls commences June and is planned to continue weekly in the next quarters . Further progress will be reported in the quarterly reports to the Quality Assurance Committee.

Clinical Correspondence - Outpatients
The decrease below plan is due to ongoing sickness across divisions and there is no secretarial bank. This has been escalated to the Workforce Assurance Committee (WAC)

	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%	96.2%	May-19			>= 95%	96.6%	Apr-19		>= 95%	96.4%		95.4 - 97.8%	
9 - Never Events	= 0	0	May-19			= 0	0	Apr-19		= 0	0		0 - 1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.68	May-19			<= 5.30	4.49	Apr-19		<= 5.30	5.08		3.60 - 5.88	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	2	May-19			<= 1.6	1	Apr-19		<= 3.2	3		1 - 5	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	6.0	May-19			<= 6.0	8.0	Apr-19		<= 12.0	14.0		2.0 - 10.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	May-19			<= 0.5	0.0	Apr-19		<= 1.0	0.0		0.0 - 2.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	May-19			= 0.0	0.0	Apr-19		= 0.0	0.0		0.0 - 0.0	

Integrated Summary Dashboard - May 2019

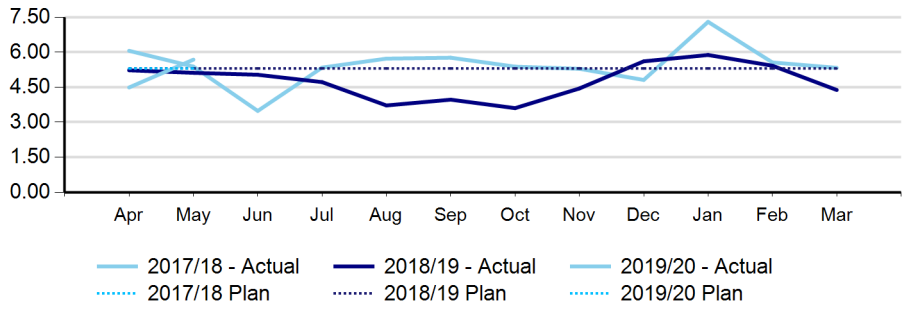
NHS Bolton NHS Foundation Trust

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	12.0	May-19			<= 7.0	8.0	Apr-19		<= 14.0	20.0		2.0 - 12.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	2.0	May-19			<= 4.0	8.0	Apr-19		<= 8.0	10.0		1.0 - 10.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	May-19			<= 1.0	0.0	Apr-19		<= 2.0	0.0		0.0 - 3.0	
21 - Total Pressure Damage due to lapses in care	<= 6	7	May-19			<= 6	3	Apr-19		<= 11	10		2 - 8	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	94.3%	Q4 2018/19			>= 90%	92.5%	Q3 2018/19		>= 90%			90.1 - 94.3%	
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q4 2018/19			>= 90%	91.7%	Q3 2018/19		>= 90%			90.0 - 100.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 80%	79.8%	May-19			>= 80%	78.5%	Apr-19		>= 80%	79.2%		76.7 - 80.9%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	51.9%	May-19			>= 72.5%	50.1%	Apr-19		>= 72.5%	51.0%		50.1 - 85.1%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	87.5%	May-19			= 100%	100.0%	Apr-19		= 100%	93.8%		33.3 - 100.0%	
88 - KPI Audits linked to Bolton System of Accreditation (BOSCA)	>= 85%	93.2%	May-19			>= 85%	92.9%	Apr-19		>= 85%	93.1%		91.6 - 94.0%	
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	100.0%	May-19			= 100%	0.0%	Apr-19		= 100%	150.0%		0.0 - 100.0%	

Bolton NHS Foundation Trust

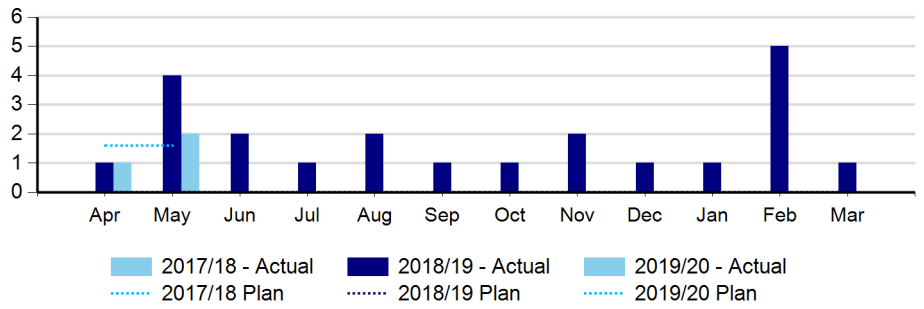
Exceptions

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



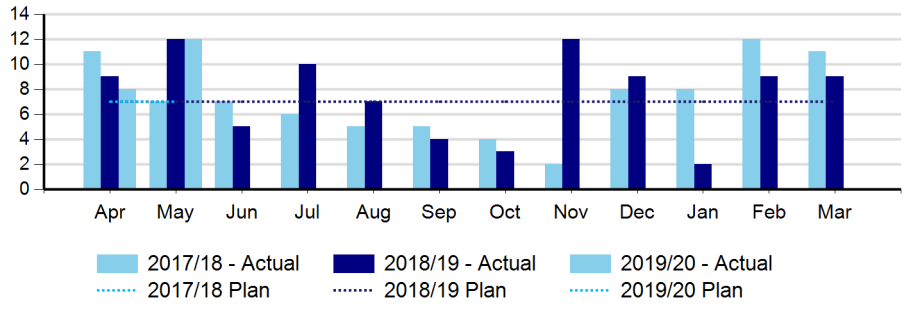
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6.06	5.38	3.48	5.34	5.72	5.76	5.38	5.29	4.81	7.30	5.56	5.33
18/19	5.22	5.11	5.03	4.72	3.72	3.97	3.60	4.45	5.61	5.88	5.42	4.38
19/20	4.49	5.68										

14 - Inpatient falls resulting in Harm (Moderate +)



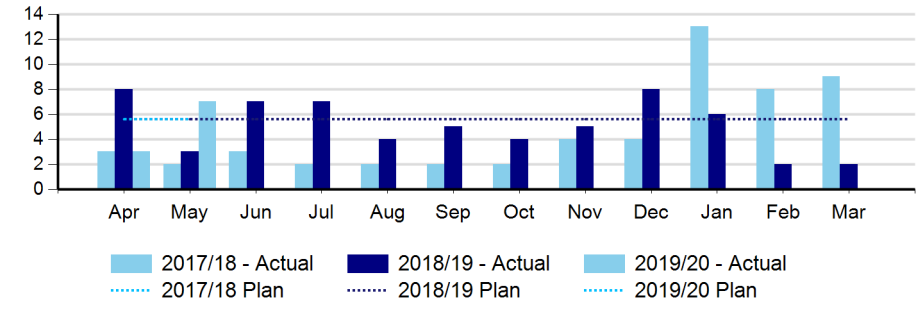
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18												0
18/19	1	4	2	1	2	1	1	2	1	1	5	1
19/20	1	2										

18 - Community patients acquiring pressure damage (category 2)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	11.0	7.0	7.0	6.0	5.0	5.0	4.0	2.0	8.0	8.0	12.0	11.0
18/19	9.0	12.0	5.0	10.0	7.0	4.0	3.0	12.0	9.0	2.0	9.0	9.0
19/20	8.0	12.0										

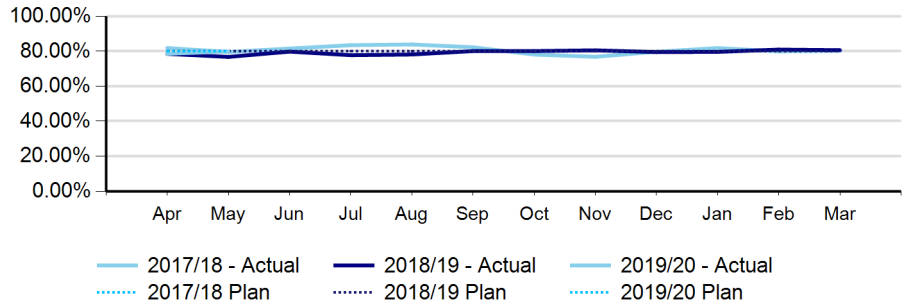
21 - Total Pressure Damage due to lapses in care



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	2	3	2	2	2	2	4	4	13	8	9
18/19	8	3	7	7	4	5	4	5	8	6	2	2
19/20	3	7										

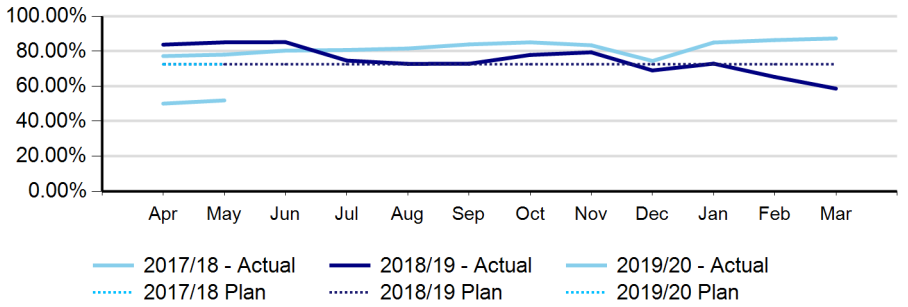
Bolton
NHS Foundation Trust

30 - Clinical Correspondence - Inpatients %<1 working day



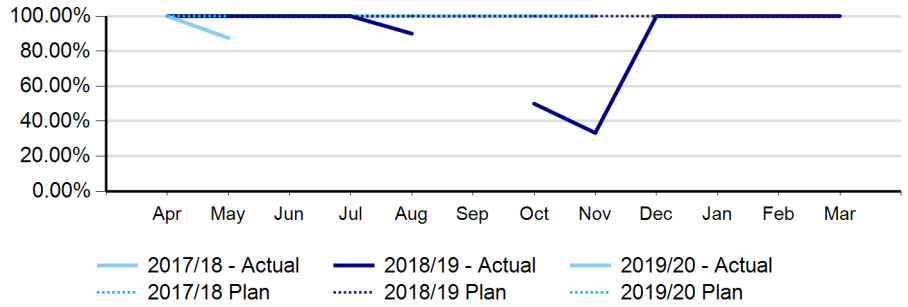
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	81.8%	79.5%	81.5%	83.4%	83.8%	82.2%	78.1%	76.8%	79.7%	81.8%	79.9%	80.2%
18/19	78.4%	76.7%	79.7%	77.7%	78.1%	80.0%	80.0%	80.5%	79.5%	79.6%	80.9%	80.6%
19/20	78.5%	79.8%										

31 - Clinical Correspondence - Outpatients %<5 working days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	77.2%	78.0%	80.3%	80.7%	81.5%	83.8%	85.0%	83.4%	74.4%	84.9%	86.3%	87.2%
18/19	83.7%	85.0%	85.1%	74.6%	72.7%	72.8%	77.8%	79.3%	69.0%	72.9%	65.3%	58.6%
19/20	50.1%	51.9%										

86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
18/19	100.0%	100.0%	100.0%	100.0%	90.0%		50.0%	33.3%	100.0%	100.0%	100.0%	100.0%
19/20	100.0%	87.5%										

NHS Bolton NHS Foundation Trust

Infection Prevention and Control

The blood culture contaminant rate across the Trust has fallen below the target 3% for the first time since it has been reported to the Board. The IPC Committee continues to monitor this metric to understand whether this is a sustained improvement.

There have been a further three CDT cases counting towards the year-end objective; a total of eight cases against the year-end target of no more than 32 cases.

