Bolton NHS Foundation Trust – Board Meeting 31 October 2019

Location: Boardroom **Time: 0900 –**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00	1.	Welcome and Introductions	Chair	verbal	
	2.	Apologies for Absence	Trust Sec.	Verbal	Apologies noted
	3.	Declarations of Interest	Chair	Verbal	To note any declarations of interest in relation to items on the agenda
	4.	Minutes of meeting held 3 October 2019	Chair	Minutes	To approve the previous minutes
	5.	Action sheet	Chair	Action log	To note progress on agreed actions
	6.	Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
	7.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
09.15	8.	Quality Assurance Committee Chair Report	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee and to escalate any items of concern to the Board
09.25	9.	Finance and Investment Committee – Chair Report	F&I – Chair	Report	F&I Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
09.35	10	Workforce Assurance Committee – Chair Report	CEO	Report	CEO to provide a summary of assurance from the Workforce Assurance Committee and to escalate any items of concern to the Board
09.45	11.	Urgent Care Delivery Board Chair Report –	CEO	Report	To receive a report on the Urgent Care Delivery Board
09.55	12.	Infection control Annual Report	DoN	Report	To note
10.10	13	Safeguarding Annual Report	DoN	Report	To note
10.25	14	Learning from Deaths quarterly report	MD	Report	To note

Coffee

11.00	15	Patient Story		Verbal	To note
11.20	16 16.1	Performance Report - 18 Week RRT Report	CEO COO	Report Report	To receive To receive
Strategy					
11.45	17	Brexit update	COO	Verbal	To note
11.55	18	Change to iFM Articles	Trust Secretary	Report	To approve
Reports from Sub-Committees (for information)					
12.00	19.	Any other business			
Questions from Members of the Public					
	20.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
	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	03 October 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
Dr F Andrews	Medical Director	FA
Dr M Brown	Non-Executive Director	MB
Mr A Ennis	Chief Operating Officer	
Ms B Ismail	Non-Executive Director	
Mrs S Martin	Director of Strategic Transformation	SM
Mr J Mawrey	Director of Workforce	JM
Mrs J Njoroge	Non-Executive Director	
Mr M North	Non-Executive Director	MN
Mr A Stuttard	Non-Executive Director	AS
Mrs A Walker	Director of Finance	
In attendance: -		
Mrs E Steel	Trust Secretary	ES
Ms R Ganz	Associate NED	RG

Apologies Mr A Thornton

The Chair welcomed attendees and observers

Patient Story

S, an inpatient on ward C1 attended to share her story of her recent admission to the Trust. S was admitted through Accident and Emergency following an episode of severe chest pain. S was admitted to CCU where she spent a week before being transferred to C1 where has been an inpatient for the previous three weeks. At the time of sharing her story she was waiting for an MR angiogram at Wythenshawe and had been waiting for this procedure for the previous two weeks.

S was very complementary with regard to the treatment she had received during her stay on both CCU and C1, food on the whole had been good and she had not been troubled by noise at night.

Board members thanked S for sharing her story, questions were asked for clarification and further understanding, the Medical Director and the COO undertook actions to understand the background to the long wait for a scan and to provide clarity with regard to diagnosis – although S was happy with communication and felt she was able to ask questions about her care she was not clear about her diagnosis.

FT/19/59	AE to follow up to understand reasons for long wait for scan	AE
FT/19/60	FA to follow up for clarity of diagnosis	FA

Declarations of Interest

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

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

The minutes of the meetings held on 25 July 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. Chief Executive report

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

In addition to the awards detailed within the written report, the CEO highlighted the work of the IT team in achieving EPR implementation as planned on Tuesday 2nd October 2019.

The approach to communications both in support of EPR and in promoting the Trust including supporting the arrangements for Baroness Harding to open the new Urology department was recognised.

Board members viewed the Freedom to Speak up promotional video and gave their support and commitment to raising awareness of the opportunities for staff to speak up about matters concerning them.

Board Assurance Framework

Following the launch of the new five year strategy, the Board Assurance Framework has been revised to provide assurance that the risks to achieving the new strategic ambitions have been assessed and are being mitigated / treated in accordance with the Trust's risk appetite. Finance and Investment Committee members advised that the F&I Committee had proposed increasing the risk of achieving the financial plan to 20.

Resolved: the board noted the CEO update.

8. Finance and Investment Committee Chair Report

Mr Stuttard, the NED Chair of the Finance and Investment presented his report from the meeting held on 24 September 2019.