There have been no new CPE cases on ward B3 since 21/04/19 – weekly and admission screening continues. There has been a teleconference with NHSi including PHE to discuss this matter. No new actions were suggested and it was agreed that the Trust would consider the outbreak over once there have been four weeks of negative weekly screens following the discharge of the last CPE positive patient

	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 Hospital Onset C.diff infections	<= 2	2	May-19			<= 3	4	Apr-19		<= 5	6		0 - 4	
346 - Total Community Onset Hospital Associated C.diff infections	<= 1	3	May-19			<= 1	1	Apr-19		<= 2	4		1 - 3	
347 - Total C.diff infections contributing to objective	<= 2	5	May-19			<= 1	5	Apr-19		<= 3	10		5 - 5	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	May-19			= 0	0	Apr-19		= 0	0		0 - 1	
218 - Total Trust apportioned E. coli BSI	<= 4	0	May-19			<= 4	4	Apr-19		<= 8	4		0 - 7	
219 - Blood Culture Contaminants (rate)	<= 3%	2.8%	May-19			<= 3%	3.5%	Apr-19		<= 3%	3.2%		2.8 - 6.8%	
199 - Compliance with antibiotic prescribing standards	>= 95%	85.2%	Q3 2018/19			>= 95%	86.0%	Q1 2018/19		>= 95%			85.2 - 85.2%	
304 - Total Trust apportioned MSSA BSIs	<= 1.3	0.0	May-19			<= 1.3	1.0	Apr-19		<= 2.6	1.0		0.0 - 4.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	<= 1	0	May-19			= 0	0	Apr-19		<= 1	0		0 - 3	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	<= 1	0	May-19			= 0	0	Apr-19		<= 1	0		0 - 1	

Bolton
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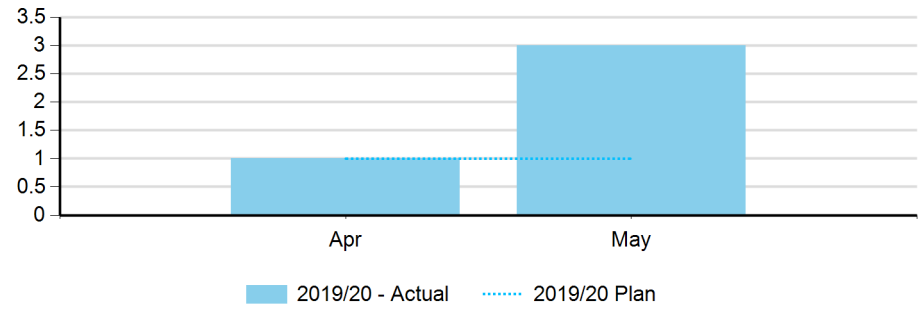
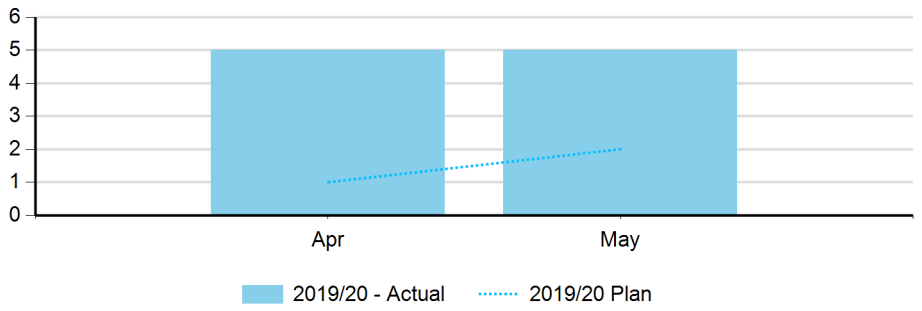
Exceptions

346 - Total Community Onset Hospital Associated C.diff infections



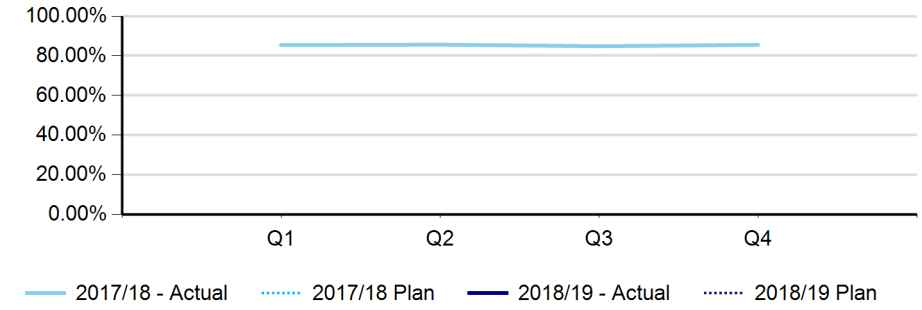
	Apr	May
19/20	1	3

347 - Total C.diff infections contributing to objective



	Apr	May
19/20	5	5

199 - Compliance with antibiotic prescribing standards



	Q1	Q2	Q3	Q4
17/18	85.4%	85.6%	84.8%	85.5%
18/19	86.0%		85.2%	

NHS Bolton NHS Foundation Trust

Mortality

There has been a slight decrease in crude mortality in May to 2.1%.

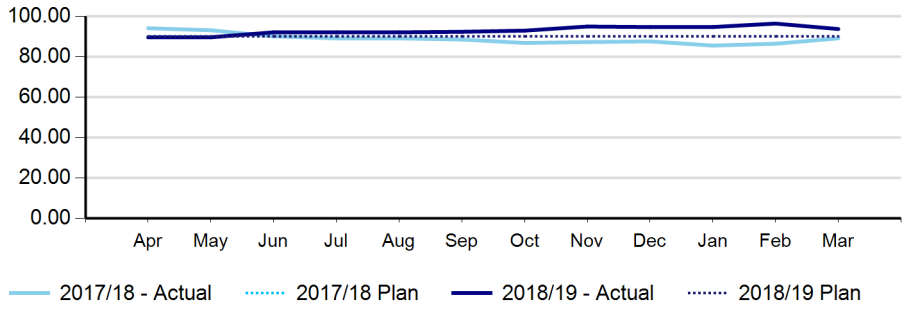
Risk Adjusted Mortality (ratio) has decreased to 93.6.

Standardised Hospital Mortality ratio is updated quarterly in arrears. This rise is due to a combination of pneumonia but also other conditions (especially congestive heart failure) and neonatal deaths. Pneumonia deaths have already been investigated. Heart failure and neonatal deaths are being examined via the Mortality Reduction Group.

	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%	90.8%	May-19		↑	>= 85%	87.5%	Apr-19		>= 85%	89.2%		85.1 - 100.0%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	93.6	Mar-19		↓	<= 90	96.3	Feb-19		<= 90			89.5 - 96.3	
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.00	119.00	Q3 2018/19		↑	<= 100.00	113.85	Q2 2018/19		<= 100.00			113.85 - 119.00	
12 - Crude Mortality %	<= 2.9%	2.1%	May-19		↓	<= 2.9%	2.2%	Apr-19		<= 2.9%	2.1%		1.9 - 2.7%	

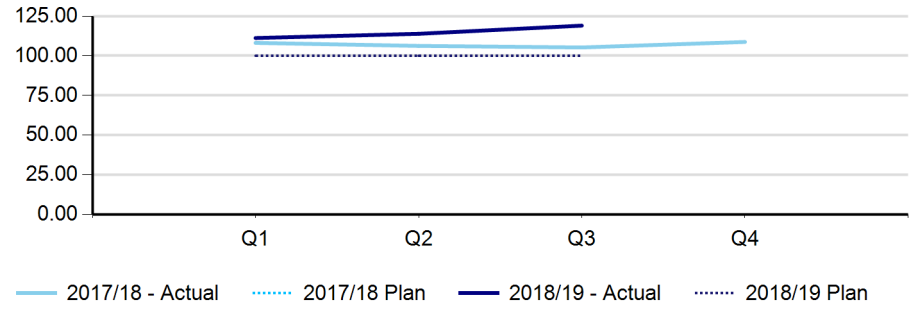
Exceptions

10 - Risk adjusted Mortality (ratio) (2 mths 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	92.0	92.2	92.8	94.9	94.6	94.6	96.3	93.6

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



	Q1	Q2	Q3	Q4
17/18	108.10	106.20	105.22	108.70
18/19	111.16	113.85	119.00	

NHS Bolton NHS Foundation Trust

Patient Experience

A&E Friends and Family
The response rate of 17.1% for May for both adults and children is an improvement overall although this remains slightly below the 20% Trust target. Although the recommended rate fell slightly to 91.1% this remains over the Trust target of 90%. The Division is reviewing the recommended rates to identify and act on any themes and is continuing with the current initiatives to improve on the responses rates.

In-Patient Friends and Family
The overall response rate for inpatient FFT improved in May at 29.5% slightly below the Trust target of 30%. Divisions are working closely with the Corporate team to support those wards that have low response rates with the inclusion and monitoring of iPad usage to improve this. Mid-month data is being provided to allow wards to have increased focus and it is expected that the response rates will continue to improve. Although recommendation rates overall fell to 96.7% this is also being monitored at Divisional level to identify any themes and to take action as appropriate. Due to a communication breakdown F5 did not collect FFT in May, this is in the process of being rectified.

Maternity Friends and Family
Response rates for Antenatal fell slightly to 15.2% but remained above Trust target of 15%. The Division continues to monitor recommendation rates and act on any negative comments received.

Complaints Responded to within the period
One complaint response was provided outside of the agreed target giving a performance of 95.2%. All breaches continue to be reviewed to identify the root cause with collaborative working between the relevant Division(s) and the PE Team. All ongoing complaints are monitored on a daily basis by the PE Team to avoid any further breaches.

	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%	18.2%	May-19			>= 20%	16.3%	Apr-19		>= 20%	17.3%		13.3 - 20.6%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	91.1%	May-19			>= 90%	91.9%	Apr-19		>= 90%	91.4%		84.2 - 91.9%	
80 - Inpatient Friends and Family Response Rate	>= 30%	29.5%	May-19			>= 30%	27.9%	Apr-19		>= 30%	28.7%		25.7 - 35.7%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.7%	May-19			>= 90%	96.9%	Apr-19		>= 90%	96.8%		95.8 - 97.4%	
81 - Maternity Friends and Family Response Rate	>= 15%	32.8%	May-19			>= 15%	31.7%	Apr-19		>= 15%	32.3%		19.0 - 43.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	95.6%	May-19			>= 90%	95.7%	Apr-19		>= 90%	95.6%		92.4 - 97.3%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	15.2%	May-19			>= 15%	38.5%	Apr-19		>= 15%	26.1%		1.7 - 43.4%	

Integrated Summary Dashboard - May 2019

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	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	May-19			>= 90%	97.6%	Apr-19		>= 90%	98.3%		88.9 - 100.0%	
83 - Birth - Friends and Family Response Rate	>= 15%	39.3%	May-19			>= 15%	28.4%	Apr-19		>= 15%	34.1%		24.9 - 50.2%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	89.4%	May-19			>= 90%	93.8%	Apr-19		>= 90%	91.2%		88.5 - 97.6%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	39.2%	May-19			>= 15%	29.2%	Apr-19		>= 15%	34.4%		17.7 - 44.5%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	95.9%	May-19			>= 90%	92.0%	Apr-19		>= 90%	94.3%		88.1 - 96.4%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	44.0%	May-19			>= 15%	28.8%	Apr-19		>= 15%	36.6%		28.8 - 75.1%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	99.5%	May-19			>= 90%	97.5%	Apr-19		>= 90%	98.7%		93.2 - 99.5%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	May-19			= 100%	100.0%	Apr-19		= 100%	100.0%		100.0 - 100.0%	
90 - Complaints responded to within the period	>= 95%	95.2%	May-19			>= 95%	100.0%	Apr-19		>= 95%	97.3%		88.5 - 100.0%	

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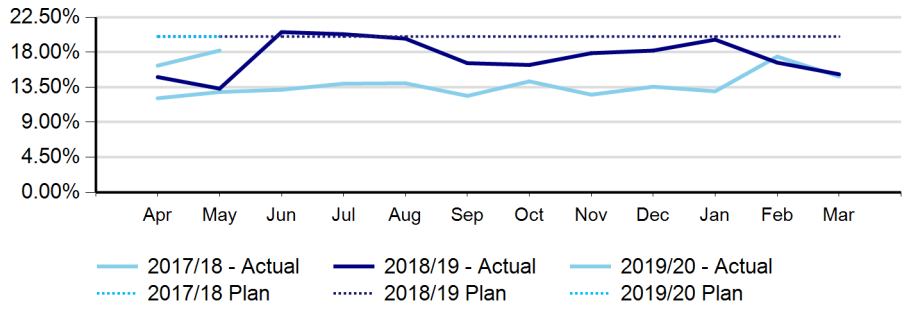
NHS Foundation Trust

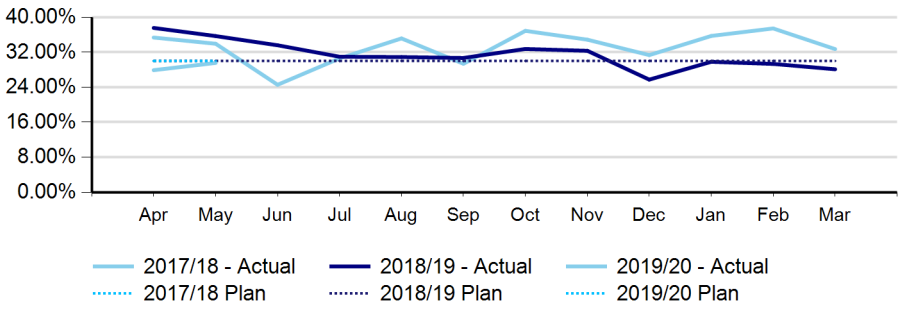
Exceptions

200 - A&E Friends and Family Response Rate



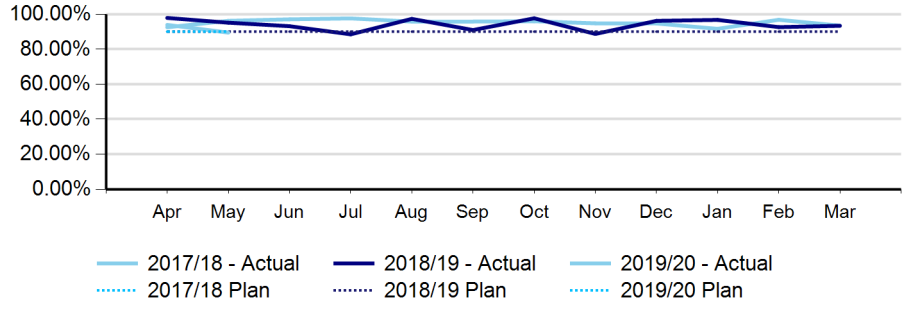
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	12.1%	12.9%	13.2%	13.9%	14.0%	12.4%	14.2%	12.5%	13.6%	13.0%	17.4%	14.9%
18/19	14.8%	13.3%	20.6%	20.3%	19.7%	16.6%	16.4%	17.9%	18.2%	19.6%	16.7%	15.2%
19/20	16.3%	18.2%										

80 - Inpatient Friends and Family Response Rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	35.3%	33.9%	24.5%	30.6%	35.1%	29.3%	36.9%	34.9%	31.3%	35.7%	37.4%	32.7%
18/19	37.5%	35.7%	33.6%	31.0%	30.9%	30.7%	32.7%	32.3%	25.7%	29.8%	29.3%	28.1%
19/20	27.9%	29.5%										

243 - Birth Friends and Family Test - Satisfaction %



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.5%	96.2%	97.0%	97.6%	95.7%	95.7%	95.9%	94.7%	94.7%	91.6%	96.7%	93.4%
18/19	97.8%	95.1%	93.1%	88.5%	97.3%	90.9%	97.6%	88.7%	96.2%	96.7%	92.6%	93.3%
19/20	93.8%	89.4%										

NHS Bolton NHS Foundation Trust

Maternity

Stillbirths - although stillbirths have increase in May, there does not appear to have been any decrease in the good practice around 'Saving Babies' Lives'. The division continue to monitor closely.