The Committee focused on the overall financial position and performance against plan. The financial position to the end of August 2019 (excluding PSF) is a deficit of £7.7m against a deficit plan of £3.4m

The Committee considered the financial position and the actions being undertaken to address the deficit.

Other matters discussed within the committee and as outlined in the written report were progress on addressing aged debt, monitoring of the ICIP programme and the Trust's capital programme.

The F&I Committee received a report on the valuation of fixed assets, while the Committee supported the proposal it was agreed that the final decision should be referred to the Audit Committee as it had an impact on the accounting treatment which would affect the Annual Accounts.

The F&I committee also received an update on iFM financial performance and noted the forecast for an outturn in excess of the planned surplus.

The Committee received an update on EPR implementation through the Chair report from the Digital Transformation Board; as previously advised, implementation of EPR went according to plan. Board members agreed that a formal note of thanks should be recorded to all staff members involved in the successful implementation of EPR.

In response to a question about the standing of the system savings board and the rigor applied to system savings Board members were advised that a System Transformation Director had been appointed to work to both the FT and CEO and provide system oversight to drive system savings.

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

FT/19/61	refer decision on accounting treatment of valuation to Audit Committee

9. **Audit Committee Chair Report**

Mrs Njoroge, the Non-Executive Chair of the Audit Committee presented her Chair's report from the meeting held on 19 September 2019. The Committee had received a number of reports providing positive assurance but had also received reports identifying areas for action. Three high risk reports had been received in draft – while it was recognised that this did not allow time for the provision of a management response Audit Committee members had previously expressed a strong preference for having early sight of any high risk report.

The Director of Nursing confirmed that she would have been happy to attend the meeting to provide a verbal update and advised that actions had been agreed to address the concerns raised within the report on ward cleaning. Ms Ganz confirmed that cleaning and security are at the forefront of iFM's focus.

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

10. **Workforce Assurance Committee Chair report**

The Director of Nursing presented her Chair's reports from the Workforce Assurance Committee meeting held on 20 September 2019. As recorded within the written summary of the meeting the Committee received a number of reports and discussed actions being taken which felt to be on the right track. Although sickness absence remains a key focus for the Trust and has not yet reached the target rates reported in the Trust are the second lowest in GM.

Board members noted the escalated concerns in regard to the Guardian of Safeworking – a new Guardian has now been appointed with a remit to develop the post and provide robust assurance reports. Concerns were also escalated with regard to the Obstetrics and Gynaecology trainee action plan – once updated the action plan for HEE will be shared with Board members.

Mr North in his capacity as Chair of the Shadow Board proposed the production of a report on the Shadow Board Leadership programme.

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

FT/19/62	Report through Workforce Assurance Committee on the Shadow Board programme

11. **Urgent Care Delivery Board**

The Chief Executive presented the chair's report from the Urgent Care Delivery Board. The main focus of the meeting held on 10 September 2019 was with regard to a recent survey of A&E attenders with an aim of understanding the reason for the recent growth in working age attendees.

The Urgent Care Delivery Board also received a first draft of a demand and capacity report commissioned from NECS (NE Commissioning support)

Board members discussed the challenge of increased attendance, the pros and

cons of alternative models of delivery including walk in centres and the need for clear well defined pathways to ensure patients are aware of and access appropriate and available services. Board members agreed that an update on system working would provide a useful opportunity for further discussion on streaming and alternative provision.

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

FT/19/63	update on system working

12. Nasogastric Tube Misplacement

The Director of Nursing presented an update on the Trust position on training in relation to the placement of nasogastric tubes. In 2016, following a patient safety alert the Board had signed off compliance with guidance in an NPSA alert. In December 2018 it was identified that although a good system was in place the Trust were no longer fully compliant with the guidance – as the original declaration of compliance was shared with Board it was agreed that the identification of an issue impacting on compliance should be escalated to the Board.

Board members noted the escalation of the issue and the recommendations within the report to be fully compliant with the guidance, including a report through the QA Committee in April 2020 to provide assurance that actions have been completed.

Resolved: The Board noted the report.

13. 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:

Quality

In response to a question about **inpatient falls**, the Director of Nursing advised that although it is recognised that increased acuity and increased frailty increases the risk of falls there is still more that can be done to protect patients from harm as a result of a fall.