Booked 12 + 6 - although the Trust didn't achieve the 90% target we did achieve booking more women under 12+6 (488) in month, (the 13 month rolling average (MRA) is 428 women and the 13 MRA is 86.7% performance for 12+6). Therefore we have proven that we can book 488 women under 12+6 which is a huge achievement. In an ordinary month this would be well over 90% performance.

Induction of labour - Has improved 45% to 40.53% against a target of 35%. Work is still ongoing as we work towards this.

C Sections - Total C/S births is 24.64% lowest in last 13 MRA -Subsequently vaginal births is 60.9% , first time over 60% in last 13 months. (57.4% 13MRA).

Breastfeeding initiation - 70.49% (average 66.7% last 13 MRA).

Births at Bolton Bee Hive have increased to 8.96%, the best performance for 6 months. On the way to the target of 13-15%.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
322 - Maternity - Stillbirths per 1000 births	<= 3.50	7.94	May-19			<= 3.50	6.71	Apr-19		<= 3.50	7.36		0.00 - 7.94	
23 - Maternity -3rd/4th degree tears	<= 2.5%	3.3%	May-19			<= 2.5%	2.5%	Apr-19		<= 2.5%	2.9%		1.6 - 3.3%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.7%	May-19			>= 95.0%	98.7%	Apr-19		>= 95.0%	98.7%		97.8 - 99.8%	
203 - Booked 12+6	>= 90.0%	87.1%	May-19			>= 90.0%	87.5%	Apr-19		>= 90.0%	87.3%		82.9 - 89.4%	
204 - Inductions of labour	<= 35%	40.5%	May-19			<= 35%	45.0%	Apr-19		<= 35%	42.6%		37.6 - 45.0%	
208 - Total C section	<= 29.0%	24.6%	May-19			<= 29.0%	26.6%	Apr-19		<= 29.0%	25.6%		24.6 - 31.4%	
210 - Initiation breast feeding	>= 65%	70.06%	May-19			>= 65%	67.50%	Apr-19		>= 65%	68.85%		63.30 - 72.60%	
213 - Maternity complaints	<= 5	2	May-19			<= 5	3	Apr-19		<= 10	5		0 - 8	

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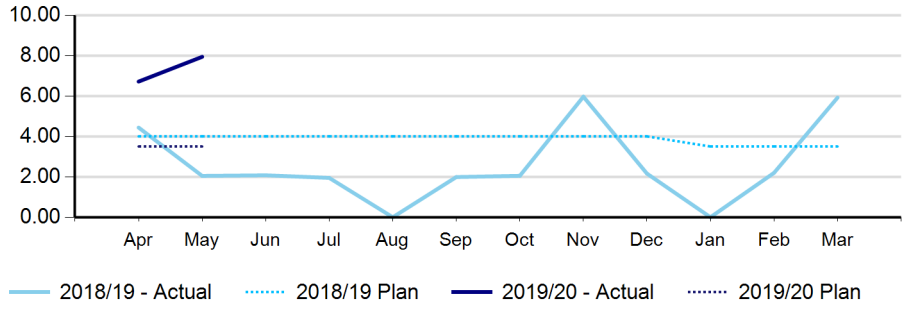
Bolton NHS Foundation Trust

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
319 - Maternal deaths (direct)	= 0	0	May-19			= 0	0	Apr-19		= 0	0		0 - 1	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	10.7%	May-19			<= 6%	8.9%	Apr-19		<= 6%	9.9%		7.6 - 11.4%	

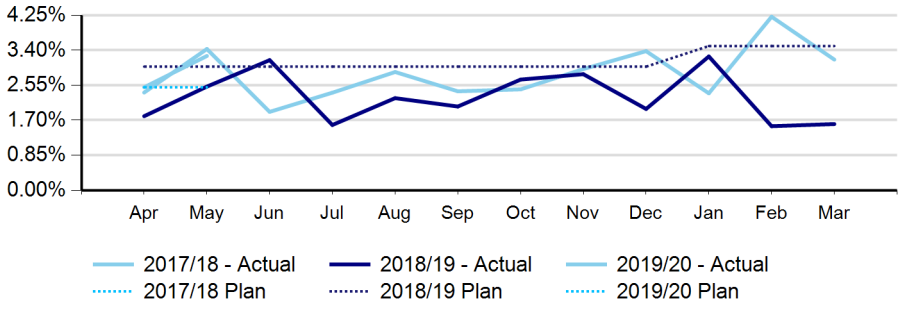
Exceptions

322 - Maternity - Stillbirths per 1000 births



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	4.43	2.04	2.07	1.95	0.00	1.99	2.05	5.96	2.16	0.00	2.19	5.92
19/20	6.71	7.94										

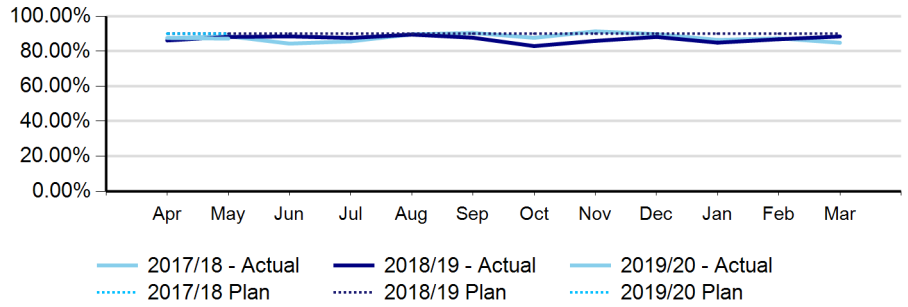
23 - Maternity -3rd/4th degree tears



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2.4%	3.4%	1.9%	2.4%	2.9%	2.4%	2.4%	2.9%	3.4%	2.4%	4.2%	3.2%
18/19	1.8%	2.5%	3.2%	1.6%	2.2%	2.0%	2.7%	2.8%	2.0%	3.2%	1.6%	1.6%
19/20	2.5%	3.3%										

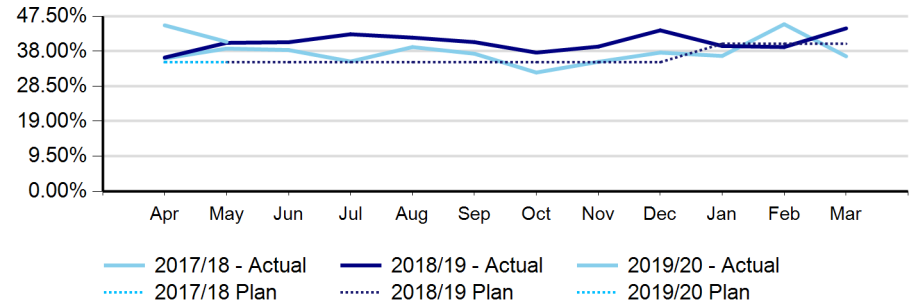
Bolton NHS Foundation Trust

203 - Booked 12+6



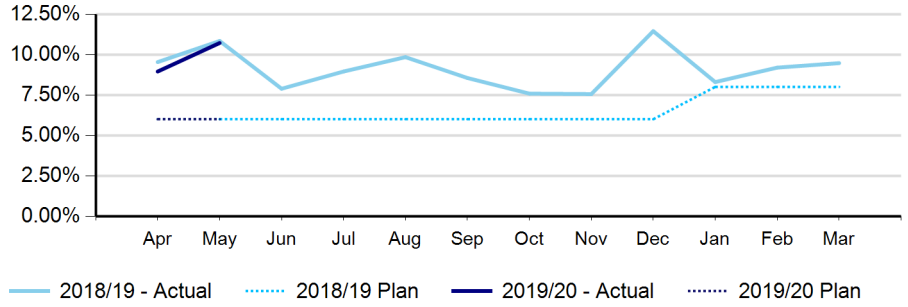
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	87.4%	88.5%	84.3%	85.6%	89.6%	90.4%	87.6%	91.3%	89.7%	86.4%	87.3%	84.8%
18/19	86.1%	88.1%	88.4%	87.5%	89.4%	87.7%	82.9%	85.9%	88.1%	84.8%	86.8%	88.4%
19/20	87.5%	87.1%										

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%	41.7%	40.4%	37.6%	39.2%	43.6%	39.4%	39.1%	44.2%
19/20	45.0%	40.5%										

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	9.5%	10.8%	7.9%	8.9%	9.8%	8.5%	7.6%	7.6%	11.4%	8.3%	9.2%	9.5%
19/20	8.9%	10.7%										

Bolton NHS Foundation Trust

Operational Performance

Access

RTT/52 weeks
The pressure on the 18 week referral to treatment time remains, although the waiting list is growing, it is expected to reduce, focus has been placed on validation and Orthopaedics to carry extra work out to clear the back log.

The number of 52 week breaches has grown in month, weekly monitoring and reporting is taking place but the expected clearance is not likely before q3, given pressure on waiting lists. Discussions are taking place through the contract with the CCG about capacity to meet this standard.

Urgent care
Although off the trajectory for improvement set by NHSE the Trust continues to see improvement month on month, nationally performance has deteriorated by 4% compared to the same period last year, in Greater Manchester it is 6%, Bolton has seen an improvement by 1.7%. Ambulance handovers have been particularly positive and we are now consistently achieving the ambulance turnaround times of 30 minutes.

	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)	<= 31	42	May-19			<= 30	45	Apr-19		<= 61	87		15 - 45	
8 - Same sex accommodation breaches	= 0	11	May-19			= 0	13	Apr-19		= 0	24		2 - 20	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	66.7%	May-19			>= 75%	80.0%	Apr-19		>= 75%	73.0%		55.6 - 90.6%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	86.3%	May-19			>= 92%	86.2%	Apr-19		>= 92%	86.3%		86.2 - 90.3%	
42 - RTT 52 week waits (incomplete pathways)	= 0	6	May-19			= 0	3	Apr-19		= 0	9		1 - 10	
314 - RTT 18 week waiting list	<= 22,812	24,259	May-19			<= 22,812	23,298	Apr-19		<= 22,812	24,259		22,344 - 24,259	
53 - A&E 4 hour target	>= 95%	85.3%	May-19			>= 95%	84.4%	Apr-19		>= 95%	84.9%		78.9 - 91.3%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0%	4%	May-19			= 0%	4%	Apr-19		= 0%	4%		4 - 10%	

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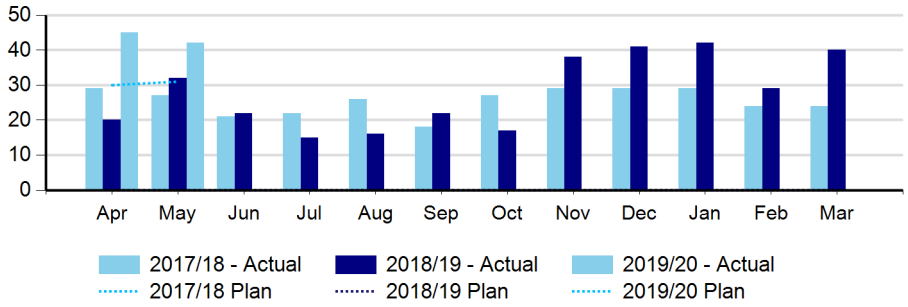
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	1.05%	May-19			= 0.00%	1.36%	Apr-19		= 0.00%	1.21%		0.35 - 3.50%	
72 - Diagnostic Waits >6 weeks %	<= 1%	1.0%	May-19			<= 1%	1.2%	Apr-19		<= 1%	1.1%		0.3 - 3.2%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	40.0%	May-19			= 100%	91.7%	Apr-19		= 100%	65.8%		0.0 - 91.7%	

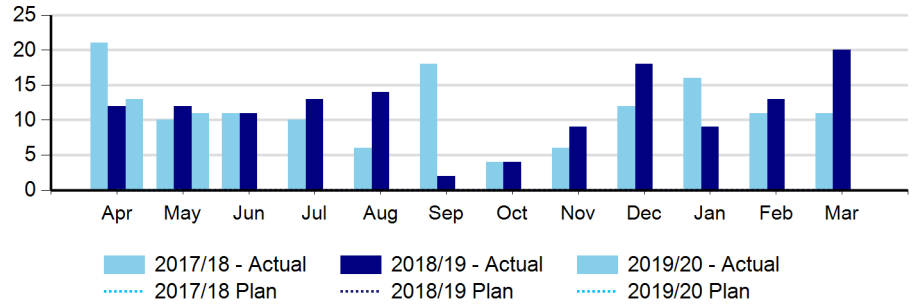
Exceptions

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	17	38	41	42	29	40
19/20	45	42										

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	4	9	18	9	13	20
19/20	13	11										

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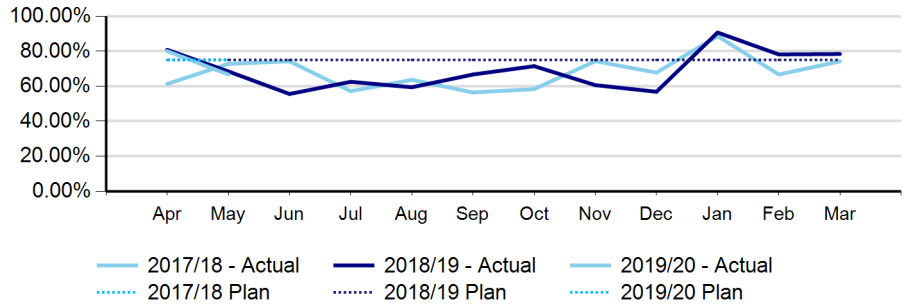
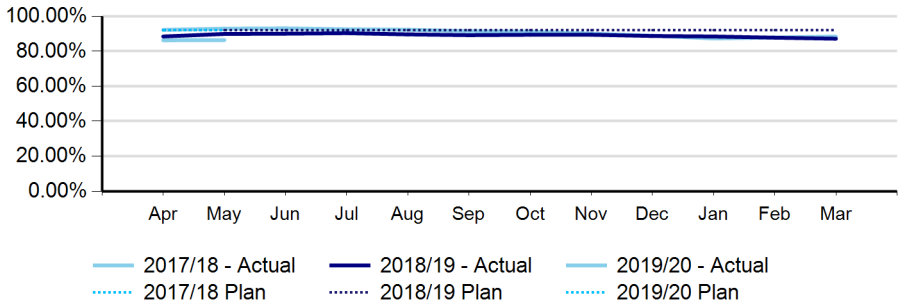
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



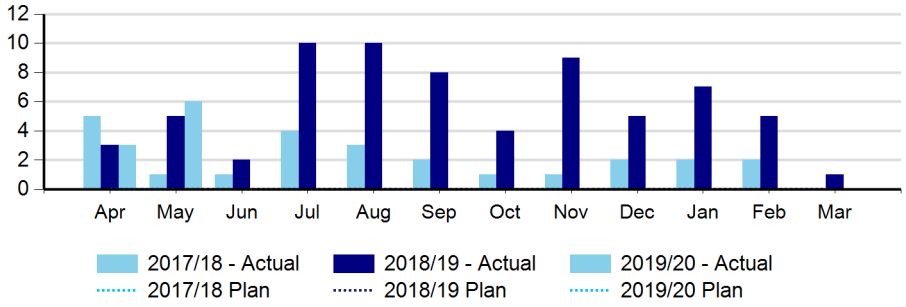
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	61.3%	72.7%	74.2%	57.1%	63.6%	56.4%	58.3%	74.3%	67.7%	88.6%	66.7%	74.2%
18/19	80.8%	68.4%	55.6%	62.5%	59.4%	66.7%	71.4%	60.6%	56.8%	90.6%	78.1%	78.4%
19/20	80.0%	66.7%										

41 - RTT Incomplete pathways within 18 weeks %



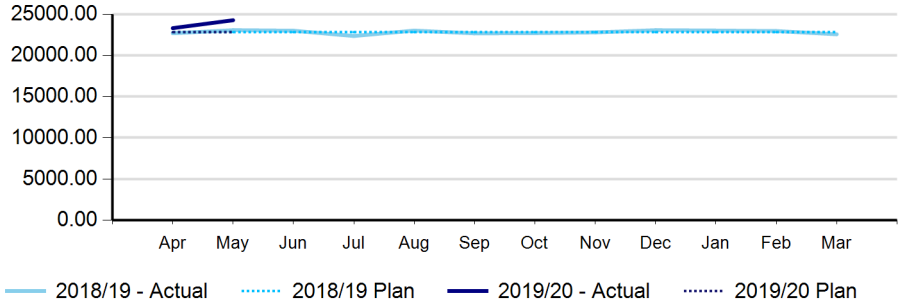
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.1%	92.9%	93.0%	92.5%	92.2%	91.4%	91.1%	90.0%	88.8%	87.2%	87.8%	88.3%
18/19	88.4%	89.8%	90.0%	90.3%	89.6%	89.1%	89.4%	89.4%	88.7%	88.4%	87.7%	87.1%
19/20	86.2%	86.3%										

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	4	9	5	7	5	1
19/20	3	6										

314 - RTT 18 week waiting list



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	22,675	23,052	22,985	22,344	23,003	22,663	22,691	22,783	23,050	23,004	22,949	22,554
19/20	23,298	24,259										

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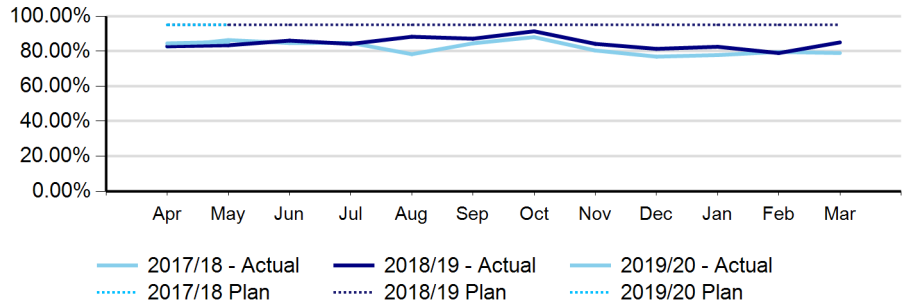
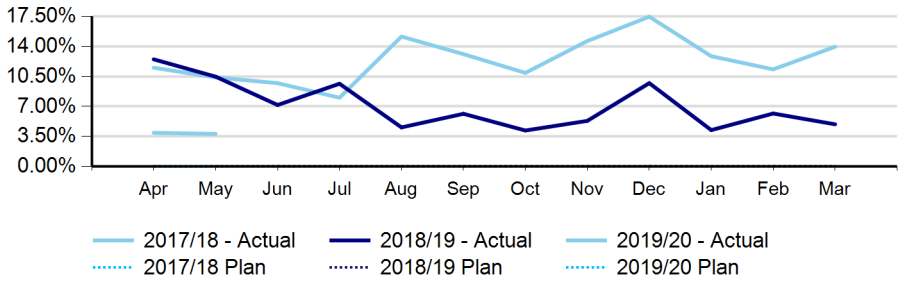
53 - A&E 4 hour target



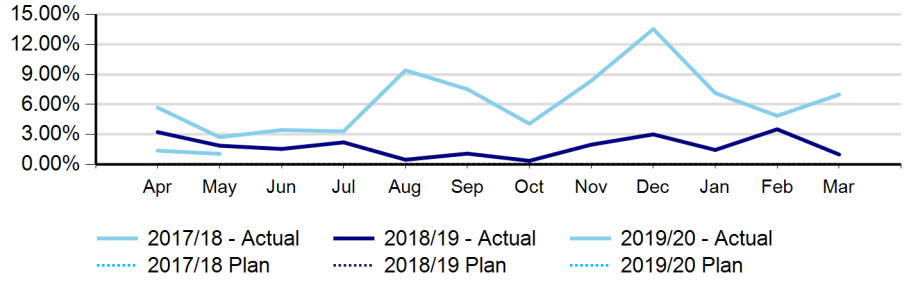
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	82.5%	86.3%	84.6%	84.7%	78.3%	84.5%	88.0%	80.4%	76.9%	77.8%	79.5%	78.9%
18/19	82.7%	83.4%	86.0%	84.1%	88.2%	87.1%	91.3%	84.2%	81.3%	82.5%	78.9%	85.0%
19/20	84.4%	85.3%										

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



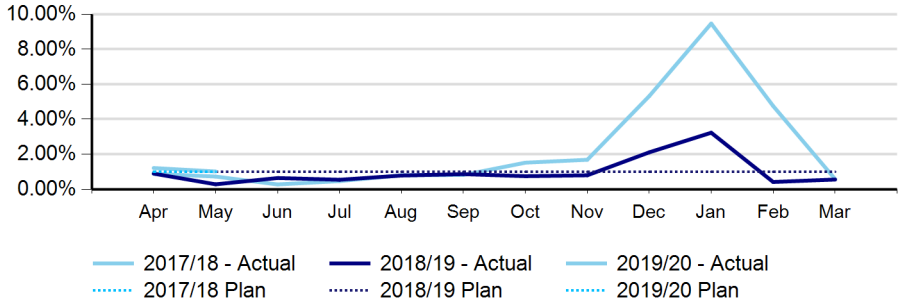
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	12%	10%	10%	8%	15%	13%	11%	15%	17%	13%	11%	14%
18/19	12%	10%	7%	10%	5%	6%	4%	5%	10%	4%	6%	5%
19/20	4%	4%										

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%	0.35%	1.97%	2.99%	1.44%	3.50%	0.98%
19/20	1.36%	1.05%										

72 - Diagnostic Waits >6 weeks %



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0.9%	0.7%	0.3%	0.5%	0.8%	0.8%	1.5%	1.7%	5.3%	9.5%	4.8%	0.6%
18/19	0.9%	0.3%	0.6%	0.5%	0.8%	0.9%	0.8%	0.8%	2.1%	3.2%	0.4%	0.6%
19/20	1.2%	1.0%										

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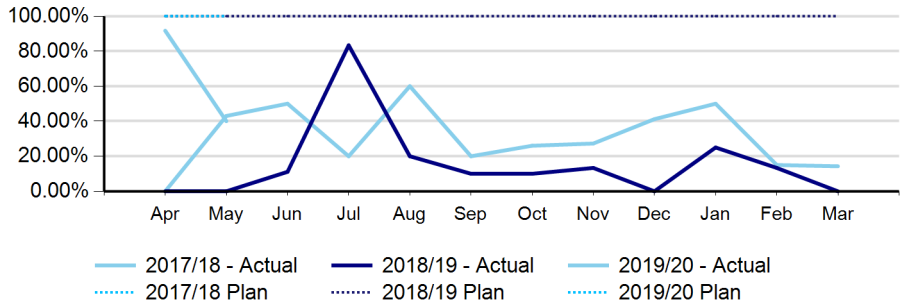
27 - TIA (Transient Ischaemic attack) patients seen <24hrs



	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%	10.0%	10.0%	13.3%	0.0%	25.0%	13.3%	0.0%
19/20	91.7%	40.0%										

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Productivity

The majority of productivity markers are improving in month, stranded and super stranded so a rise following the volume of public holidays in May. It is expected these will improve in June.

Stroke has also seen sustained improvement, and is part why they have been rated one of the highest none stroke centre units in England.

	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	247	May-19			<= 200	269	Apr-19		<= 200	247		199 - 269	
307 - Stranded Patients - LOS 21 days and over	<= 69	85	May-19			<= 69	100	Apr-19		<= 69	85		68 - 100	
57 - Discharges by Midday	>= 35%	30.0%	May-19			>= 35%	28.9%	Apr-19		>= 35%	29.4%		26.2 - 33.1%	
58 - Discharges by 4pm	>= 70%	69.2%	May-19			>= 70%	64.3%	Apr-19		>= 70%	66.7%		63.4 - 70.0%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	9.7%	Apr-19			<= 13.5%	11.6%	Mar-19		<= 13.5%	9.7%		9.7 - 12.9%	
60 - Daycase Rates	>= 80%	89.8%	May-19			>= 80%	89.4%	Apr-19		>= 80%	89.6%		87.1 - 90.6%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.7%	May-19			<= 1%	2.1%	Apr-19		<= 1%	1.9%		0.9 - 2.4%	
62 - Cancelled operations re-booked within 28 days	= 100%	85.4%	May-19			= 100%	70.8%	Apr-19		= 100%	77.5%		63.6 - 100.0%	
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	2.6%	May-19			<= 3.3%	2.8%	Apr-19		<= 3.3%	2.7%		1.1 - 3.0%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.36	May-19			<= 2.00	2.90	Apr-19		<= 2.00	2.63		2.06 - 2.90	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.66	May-19			<= 3.70	4.55	Apr-19		<= 3.70	4.61		4.09 - 4.67	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	95.0%	Apr-19			>= 80%	92.3%	Mar-19		>= 80%	95.0%		66.7 - 95.0%	