Infection Control – the number of c. diff cases has reported has increased over recent months; this has included a cluster of cases on one ward. In response to this a weekly meeting has been implemented to provide increased oversight with regard to the factors that could have contributed to this cluster. Board members asked if this was linked to the report presented to the Audit Committee discussed earlier in the meeting. The Director of Nursing advised that the review had been targeted in response to concerns, although a robust deep clean of an areas is undertaken after an infection a full decant programme of cleaning had not been undertaken. Ms Ganz in her capacity of Chair of iFM confirmed that action is being taken within iFM including a full decant programme for cleaning and

maintenance.

Mortality – There has been a reduction in the trust's SHMI rate however this is still higher than it should be, it is hoped that the new EPR system will enable coders to look at co-morbidities and recording. Mr North in his capacity of Chair of the Shadow Board advised that the Shadow Board had discussed the July mortality report; this had prompted a request for an update on the action plan. The Medical Director confirmed that the mortality review had since been completed and had not identified any concerns with the quality of care. The Board and QA Committee would continue to receive regular reports on plans for mortality reduction.

Maternity metrics to be covered in the presentation later on the agenda, the Director of Nursing suggested that metrics should be reviewed in 2020 to deliver a more sophisticated approach and ensure a focus on outcomes

Operational

There has been an increase in the time patients wait for surgery following a **fractured neck of femur**, this was a disappointment to the team who had worked to reduce this – the increase was attributed to the impact of the bank holiday and theatre pressures and the team had advised that they were confident of recovering performance.

The Chief Operating Officer advised that the Trust would not achieve the **18 week target**, waiting times have increased and there is a risk that performance against this target will deteriorate further. A proposed recovery plan has been submitted to the CCF but this will require funding. Board members discussed the reason for the increased waiting times, the Chief Operating Officer advised that the causative factors are not the same in all specialities with some areas affected by an increase in referrals and others feeling an impact from increased urgent cases.

The Chief Operating Officer advised that while he could not assure the Board that the position would improve, he was assured that a robust tracking process was in place with patients prioritised according to clinical risk.

The challenges in the system impacting on A&E performance remain an issue, there is an overall increase in the number of patients and an increase in acuity – the EPR implementation plan had included an ambition to create empty beds but this had not been possible.

The Board noted the Model Hospital data now included within the performance pack to provide an insight on some of the data used by regulators for oversight. A Board development session on Model Hospital has been scheduled for the October Board.

In response to questions about the impact of actions to reduce did not attends, it was agreed that an update on the outpatient improvement plan and impact of actions to reduce the DNA rate would be provided.

Resolved: the Board noted the integrated performance report

JN left the meeting

FT/19/64	Mortality update
FT/19/65	update on outpatient improvement plan including action to reduce DNA

15. **Workforce and OD Strategy update**

The Director of Workforce provided a summary of the key points covered within his 12 month update on the implementation of the Workforce and OD strategy.

Board members commended the report and the progress made and supported the need to continue focus on engaging with staff and reducing sickness absence.

Board members discussed the key points within the report including actions taken to ensure staff undertake the required statutory and mandatory training; actions to support staff retention and performance management of staff.

A number of follow up actions were agreed in response to questions raised.

FT/19/66	JM to email BI with details of update of Neybur
FT/19/67	JM to share staff pledges with Board members
FT/19/68	WAC to undertake a focus on retention and report back thru Chair report

14. **Maternity Services Update**

The Divisional Medical Director, Head of Midwifery and Clinical Lead for Obstetrics attended to provide the regular six month update on maternity services.

One quarter of all GM babies are delivered by Bolton maternity services which offer a choice of four places to birth and have a CQC rating of good. The Trust also provides tertiary neonatal services and has the best performing NICU in GM.

Board members discussed the metrics provided with a focus on the link between intervention in labour, the national Saving Babies Lives initiative and the aim for a reduction in still births which has been achieved. Team members advised that they were confident that inducing delivery at the right time contributed to a reduction in C Section rates and a good outcome for baby.

The division described their achievements and challenges including an increased sickness rate which with a number of staff off sick with long term and critical illness is 7.65% against a target of 4.2%.

Board members recognised the challenges within maternity services and asked what measures were in place to support staff and teams during difficult times. The Clinical Lead advised that debrief and support are offered at the end of cases and a working party has been established to discuss support and engagement. The Director of Nursing extended an offer of further support if needed.

In response to a question about the utilisation of Ingleside the Head of Midwifery advised that the continuity of carer team are now building their case loads and predicting increased use of Ingleside, the team are also working with Pennine to offer as an option.

Board members discussed the impact of the environment and the need for refurbished or ideally new facilities, the Director of Finance advised that the Estates Strategy group had approved work on cosmetic improvements as a

temporary measure until a new build could go ahead – if funding for a significant cap ex project is made available this will be a project that is ready to go.

Resolved: the Board noted the update and thanked the team for their time.

16. Complaints Report

The Director of Nursing presented the Annual Complaints report (previously presented for discussion and approval by the QA Committee.)

Performance has been strong, 95% of all complaints received a response within 35 working days, reopened cases reduced by 24% and no complaints were upheld by the PHSO.

There are however still times when things could be better, actions are planned to ensure more support is available for the most vulnerable members of the community and to ensure that people with protected characteristics have equal access to support and care.

An action was agreed to check data within the report which showed a reduction in activity.

Resolved: The Board noted the report and agreed the importance of ensuring learning from concerns and complaints.

FT/19/69	check activity figures recorded in the complaints report

17. Revalidation

The Medical Director presented the revalidation report and annual return to NHS E for review and approval.

The submission is a mandated return that forms part of a robust system of assurance to ensure continued competence of doctors.

The Medical Director confirmed that the six doctors shown in the report as having an unapproved, incomplete or missed appraisal had all been addressed, there is a system to defer when an individual is off sick. The Trust has not had to take any formal action with regard to this process.

18. Standing Orders

The Trust Secretary presented the Standing Orders and advised that the document had been reviewed with terminology updated to a more appropriate gender neutral language.

It was felt that clauses 7.1 and 7.3 repeated the same requirement for a director to be excluded from discussions where they have a pecuniary interest – 7.1 to be removed.

The Trust Secretary confirmed that a record is kept of requests to view

documents.

Resolved: The Board approved the revised Standing Orders.

19 **Planning for new format Board performance report**

Board members supported the proposal to shift metrics in the performance report to SPC run charts – an automated process is being developed to build this report with the aim of reporting all metrics in this format by the end of the financial year.

20. **Any other business**

21. **Questions from members of the public**

No questions submitted

Date and Time of Next Meeting

31 October 2019

October 3 2019 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/19/59	03/10/2019	patient story	AE to follow up to understand reasons for long wait for scan	AE	Oct-19	verbal update
FT/19/60	03/10/2019	patient story	FA to follow up for clarity of diagnosis	FA	Oct-19	verbal update
FT/19/55	29/07/2019	Strategy	Update on Estates Vision to October part two Board meeting		Oct-19	agenda item
FT/19/40	27/06/2019	performance report	Further information for Board members on Model Hospital	AW	Oct-19	development session confirmed
FT/19/53	25/07/2019	BCMS	Full business case to September Board	TAC	Oct-19	deferred to October Board
FT/19/49	25/07/2019	AoB - Data	Data effectiveness debate and review - Exec discussion and	ES	Oct-19	complete - agreed internal audit review
FT/19/66	03/10/2019	Workforce strategy update	JM to email BI with details of update of Neybur	JM	Oct-19	email
FT/19/67	03/10/2019	Workforce strategy update	JM to share staff pledges with Board members	JM	Nov-19	to be presented to Board in November
FT/19/61	03/10/2019	F and I Chair report	refer decision on accounting treatment of valuation to Audit Committee	AW	Nov-19	
FT/19/69	03/10/2019	Complaints report	check activity figures recorded in the complaints report	TAC	Nov-19	
FT/19/36	27/06/2019	Urgent Care Board	System wide discussion/report on mental health including proactive approach	AE	Dec-19	update on approach to mental health patients to December QA committee
FT/19/38	27/06/2019	Seven Day services	Verbal update on benchmarking, written update in six months	FA	Dec-19	verbal update provided - written update due 6 months
FT/19/51	25/07/2019	Car parking -	update on work of the sustainability group	AE	Dec-19	
FT/19/64	03/10/2019	performance report	Mortality update	FA	Dec-19	
FT/19/65	03/10/2019	performance report	update on outpatient improvement plan including action to	SM	Dec-19	
FT/19/63	03/10/2019	Urgent Care Board	update on system working	JB	Jan-20	
FT/19/68	03/10/2019	Workforce strategy update	WAC to undertake a focus on retention and report back thru Chair report	JM	Jan-20	
FT/19/62	03/10/2019	Shadow Board	Report through Workforce Assurance Committee on the	JM	Feb-20	