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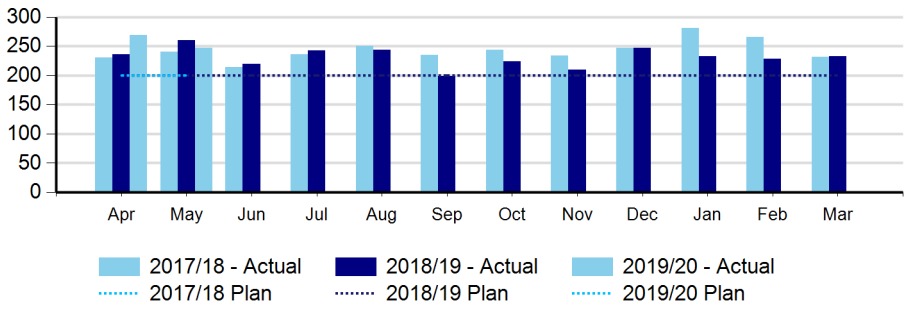
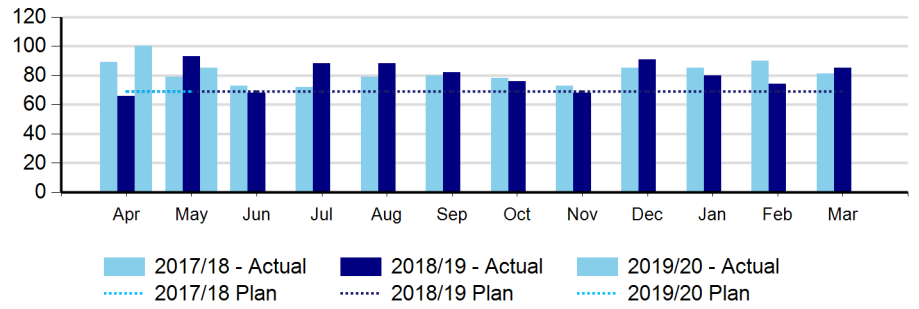
Exceptions

56 - Stranded patients



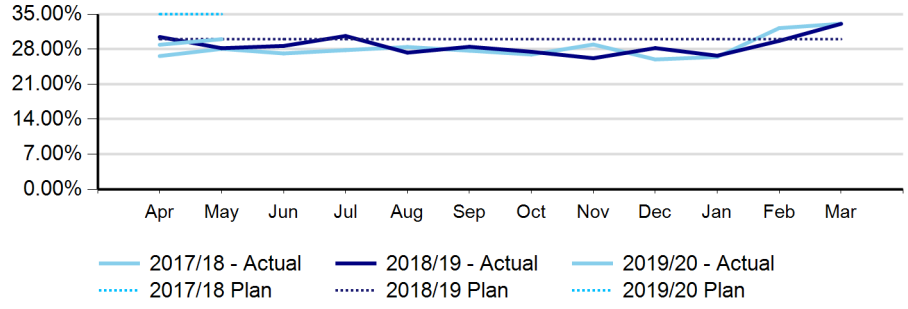
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	230	240	214	236	250	235	244	234	247	281	265	232
18/19	236	260	219	242	243	199	224	210	247	233	228	233
19/20	269	247										

307 - Stranded Patients - LOS 21 days and over



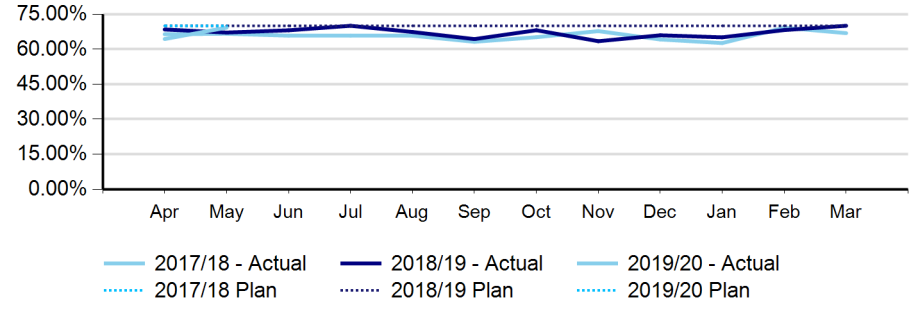
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	89	79	73	72	79	80	78	73	85	85	90	81
18/19	66	93	68	88	88	82	76	68	91	80	74	85
19/20	100	85										

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%	27.5%	26.2%	28.2%	26.7%	29.7%	33.1%
19/20	28.9%	30.0%										

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%	68.1%	63.4%	65.9%	65.1%	68.2%	70.0%
19/20	64.3%	69.2%										

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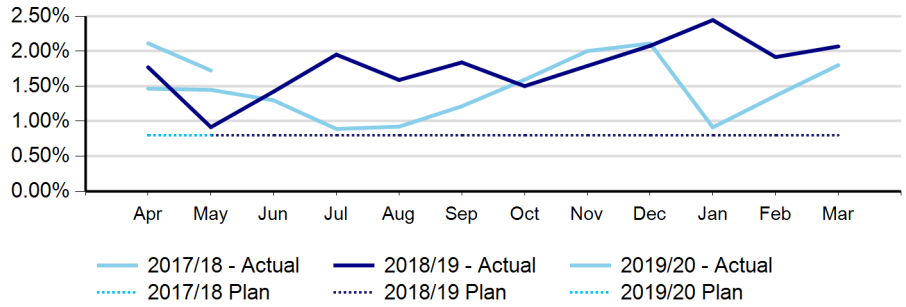
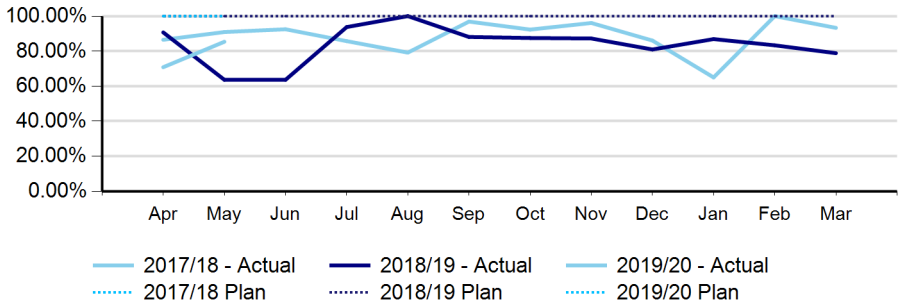
61 - Operations cancelled on the day for non-clinical reasons



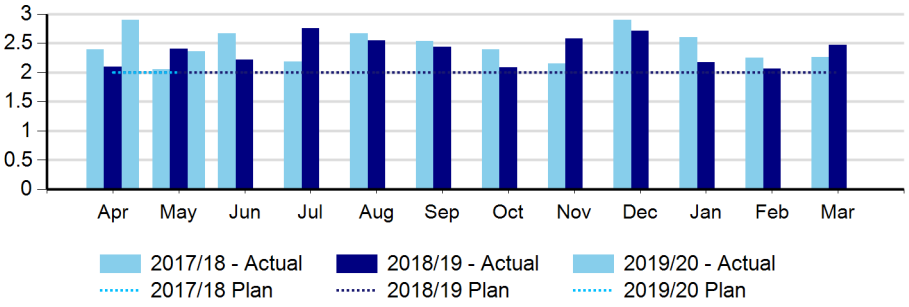
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1.5%	1.4%	1.3%	0.9%	0.9%	1.2%	1.6%	2.0%	2.1%	0.9%	1.4%	1.8%
18/19	1.8%	0.9%	1.4%	2.0%	1.6%	1.8%	1.5%	1.8%	2.1%	2.4%	1.9%	2.1%
19/20	2.1%	1.7%										

62 - Cancelled operations re-booked within 28 days



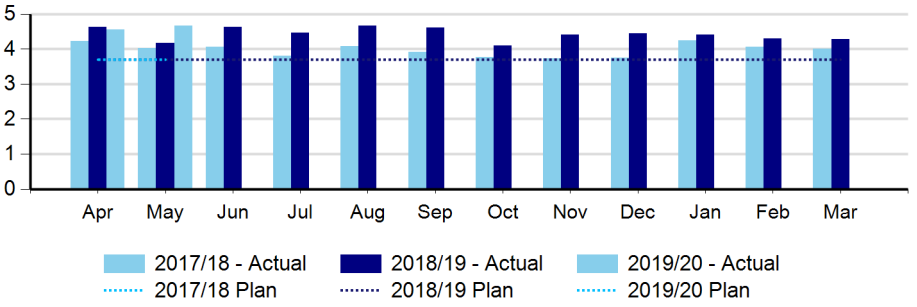
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86.5%	90.9%	92.5%	85.7%	79.2%	96.9%	92.3%	96.1%	86.0%	65.0%	100.0%	93.3%
18/19	90.7%	63.6%	63.6%	93.8%	100.0%	88.1%	87.5%	87.2%	81.0%	86.9%	83.3%	78.8%
19/20	70.8%	85.4%										

65 - Elective Length of Stay (Discharges in month)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2.39	2.05	2.66	2.18	2.66	2.53	2.39	2.15	2.90	2.60	2.25	2.26
18/19	2.10	2.40	2.22	2.75	2.54	2.44	2.08	2.58	2.71	2.17	2.06	2.47
19/20	2.90	2.36										

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4.23	4.02	4.05	3.80	4.07	3.91	3.76	3.72	3.75	4.25	4.06	4.00
18/19	4.62	4.17	4.62	4.47	4.67	4.60	4.09	4.41	4.44	4.40	4.29	4.28
19/20	4.55	4.66										

Bolton NHS Foundation Trust

Cancer

Board will be aware that finalised Cancer performance is always 6 weeks in arrears, the full year to March figures have been published and the Trust was rated 3rd in the country for 62 day performance, with over 2/3rds of Trusts now not meeting the standard nationally. Mays unvalidated figures suggest a marginal pass reflecting the pressure in the last 9 months, with referrals up by over 20% on the Cancer pathway. Breast referrals are up by near 30% putting real strain on the two week wait times, careful monitoring is taking place, with 99% seen by 3 weeks and no patients breaching the 62 day standard who has cancer. Work is being done to increase capacity for Breast services. This growth in cancer referrals is reflected across Greater Manchester and work is ongoing to see how this can best be managed.

	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%	88.5%	Apr-19			>= 85%	91.2%	Mar-19		>= 85%	88.5%		85.8 - 95.4%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	75.6%	Apr-19			>= 90%	89.7%	Mar-19		>= 90%	75.6%		67.9 - 100.0%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	99.0%	Apr-19			>= 96%	98.1%	Mar-19		>= 96%	99.0%		98.1 - 100.0%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Apr-19			>= 94%	100.0%	Mar-19		>= 94%	100.0%		87.5 - 100.0%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Apr-19			>= 98%	100.0%	Mar-19		>= 98%	100.0%		100.0 - 100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	98.0%	Apr-19			>= 93%	98.7%	Mar-19		>= 93%	98.0%		93.6 - 98.7%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	27.1%	Apr-19			>= 93%	49.5%	Mar-19		>= 93%	27.1%		27.1 - 95.0%	

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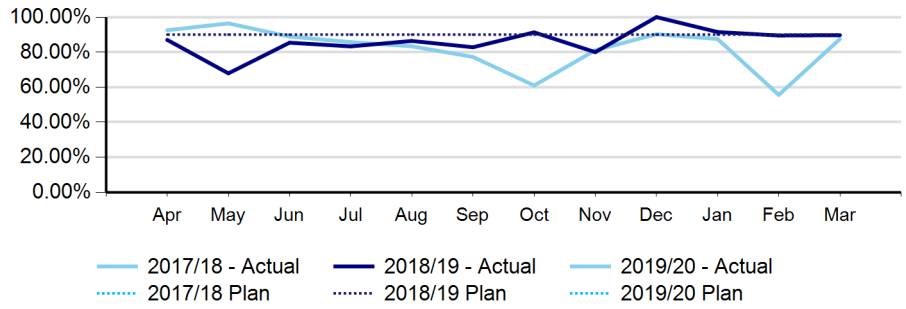
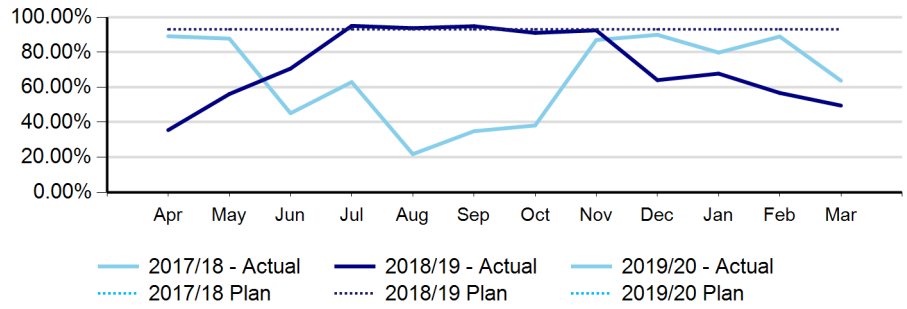
Exceptions

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%	82.8%	91.3%	80.0%	100.0%	91.5%	89.5%	89.7%
19/20	75.6%											

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	89.1%	87.7%	45.1%	62.9%	21.8%	34.9%	38.1%	86.9%	89.9%	79.8%	88.9%	63.7%
18/19	35.5%	56.1%	70.6%	95.0%	93.7%	94.8%	91.0%	92.4%	64.0%	67.7%	56.7%	49.5%
19/20	27.1%											

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Community

Total Deflections from ED - this new metric provides the sum of all deflection work carried out within the crisis response pathway of the Intermediate Tier Services. This is carried out by the Admission Avoidance Team who take step up referrals from community services such as GPs and ambulance crews in order to avoid patients coming to hospital. It is also carried out by the Home First Team who are based in ED and work to prevent patients from being admitted where possible. The combined number of deflections has dropped slightly in May but remains above target.