Key

complete	agenda item	due	overdue	not due

Agenda Item No:	
Meeting:	Board of Directors
Date:	31 October 2019

NHS Bolton NHS Foundation Trust

Title:	Chief Executive Report

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

Executive Summary:	
Previously considered by:	
Recommendation Please state if approval required or if for information	Provided for information

Confidential y/n	no

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

Prepared by:	Esther Steel Trust Secretary	**Presented by:**	Dr J Bene Chief Executive

1. Awards and recognition

Internal

Employee of the Month – Rebecca Walpole, Newly Qualified Staff Nurse, Ward E3 - Rebecca arranged a video link, so that one of her patients could watch her son's wedding in real-time so that she although she could not be there she had the opportunity to watch the whole ceremony

Team of the Month – Biomechanics Services Team Therapies) – awarded for their engagement in clinical audit

2. News and Developments

2.1 **The Queen's Speech** introduced two bills directly related to health and social care (the Health Service Safety Investigations Bill and the Medicines and Medical Devices Bill), with the possibility of two more (on the NHS long term plan and on adult social care). The government has also committed to continuing to reform the current Mental Health Act.

Provisions of the Health Service Safety Investigations Bill will include:

- Establishing a Health Service Safety Investigations Body as a new Executive Non-Departmental Public Body, with powers to conduct investigations into incidents that occur during the provision of NHS services
- Prohibiting the disclosure of information held by that investigations body, except in limited circumstances. This will allow participants to be candid in the information they provide and ensure thorough investigations.
- Improving the quality and effectiveness of local investigations by developing standards and providing advice, guidance and training to organisations.
- Amending the Coroners and Justice Act 2009, giving English NHS bodies the power to appoint medical examiners and placing a duty on the Secretary of State to ensure that enough medical examiners are appointed in England.

Provisions of the Medicines and Medical Devices Bill will include:

- Replicating powers over medicines and medical devices regulations contained in EU law.
- Making it simpler for NHS hospitals to manufacture and trial the most innovative medicines and diagnostic devices.
- Enabling the UK to be a world leader in the licensing and regulation of innovative medicines and devices, ensuring patients have access to the best possible treatments and supporting our domestic life sciences industry.
- Ensuring that the government can update legislation relating to medical devices, medicines, veterinary medicines, new innovative practices and clinical trials both in response to patient safety concerns and as it agrees the future global relationship of the UK in these areas.

The government has also committed to implementing NHS England's proposals for legislative change to support the delivery of the long term plan.

2.2 NHSI/NHSE

Our current performance with regard to A&E and finance has been discussed in a number of calls with NHSI

Winter Planning – NHSE/I undertook a round of "Winter stocktake calls with all North West trusts to understand common challenges and the overall position.

Long Term plan submission - NHS England, NHS Improvement and Health Education England are collecting information from Integrated Care Systems/Strategic Transformation Partnerships to help them develop five-year strategic plans. System plan submissions will be made of a report on the finance and operational forecast, the Long Term Plan headline metrics, and a narrative system plan. Planning tools have been provided to CCGs and providers to complete. (anticipated agenda item for November Board)

2.3 CQC

The Care Quality Commission (CQC) has published its report State of health care and adult social care in England 2018/19. The report is CQC's annual assessment of health and social care in England and looks at trends in quality, shares examples of good and outstanding care, and highlights where care needs to improve.

- The CQC has found that the overall quality of care that people receive in England has improved very slightly from last year. When people are receiving care, it is mostly of good quality. However, the CQC has found many people can struggle to get access to the care they need and want, impacting on their experience of care.
- Access and staffing are presenting challenges across all care settings, with geographic disparities in provision presenting particular barriers in some parts of the country.
- The report highlights pressures in A&E and across the system. It states figures for emergency attendances and admissions are continuing to rise year-on-year, and patients struggling to access non-urgent services in their local community can have a direct impact on secondary care services.
- The report calls for actions in the following areas: more and better services in the community; innovation in technology, workforce and models of care; system-wide action on workforce planning; and long-term sustainable funding for adult social care.

2.3 Freedom to speak up month

The Trust hosted a visit from Dr Henrietta Hughes the National Guardian, the visit was very well received and Dr Hughes has written to thank us for the opportunity to visit and to commend the Speaking up arrangements we have in place

3.0 Reportable Issues Log

Issues occurring between 18/07/19 and 25/09/19

3.1 Serious Incidents and Never events

The Trust reported one serious incidents relating to patient care.