Intermediate Tier Total LOS - this new metric provides a view of the total length of stay across all parts of the Intermediate Tier including bed based services and home based services. The average LOS remains below target for May.

Medically Optimised Patients - The number of patients on the medically optimised list has started to reduce in May and this is expected to continue through June. This may be in part due to seasonal effect but also due to incremental gains achieved through focused work between the Integrated Discharge Team and ward based teams commenced in Spring into Action during April. The bed days occupied by patients who are medically optimised did not show a corresponding reduction in May but is showing signs of improvement for June.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
334 - Total Deflections from ED	>= 400	518	May-19			>= 400	537	Apr-19		>= 800	1,055		300 - 537	
335 - Total Intermediate Tier LOS (weeks) (in arrears)	<= 6.00	4.40	Apr-19				5.09	Mar-19		<= 6.00	4.40		3.86 - 6.75	
230 - Medically Optimised Numbers	<= 50	86	May-19			<= 50	98	Apr-19		<= 100	184		59 - 98	
231 - Medically Optimised Days	<= 209	683	May-19			<= 209	553	Apr-19		<= 418	1,236		388 - 790	

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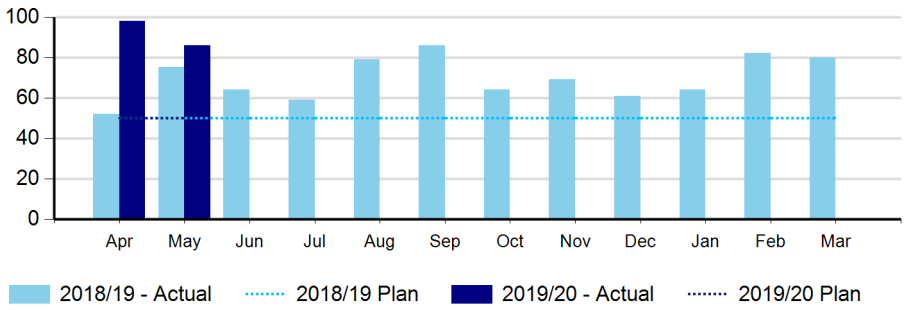
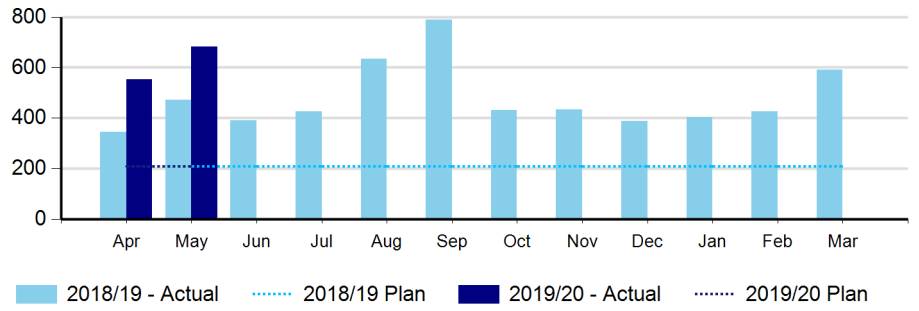
Exceptions

230 - Medically Optimised Numbers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	52	75	64	59	79	86	64	69	61	64	82	80
19/20	98	86										

231 - Medically Optimised Days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	344	472	391	426	634	790	430	434	388	403	425	591
19/20	553	683										

NHS Bolton NHS Foundation Trust

Workforce

Sickness, Vacancy and Turnover

The sickness rate in May 2019 was 4.93%; this is higher than target and higher than last month, it is also higher than May 2018 (4.72%). The reason for this is an increase in the number of long term sick cases, which are reviewed individually to support early return to work where possible. A plethora of actions continue to be taken to support our staff to maintain good health.

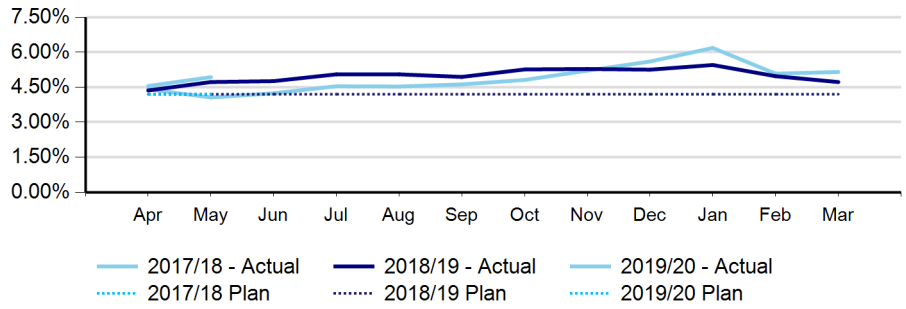
Performance on the recruitment & retention metrics remains strong. Colleagues will recall that the KPI for some of the workforce metrics was discussed and it was agreed that a paper will come to the Workforce Assurance Committee in July to review the rationale for the metrics set, noting that the Trust does not use a statistical deviation approach. The Workforce Assurance Committee is sighted on the areas within the organisation that remain 'hard to fill' and a clear set of actions is in place for these roles with strong partnership working between the Division & Workforce Teams.

	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	<= 4.20%	4.93%	May-19			<= 4.20%	4.55%	Apr-19		<= 4.20%	4.74%		4.55 - 5.45%	
120 - Vacancy level - Trust	<= 6%	4.69%	May-19			<= 6%	6.78%	Apr-19		<= 6%	5.74%		2.61 - 6.78%	
121 - Turnover	<= 9.90%	9.93%	May-19			<= 9.90%	9.81%	Apr-19		<= 9.90%	9.87%		9.16 - 10.65%	

Bolton
NHS Foundation Trust

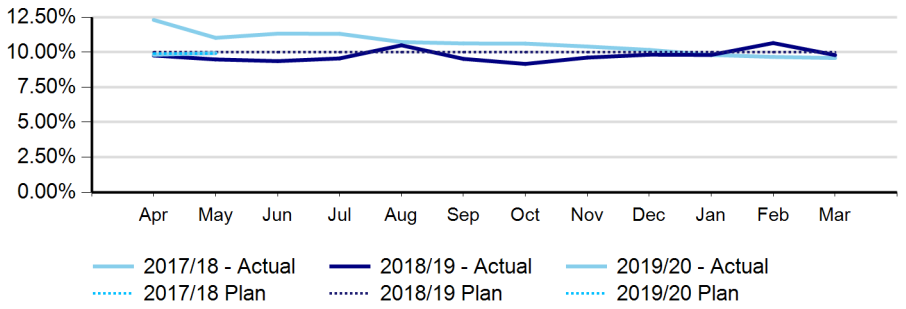
Exceptions

117 - Sickness absence level - Trust



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4.41%	4.06%	4.24%	4.54%	4.53%	4.62%	4.81%	5.21%	5.60%	6.18%	5.08%	5.15%
18/19	4.36%	4.72%	4.76%	5.05%	5.05%	4.94%	5.26%	5.28%	5.25%	5.45%	4.97%	4.72%
19/20	4.55%	4.93%										

121 - Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	12.30%	11.02%	11.32%	11.31%	10.72%	10.62%	10.61%	10.40%	10.16%	9.80%	9.66%	9.58%
18/19	9.76%	9.48%	9.36%	9.55%	10.49%	9.52%	9.16%	9.61%	9.82%	9.80%	10.65%	9.79%
19/20	9.81%	9.93%										

NHS Bolton NHS Foundation Trust

Organisational Development

The Organisational Development (OD) indicators remain strong, although colleagues will note for another month there has been slight reduction in some key metrics. This slight downward trend was discussed in detail at the Workforce Assurance Committee and the Divisions committed to a sharpened focus in this area as the summer months are critical as there is an increased difficulty in releasing staff in the winter months. Furthermore the Workforce & OD team have commited to providing additional places based around service demands.

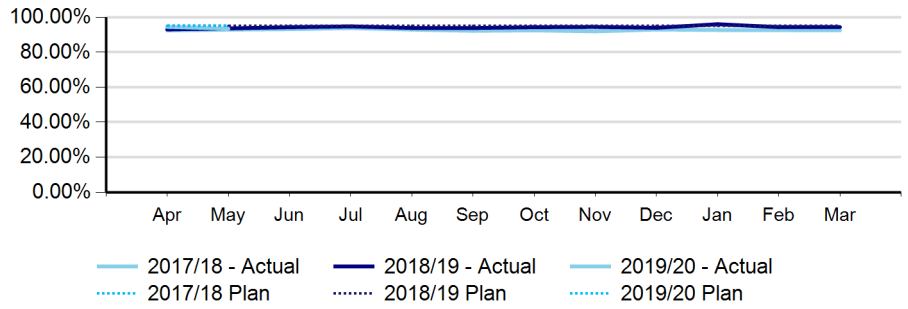
It was noted in a previous meeting that the staff engagement KPI's may benefit from a further review. This matter will be considered at the July Workforce Assurance Committee when the meeting will receive the full findings of the first feedback from the GoEngage programme.

	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%	93.4%	May-19			>= 95%	94.4%	Apr-19		>= 95%	93.9%		93.4 - 96.0%	
38 - Staff completing Mandatory Training	>= 85%	91.8%	May-19			>= 85%	92.0%	Apr-19		>= 85%	91.9%		85.9 - 93.1%	
39 - Staff completing Safeguarding Training	>= 95%	95.55%	May-19			>= 95%	95.70%	Apr-19		>= 95%	95.63%		94.56 - 95.81%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.3%	May-19			>= 85%	84.2%	Apr-19		>= 85%	84.2%		83.4 - 89.4%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	68.0%	Q4 2018/19			>= 66%	70.0%	Q3 2018/19		>= 66%			68.0 - 70.0%	
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	82.0%	Q4 2018/19			>= 80%	75.0%	Q3 2018/19		>= 80%			75.0 - 83.0%	

Bolton
NHS Foundation Trust

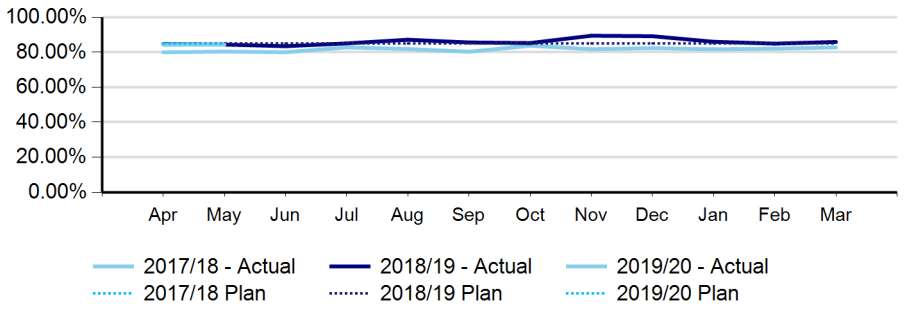
Exceptions

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%	94.2%	94.4%	93.9%	96.0%	94.3%	94.3%
19/20	94.4%	93.4%										

101 - Increased numbers of staff undertaking an appraisal



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	79.9%	80.3%	80.0%	82.7%	81.8%	80.3%	83.7%	81.7%	82.3%	81.7%	82.0%	82.7%
18/19	84.5%	84.3%	83.4%	85.0%	87.1%	85.5%	85.2%	89.4%	89.1%	85.9%	84.9%	85.8%
19/20	84.2%	84.3%										

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NHS Foundation Trust

Agency

Colleagues will note the in-month agency spend remains below the Trust's forecast. As would be expected the two areas of greatest spend being nursing and medical. The Trust benchmarks favourable on agency spend when compared to peer organisations for % agency spend versus overall pay, that said the Workforce Assurance Committee is sighted on the multiple actions that are being taken to drive down agency spend to the lowest possible level. Vacancies, short term sickness absence and escalation wards are the main drivers of agency spend.

The Workforce Assurance Committee is closely reviewing why agency pressures remain despite the strong vacancy position.

	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)	<= 0.71	0.71	May-19			<= 0.72	0.67	Apr-19		<= 1.44	1.38		0.56 - 0.90	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.31	0.28	May-19			<= 0.31	0.29	Apr-19		<= 0.62	0.57		0.26 - 0.33	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.33	0.31	May-19			<= 0.33	0.30	Apr-19		<= 0.66	0.61		0.19 - 0.50	

Bolton NHS Foundation Trust

Finance

Finance

The May YTD performance against the control total is a deficit of £4.6m, £2.3m worse than the plan. The variance is mainly as a result on the under delivery of ICIP, income performance and control of costs.

PSF/MRET of £0.7m has been earned year to date compared to a plan of £0.7m. The PSF element is subject to achievement of the finance plan in Quarter 1.

Overall, the Trust has made a deficit after PSF/MRET and Impairments of £3.9m year to date compared to a plan of £1.7m.

At this time the Trust is reporting that it will achieve the plan, but there are significant risks associated with this, particularly in the light of month 2 performance. The risk range for the forecast is from £9.8m surplus (plan) to a £22.2m deficit; with the most probable being £8.3m deficit. Recovery plan actions have been developed.

The Trust capital plan for the year is £15.0m. The spend for May YTD was £0.4m which is on plan.