3.2 **Red Complaints** – One red complaints has been received, relating to maternity services – this is being investigated in accordance with the policy

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

3.4 **Whistleblowing**

No concerns to escalate to board

3.5 **Media Coverage**

There has been some very positive media coverage this month:

- The annual staff awards generated a double page spread in the Bolton News, significant engagement on social media and follow up interviews arranged with Bolton FM.
- The replacement of the sculpture in the baby memorial garden, and Wave of Light ceremony to mark Baby Loss Awareness Week also generated significant engagement on social media and coverage in the Bolton News.
- Bolton FM interviewed Ashley Mason ahead of the 0-19 launch event and advertised the event to their listeners.
- There was also positive coverage around the development of the mortuary bereavement garden. Our staff profiles continue to generate positive engagement on Facebook.

To balance this, there was negative coverage in the Bolton and Manchester media about the data breach in school nursing, the Trust's financial position and pressures on waiting lists and A&E.

Other projects and campaigns that have been publicised in various ways this month include; EPR go live, AHP Day, Freedom to Speak Up Champion Month, Flu Campaign, Mental Health Awareness and Black History Month.

4 Board Assurance Framework

The full Board Assurance Framework (BAF) is used to record and report the risks to the achievement of the Trust's strategic objectives, the controls to reduce or mitigate these risks, any identified gaps in these controls and the assurance that the controls are effective.

The BAF has been reviewed to align with the new five year strategy; comments are welcome on how the risks to our new ambitions are reflected within the BAF

The full BAF will be reviewed in detail within the November Audit Committee

Ambition	Lead	I	L	Oct	Key Risks/issues	Key actions	Oversight
To give every person the best care every time – reducing deaths in hospital	FA	4	4	16	Escalation of ill patients Increase in HSMR/RAMI	Ensure learning points are captured by Learning from deaths committee and that assurance fed back Ensure KPIS for E-obs/NEWS are agreed and monitored for improvement Ensure learning from deaths committee looks at diagnostic groups with greater than expected deaths using SJRs End of life strategy role out including education on identifying patients who are nearing end of life	QA committee Mortality Reduction Group Learning from Deaths
To give every person the best care every time – Delivery of Operational Performance	AE	4	5	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
To be a great place to work	JM	4	4	16	Recruitment, limited pool of staff Pensions / Tax implications Sickness rates Reliance on Non-Core Staff – Premium spend (Agency)	Recruitment workplan in place Reviewing options to mitigate pension/tax implications Targeted actions to reduce sickness absence Tight focus on controls of Agency staff	IPM Workforce committee
To use our resources wisely Financial sustainability	AW	4	5	20	Delivery of ICIPs In year cost pressures Agency cost pressures 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
To make our hospital and our buildings fit for the future		4	3	12	Availability of capital funding Changes to capital regime Technical accounting rules Lack of revenue to support capital Planning considerations – traffic and car parking constraints	Development of detailed Business Cases Detailed Strategy Working with LA and other partners	Strategic Estates Board Strategic Estates Group Finance Committee
To join up services to improve the health of the people of Bolton	SM	4	3	12	Failure to Deliver Integrated Care Partnership	Locality Plan to be produced November 2019 Business Case for ICP to be developed December to include:- • Identify target population • Define core elements of delivery model • Translate the core elements to activity • Identify and model the workforce requirements • Model the financial requirement Robust Communication and Engagement Plan across all providers in place	Strategy / Transformation Board QA Board

						Development of an OD Framework to support cultural change Development of a system approach to community engagement.	
To develop partnerships across Greater Manchester to improve services	JB/SM	4	4	16	Delivery of Healthier together/Improving Specialist Care	Executive Provider Oversight Group overseeing implementation of Healthier Together NW Sector Partnership Board in place to oversee the delivery of the outputs of the Improving Specialist Care programme. Robust Programme Plan in place across GM for the delivery of the Improving Specialist Care Programme. Executive Level involvement in the Improving Specialist Care Programme.	Strategy / Transformation Board QA F and I Board

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	16 Oct 2019	Date of next meeting:	
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	D Hall, M Brown, J Njoroge, A Ennis, F Andrews, M Forshaw, E Steel. Representation from the four clinical divisions	Quorate (Yes/No):	NO
		Key Members not present:	T Armstrong Child, J Bene, D Sankey