In April there was a net cash outflow of £1.3m with a closing cash balance of £11.3m, which is £0.1m above plan.

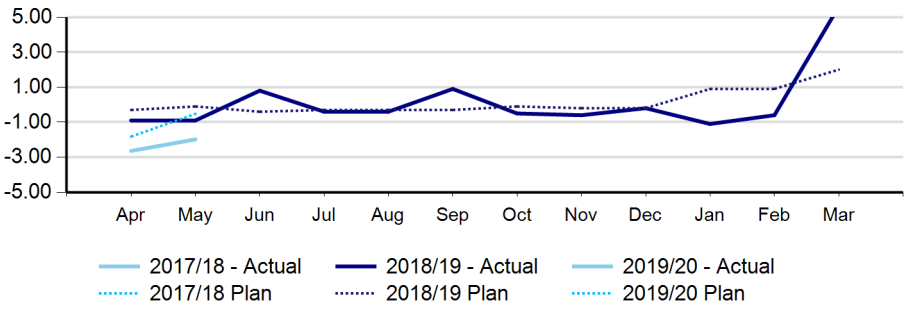
The Trust overall risk rating for Use of Resources was a 3 in May compared to a plan of 3.

	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)	>= -0.5	-2.0	May-19			>= -1.8	-2.6	Apr-19		>= -2.3	-4.6		-2.6 - 5.6	
221 - Provider Sustainability Fund (£ millions)	>= -0.01	-0.01	May-19			>= -0.01	-0.01	Apr-19		>= -0.02	-0.02		-0.01 - 1.30	
222 - Capital (£ millions)	>= 0.2	0.2	May-19			>= 0.5	0.2	Apr-19		>= 0.7	0.4		0.2 - 4.2	
223 - Cash (£ millions)	>= 11.3	11.3	May-19			>= 17.9	12.6	Apr-19		>= 11.3	11.3		6.0 - 19.1	
224 - Use of Resources	>= 3	3	May-19			>= 3	3	Apr-19		>= 3	3		2 - 4	

Bolton
NHS Foundation Trust

Exceptions

220 - Control Total (£ millions)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18												2.3
18/19	-0.9	-0.9	0.8	-0.4	-0.4	0.9	-0.5	-0.6	-0.2	-1.1	-0.6	5.6
19/20	-2.6	-2.0										

Bolton NHS Foundation Trust

Use of Resources

Model Hospital

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, however 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 Quality Assurance Committee (QAC) March 2018, and a refreshed paper came to QAC in October 2018. Originally it was planned for the Director of Corporate Governance, the Director of Quality Governance, Deputy Director of Finance and PMO Programme Manager would meet to review in quarter three 18/19 to ensure these arrangements are embedded, given the proximity of the UoR NHSI review, this exercise should be conducted only once the outcome is understood.

	Latest					Previous				Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Range	Trend
175 - Pre-procedure non-elective bed days	<= 0.78	1.40	Q3 2018/19			<= 0.78	1.34	Q2 2018/19		1.34 - 1.40	
176 - Pre-procedure elective bed days	<= 0.133	0.140	Q3 2018/19			<= 0.133	0.120	Q2 2018/19		0.120 - 0.140	
177 - Emergency readmissions (30 days)	<= 7%	8.2%	Q3 2018/19			<= 7%	10.0%	Q2 2018/19		8.2 - 10.0%	
178 - Did not attend (DNA) rate	<= 7%	10.3%	Q4 2018/19			<= 7%	9.2%	Q3 2018/19		9.0 - 10.3%	
179 - Staff retention rate		86.9%	Dec-18				87.2%	Nov-18		86.9 - 87.8%	
180 - Sickness absence rate		5.52%	Nov-18				5.53%	Oct-18		4.96 - 5.53%	
181 - Pay cost per weighted activity unit (WAU) - £	<= 2,180	2,434	Mar-18			<= 2,157	2,348	Mar-17			
182 - Doctors cost per WAU - £	<= 533	411	Mar-18			<= 526	424	Mar-17			
183 - Nurses cost per WAU - £	<= 710	967	Mar-18			<= 718	961	Mar-17			
184 - Allied health professionals cost per WAU (community adjusted) - £	<= 114	129	Mar-18			<= 89	106	Mar-17			
185 - Top 10 medicines – percentage delivery of savings target		72.6%	Nov-17				83.0%	Oct-17			
186 - Overall cost per test	<= 1.96	1.65	Mar-17			<= 1.96	1.65	Mar-17			

Integrated Summary Dashboard - May 2019

Bolton NHS Foundation Trust

	Latest					Previous				Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Range	Trend
187 - Non-pay cost per WAU	<= £1,307	£1,058	Mar-18			<= £1,301	£1,139	Mar-17			
188 - Finance cost per £100 million turnover	<= £67,648	£741,214	Mar-18			<= £670,512	£578,035	Mar-17			
189 - Human resources cost per £100 million turnover	<= £89,802	£827,230	Mar-18			<= £874,010	£790,403	Mar-17			
190 - Procurement Process Efficiency and Price Performance		69.00	Q3 2018/19				73.00	Q2 2018/19		69.00 - 73.00	
191 - Estates cost per square metre	<= £342	£292	Mar-18			<= £327	£273	Mar-17			
192 - Capital service capacity		5.73	Mar-19				2.31	Feb-19		1.19 - 5.73	
193 - Liquidity (days)		18.16	Mar-19				-4.85	Feb-19		-8.82 - 18.16	
194 - Income and expenditure margin		5.10%	Mar-19				1.20%	Feb-19		-0.30 - 5.10%	
195 - Distance from financial plan		1.30%	Mar-19				-1.90%	Feb-19		-1.90 - 1.30%	
196 - Distance from agency spend		46.63%	Mar-19				47.50%	Feb-19		30.84 - 50.13%	

Board Assurance Heat Map - Hospital - May 2019

	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		30			23	22	10	21	0	25	24	26	27	10	14	26	22	26	25	24	10	8	25	25	25	24	24	23	16	25	9	11	4	31	7	17	6	26	15	5	4	44	38	777
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	G>=100%, A>80% <99.9%, R = <80%=R, >80% <94.9%=A, >95%	90.0%	80.0%	100.0%	95.0%	100.0%	95.0%	100.0%		85.0%	100.0%	100.0%	95.0%	100.0%	95.0%	non return	95.0%	95.0%	85.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	80.0%	100.0%	100.0%	100.0%	non return		90.0%		100.0%	non return	85.0%		100.0%	95.0%	97.3%
	IPC Rapid Improvement Tool %		91.0%	77.0%	91.0%	non return	88.0%	non return	83.0%		65.0%	88.0%	92.0%	92.0%	96.0%	100.0%	88.0%	96.0%	non return	96.0%	96.0%	100.0%	100.0%	92.0%	91.0%	91.0%	100.0%	100.0%	87.0%	96.0%	non return	100.0%	100.0%	91.0%	100.0%	100.0%		91.0%		100.0%	non return	100.0%		96.0%	95.0%	93.8%
	Mattress Audit Compliance %	Yes=G, No Return=White	100.0%			100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					non return		100%		100%	non return	100%		100%	100%	100.0%
	C - Diff	0	0	0	0	0	0	0	0		0	1	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	2
	New MSSA BSIs	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	New E.Coli BSIs	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MRSA acquisitions	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harm Free Care	Safety Express Programme Harm Free Care (%)	95%	100.0%			88.9%	100.0%	92.3%	95.2%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.6%	88.9%	95.7%	87.5%	100.0%	96.0%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%		100.0%		90.9%	100.0%	non return		100.0%	100.0%	97.6%
	All Inpatient Falls (Safeguard)	0	4	1	0	10	4	7	9		4	6	7	7	0	4	6	1	6	4	3	0	0	2	3	2	1	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	95
	Harms related to falls (moderate and above)	0	0	1	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	VTE Assessment Compliance	95%				0.0%	100.0%	90.9%	100.0%		100.0%	100.0%	89.6%	66.7%	100.0%	97.4%	97.0%	96.7%	94.1%	89.5%	79.0%	100.0%	100.0%	96.9%	100.0%	99.7%	90.4%	96.1%	95.89%	86.9%	98.6%	99.1%	95.1%	71.4%			98.7%	75.3%	99.2%	100.0%	82.6%	38.5%	100.0%		96.2%
	Monthly New pressure Ulcers (Grade 2)	0	0	0	0	2	0	0	1		0	0	1	1	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	6
	Monthly New pressure Ulcers (Grade 3)	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0
	Monthly New pressure Ulcers (Grade 4)	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0
	PU due to lapses in care	0	0	0	0	2	0	0	1		0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	5
Audit	Monthly KPI Audit %	R=<80%,A>80%<94.9%,G>=95%	98.4%	94.6%	non return	94.1%	94.6%	90.4%	90.6%		97.1%	94.0%	82.1%	90.9%	98.4%	98.8%	98.0%	97.5%	89.5%	85.3%	97.9%	100.0%	100.0%	96.5%	98.9%	97.1%	96.4%	96.4%	97.2%	93.6%	90.5%	100.0%	96.3%	93.9%		94.6%		97.5%		98.1%	95.7%	77.4%		89.5%	98.1%	94.6%
	Bolton System of Care Accreditation (BoSCA)	R=<50%,A=50-74.9%,S=>75%<89.9%,G=>90%	93.4%			80.5%	76.3%	58.3%	91.2%		77.0%	79.4%	76.0%	79.3%	91.7%	81.2%	80.3%	81.9%	92.9%	90.0%	90.2%	90.7%	93.9%	75.1%	90.4%	90.9%	82.8%	90.4%	92.5%	93.7%				90.4%		90.1%		75.3%		91.9%	88.0%	83.4%		90.4%	85.9%	85.3%
Patient Experience	Friends and Family Response Rate	**30%**	100.0%	17.7%	17.1%	55.9%	73.8%	9.5%	34.4%		25.9%	41.4%	11.0%	28.9%	64.3%	25.7%	36.9%	25.5%	23.9%	76.6%	46.7%	82.4%	71.4%	16.9%	29.1%	35.6%	22.2%	67.5%	62.3%	60.0%	25.5%	27.0%	32.3%	33.3%	41.1%	0.0%	29.1%		15.2%	27.0%	39.3%		39.2%	54.8%	29.6%
	Friends and Family Recommended Rate	**97%**	100.0%	89.0%	96.8%	100.0%	87.1%	100.0%	100.0%		100.0%	100.0%	100.0%	92.3%	97.8%	91.3%	88.7%	97.1%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	96.9%	98.6%	95.2%	100.0%	94.7%	100.0%	92.5%	94.8%	95.2%	100.0%	99.2%	N/A	98.3%		100.0%	88.1%	89.4%		95.9%	100.0%	96.7%
	Number of complaints received	**0**	0	2	0	0	0	1	0		0	1	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0		1	0	1	0	0		2	0	12
Governance	SIs in Month	**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	0	1	2
	Total Incidents	**0**	21	52	9	26	21	25	35		14	28	22	33	2	22	63	69	17	28	11	21	19	14	28	20	7	20	33	20	24	22	1	2	23	8	14	1	3	63	5	9	17	40	912
	Harms related to Incidents (Moderate and above)	**0**	0	5	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	7
Staff Development	Appraisals	85%	98.2%	91.6%		57.1%	94.4%		93.6%		79.4%	100.0%	80.0%	56.0%	79.3%	81.0%	66.0%	73.5%	92.7%	80.4%	77.5%	97.7%	92.4%	96.6%	81.1%	92.7%	90.6%	94.0%	95.2%	95.2%	86.1%	94.9%	64.0%	100.0%	64.4%		81.5%	84.6%					79.8%		
	Statutory Training	95%	96.50%	95.00%		87.08%	87.24%		88.8%		88.73%	91.78%	89.58%	85.77%	95.36%	85.04%	85.88%	88.07%	95.32%	82.21%	95.72%	99.00%	99.11%	88.41%	93.04%	97.46%	93.56%	93.93%	90.85%	98.57%	93.31%	92.63%	93.41%	96.83%	98.0%		98.31%	89.6%					96.52%		
	Mandatory Training	85%	95.2%	96.01%		88.0%	87.5%		90.4%		88.7%	92.8%	88.1%	81.8%	96.7%	88.8%	85.0%	87.3%	92.6%	82.8%	94.4%	100.0%	98.6%	87.0%	93.7%	96.6%	91.5%	94.2%	92.3%	98.8%	97.2%	93.8%	92.9%	97.1%	96.8%		86.8%	88.6%					96.7%		
Staffing & Workforce	% Qualified Staff (Day)					87.5%	101.0%				87.7%	90.7%	93.2%	96.3%	103.3%	-	-	-	97.8%	114.9%	oorts\Workir	89.4%	84.1%	98.6%	99.3%	-	102.7%	95.2%	88.6%	89.3%							88.2%		92.3%	63.6%	61.6%		77.2%	0.0%	
	% Qualified Staff (Night)					100.0%	100.0%		98.4%		98.6%	98.5%	100.0%	100.5%	100.0%	-	-	-	101.3%	99.0%	100.0%	90.9%	83.1%	99.0%	100.4%	-	143.6%	97.9%	96.8%	102.6%							99.5%		80.3%	72.6%	51.8%		66.3%	0.0%	
	% un-Qualified Staff (Day)					86.9%	100.3%		91.5%		56.1%	106.8%	75.2%	84.4%	98.2%	-	-	-	81.4%	109.7%	99.5%	96.8%	76.1%	71.2%	111.9%	-	102.0%	73.4%	70.6%	111.2%							69.2%		73.5%	75.5%	85.5%		96.8%		
	% un-Qualified Staff (Night)					100.8%	98.9%		105.2%		65.5%	119.2%	80.8%	86.5%	103.2%	-	-	-	72.0%	120.6%	125.0%	51.6%	34.9%	60.0%	134.0%	-	127.8%	67.0%	58.6%	138.5%							135.3%		90.5%	88.2%	87.1%		97.7%		
	Budgeted Nurse: Bed Ratio (WTE)		1.56	-4.10	-	-8.34	1.08	3.69	-1.52		-0.25	-0.56	8.22	0.69	1.32	-1.39	1.09	-9.44	0.12	-5.14	1.82	1.09	-1.58	2.66	-2.06	-1.43	0.01	2.12	-2.28	-5.85	-2.34	7.01	-1.67	0.19	-5.37		-	-	-	-	-		-	-	
	Current Budgeted WTE (From Ledger)		43.38	146.54	-	38.03	32.83	40.69	43.34		33.71	41.23	42.69	40.69	26.93	19.97	50.82	40.30	40.01	39.97	36.15	38.58	55.02	35.52	30.21	37.79	30.21	44.49	44.49	18.07	29.25	60.39	50.91	15.88	67.65		25.72						106.59	1,448.05	
	Actual WTE In-Post (From Ledger)		41.82	143.64	-	33.37	30.75	36.00	40.14		33.96	37.57	33.47	36.00	25.61	21.36	45.73	41.13	35.89	39.11	32.33	37.49	54.60	29.86	32.27	36.30	28.20	41.37	43.77	15.92	29.59	52.38	44.42	15.69	73.02		21.97						98.40	1363.13	
	Actual Worked (From Ledger)		43.19	148.06	-	40.28	34.03	48.87	44.86		35.84	41.24	40.03	48.87	25.62	20.42	52.10	43.62	40.83	49.27	38.91	35.49	53.22	35.35	39.37	42.81	38.28	46.44	46.30	17.10	30.06	53.72	45.28	16.28	70.96		24.65						95.53	1486.88	
	Sickness (%) (April)	R = >4.75, A = 4.2 - 4.75, G = <4.2	3.86%	1.93%		5.44%	3.15%		11.87%		16.62%	1.23%	2.77%	4.46%	7.00%	4.03%	5.06%	3.85%	4.99%	8.96%	8.02%	1.70%	3.31%	3.23%	8.05%	5.95%	16.17%	13.37%	4.78%	5.80%	8.03%	7.44%	12.66%	6.07%	4.25%		8.54%						2.94%		
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)		1.56	-4.10	-	-8.34	1.08	3.69	-1.52		-0.25	-0.56	8.22	0.69	1.32	-1.39	1.09	-9.44	0.12	-5.14	1.82	1.09	-1.58	2.66	-2.06	-1.43	0.01	2.12	-2.28	-5.85	-2.34	7.01	-1.67	0.19	-5.37		2.95						7.19	-10.51	
	Pending Appointment			7		13	1	1	4.72			4.22	1	4			4	8.61	4	6	2		2.0	3		2.92	2	1	3	8	2	1	8.16			0.8						1	95.43	
	Substantive Staff Turnover Headcount (rolling average 12 months)	10%	16.6%	7.2%		20.6%	16.1%		5.9%		10.5%	11.2%	17.9%	25.7%	0.0%	20.6%	3.8%	13.0%	22.3%	4.6%	15.0%	0.0%	12.1%	3.0%	17.3%	12.3%	3.1%	5.8%	11.4%	4.9%	8.3%	10.9%	1.9%	3.0%	8.0%		17.5%	9.7%					10.5%		

Bolton NHS Foundation Trust

Board Assurance Heat Map - District Nursing Domiciliary - May 2019

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 (%)	100.00%	98.55%	96.92%	96.77%	100.00%	100.00%	96.15%	97.92%	100.00%	100.00%		98.59%
Total Monthly New pressure Ulcers (Grade 2+)(Lapse in Care + No Lapse in Care)	0	1	4	0	1	1	0	4	1	2		14
Total Monthly New pressure Ulcers (Grade 2+) *(No Lapse in Care only)*	0	1	4	0	1	1	0	4	0	1		12
Number of Home Visits (from Lorenzo) **	35	37	58	32	142	141	91	199	7	75	1925	2742
Monthly KPI Audit % (Revised Buddy Assessed Audit)	97.25%	99.12%	97.88%	96.69%	99.13%	92.58%	95.53%	95.53%	96.28%	96.44%	92.49%	
BoSCA - Bolton Safe Care Accreditation	95.74%	94.15%	94.17%	85.67%	98.18%	91.42%	96.15%	94.74%	91.74%	91.62%	84.43%	
Current Budgeted WTE	11.64	13.72	24.13	18.24	7.11	13.15	17.13		9.13	11.09	19.96	145.30
Actual WTE In-Post	12.04	15.60	15.03	17.60	8.11	13.60	16.53		12.61	9.00	18.87	139.00
Actual WTE Worked	11.93	15.47	15.78	17.99	8.20	13.66	16.24		13.76	9.00	20.08	142.10
Pending Appointment												
Current Budgeted Vacancies (WTE)	1.00		1.53						1.60	1.40		5.53
Sickness (%) April 2019	1.00%	0.85%	0.36%	18.75%	0.82%	0.68%	8.39%		0.78%	0.42%	1.62%	4.69%
Substantive Staff Turnover Headcount (rolling average 12 months)	7.64%	5.36%	12.63%	10.17%	0.00%	0.00%	4.69%		19.35%	10.34%	9.25%	6.12%
12 month Appraisal	91.7%	100.0%	61.1%	72.7%	100.0%	88.2%	100.0%		87.5%	90.0%	94.30%	81.2%
12 month Statutory Training	95.45%	96.30%	85.96%	84.17%	100.00%	99.02%	89.81%		92.16%	100.00%	94.44%	92.58%
Number of complaints received	1	0	0	0	0	0	0	0	1	0	0	2
Total Incidents reported on Safeguard (see end total column)	4	0	0	15	11	10	8	10	0	4	4	66

NHS
Bolton
NHS Foundation Trust

Agenda Item No: 16

Meeting	Board of Directors

Date	27th June 2019

Title	Compliance with condition FT4 (8)

Executive Summary	NHS foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS Provider licence. NHSI will contact a number of FTs to ask for evidence of self-certification either through the templates or through relevant minutes and papers. Although the template has not changed since 2017, the risks and mitigations have been reviewed. Board members are asked to consider the risks highlighted within this report

Previously considered by	

Next steps/future actions	To approve the self certification			
	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

Declaration

1. PURPOSE

To inform and support the June declaration to NHS Improvement covering corporate governance and Governor training.

2. BACKGROUND

Bolton NHS FT was authorised as a Foundation Trust in October 2008, since that time declarations have been made on an annual basis with regard to on-going compliance with the *Terms of Authorisation*. NHSI have changed their guidance and a sample of declarations will now be subject to audit

3. DECLARATIONS

The suggested form for the declarations is appended to this paper - for each declaration the Trust must respond confirmed or not confirmed and should provide additional information on risks and mitigating actions.

Corporate Governance Statement	Compliant	Risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Yes	**Risk:** not adhering to accepted standards of corporate governance or best practice **Assurance and Mitigating actions:** • CQC rated as Outstanding for Well Led • Well Led review completed in 2017 • Compliance with Monitor's Code of Governance for Foundation Trusts regularly assessed and reported through Audit Committee • The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Trust Secretary who has accountability for its maintenance. • There are no material conflicts of interest in the Board. • All governors elections and by elections held in accordance with election rules. • Trust Secretary in post who holds responsibility for corporate governance.

		• Systems and controls assurances are obtained via the Audit Committee. • Further formal external governance review will take place every three years or as required by NHSI. • More complete explanations about systems of corporate governance are set out in the annual governance statement and the Trust's annual report
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Yes	**Risk**: non-compliance with Monitor's Code of Governance for foundation trusts and other governance guidance issued by the regulator **Assurance and Mitigating actions:** • Compliance with Monitor's Code of Governance for Foundation Trusts assessed each year as part of the annual reporting process. (February 2019 Audit committee • Any guidance requirements are routinely assessed and implemented as necessary - over view of guidance provided in KPMG Technical Update received at each Audit Committee meeting. Assurance and advice is provided as required by the Audit Committee
3. The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	Yes	**Risk**: Ineffective board and committee structures in place which are not reviewed and updated. Unclear reporting lines **Mitigating actions:** • CQC outstanding for Well Led domain • Well Led review undertaken in 2017 • Board committees established with clear lines of reporting. • Terms of Reference in place for all Board and other committees and groups within the Trust which are regularly reviewed and updated where necessary. These set out remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. • Standardised Chair reports to escalate assurance and concerns in line with reporting structure. • Clear delegation of actions to committees

		• Annual Governance Statement in place which identifies areas of potential risk and mitigating actions.
4. The Board is satisfied that the Licensee effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Yes	**Risk:** Lack of systems to assess compliance with Licensing requirements **Assurance and Mitigating actions:** • Risk Management Strategy in place and regularly reviewed. • Board Assurance Framework • Safeguard risk management system in place. • Use of internal and external audit services to investigate any areas of concern. • Inpatient and other CQC surveys utilised with action plans put in place where necessary. • External reviews undertaken where appropriate or necessary. • Contracts for services agreed with clinical commissioning groups. • Finance and Investment Committee considers detailed financial performance report at each meeting • Monthly performance report considered by Board, detailed performance discussed at monthly performance reviews. • Comprehensive agendas for Board meetings circulated to directors at least 3 days before each meeting • Cost Improvement Plans in place which are risk assessed for quality • Standing Financial Instructions and Standing Orders in place • Counter Fraud specialist reports to the Audit Committee • In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high level risks facing the Trust and ways in which these are being mitigated. The four areas are: quality and safety, finance, operations and governance • Points as set out in 1), 2) and 3) above apply.

g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.		**Risk**: Potential loss of control through devolution of authority to the Trust's wholly owned subsidiary **Mitigating actions:** • Group Audit Committee and Risk Management Committee • FT Board representation on iFM Board • Contract review process • Group Health and Safety Committee • Deloitte review of iFM Governance • iFM compliance with corporate governance requirements
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with	Yes	• The Medical Director and the Director of Nursing are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity • Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Clinical quality, patient safety & patient experience metrics are reported to the Board monthly. • Quality Assurance Committee – chaired by a NED – Terms of Reference include reporting from Clinical Governance Committee and reports from clinical divisions. • Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to Clinical Audit Committee. Full list included within the Quality Account • Learning from national reports with comparative reports undertaken and action plans devised and implemented. • National reports and benchmarking e.g. NICE guidelines – NPSA safety alerts managed via Clinical Governance Committee • Regular ward and department visits undertake by all Board members

patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		• PLACE • Ward to board heat map • Exec team ward buddies • Board go and see • Processes in place to escalate and resolve issues - risk management committee established with reporting line to the QA Committee
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Yes	• The Medical Director, Director of Nursing and Director of Finance are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • All Executive Directors' performance and competencies are reviewed through annual appraisals. • Collective & individual skill-sets reviewed as part of board development • Chairman receives an annual performance appraisal from the Senior Independent Director, • NEDs receive an annual performance appraisal from the Chairman who advises the governors • NEDs have been appointed by the Council of Governors as advised by the governors' Nominations Committee. • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance, and, OD. Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction. • Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and

		workshops as required. • NED progress is monitored by the Chair via one to one meetings including a formal appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established. • This is supplemented by a number of Board development/strategy sessions to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. • Divisions are led by experienced and capable teams consisting of a Divisional Medical Director, a Divisional Director of Operations and a Divisional Director of Nursing. • Nursing levels on wards are reported to Board and are monitored and published on a daily basis on the ward staffing boards.

The training of governors		
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Yes	A Governor training programme has been in place since the election of the shadow council of Governors in 2008. However in response to the formal requirement in the Health and Social Care act and the changes to Governor responsibilities within the same act, the training has been reviewed and enhanced. In 2018/19 Training provided to Governors included: • a full day formal induction for new governors shared with WWL NHS FT • Attendance at staff induction for all new Governors • a quarterly rolling programme for "soft skills" including interview techniques and communication skills • A rolling programme of meetings with members of the executive team for enhanced understanding of director portfolios • The North West Governor forum • In addition to this other training and development opportunities including regional NW Governor meetings and training sessions provided by Mersey Internal Audit are routinely offered to and taken up by significant numbers of Bolton Governors. A similar programme is in place for 2019/20

4. RECOMMENDATIONS

Board members are asked to consider and debate the proposed declarations for submission to NHSI.

Appendices

declaration

Appendix One

Declaration templates

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		[including where the Board is able to respond 'Confirmed']	Please Respond
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		[including where the Board is able to respond 'Confirmed']	Please Respond
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		[including where the Board is able to respond 'Confirmed']	Please Respond
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and		[including where the Board is able to respond 'Confirmed']	Please Respond

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		[including where the Board is able to respond 'Confirmed']	Please Respond
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under

A Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Please Respond

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A