Key Agenda Items:	RAG	Key Points	Action/decision
Theatre Safety		Mr P Wykes delivered a presentation on the development of a strong safety culture within theatres	Report noted, update requested on delivery of human factors training
Elective Care divisional quality report		The regular quarterly report included the achievements and challenges for the division. The strong performance against cancer targets was highlighted as a key success. Discussion on the work to implement pathways changes to reduce pre-operative waiting times.	Report noted with some actions agreed to follow up on items within individual portfolios
Family Care Divisional quality report		Quarterly report presented to provide a picture of successes and challenges within the division. Debate focused on the action plan to address issues raised by the deanery, a discussion on the statistical significance of still birth data and a discussion on continuing to develop a culture where all staff are empowered and enabled to speak up.	Report noted – no actions required
Bowell Cancer Screening update		Although actions have been taken since the previous report to increase capacity the overall capacity to manage increased demand remains a significant challenge.	Risks noted, update report requested in three months to include data on average waiting time. Committee assured that although delays are a concern there is no evidence of patient harm as a result of increased waiting time
Assurance Mapping – national and third party audits		Report provided summarising national audits – provided assurance that audits are reviewed with valid	Report noted

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Committee/Group Chair's Report

		discussions to ensure the results are incorporated in improvement plans	
Quality Account priority – Diabetes		Report outlined the progress made on the quality account priority relating to diabetes. Progress has been made but some areas for further work identified	Further detail requested in next iteration of the report
SI reports		Final reports from three serious incidents received for approval.	All three reports approved, actions within reports discussed with some additional actions identified for committee members.
Patient Experience, Inclusion and Partnership Committee		Matters covered included presentation on continuity of carer (maternity), an update on the Lived Experience Panel and a progress report on the use of runners to support pharmacy	Report noted – no risks escalated
Mortality Committee		The Committee received a summary of the cardiac arrest RCA report and an update on the heart failure workstream. Work is on-going with the clinical coding team to pneumonia cases	Report noted, some amber areas within the report but no risks escalated
Risk Management Committee		Review of risk registers in accordance with the workplan	Report noted, some amber areas within the report but no risks escalated
Strategy and Transformation Board		Updates provided on ICP, Model Hospital and System savings	Report noted, system savings identified as a red risk
Learning from deaths committee		Reviewed patient deaths for learning from areas where sub-optimal care was identified. Also identified learning from case where excellence was identified to share an example of good palliative care.	Report noted, some amber areas within the report but no risks escalated
Comments			
Risks Escalated –			

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	22nd October 2019	Date of next meeting:	26th November 2019
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Andy Ennis, Bilkis Ismail, Annette Walker, Catherine Hulme, Lesley Wallace, Donna Hall, Jackie Bene, Martin North, Andy Chilton, Mark Costello	Quorate (Yes/No):	Yes
		Key Members not present:	Sharon Martin

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
Month 6 Finance Report		Director of Finance	The financial position to the end of September 2019 (Month 6), excluding PSF, is a deficit of £8.4m, against a deficit plan of £3.7m, an overall shortfall of £4.7m. Taking PSF into account the deficit is £5.6m which is £4.1m off plan. The main reasons for the shortfall are: • Income shortfall of £1.3m • Expenditure overspend of £2.8m • ICIP off track by £1.2m Overall when compared to August the position after taking PSF into account has worsened slightly by £0.3m (August £3.8m off plan). This represents a stabilising of the position. A detailed piece of work has been undertaken on the issues around income. A number of improvements have been made and further work is being undertaken. With regard to pay the in-month expenditure of £20.7m is £0.1m less than August and is the lowest this financial year. Non-pay overall is in balance. The internal ICIP of £9.5m is on track to deliver savings, however the main issue is the system wide savings of c£6.0m which will not be delivered unless further schemes are identified and delivered in this financial year. The capital programme is on track to deliver the plan of £11.9m for this financial year. On the cash position there is a closing balance at the end of September of £24.9m. The Better Payments Practice Code (BPPC) is	For noting.

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			89.4% which is the highest it has been in the last four years. Work is continuing to be undertaken to reduce the aged debt as it was disappointing to note that the amount outstanding over 121 days has not reduced. Overall the Trust is forecasting a best case outcome of a deficit of £8.6m which is £11.8m adverse variance from the Control Total. The mid case more probable scenario is still a deficit of £13.2m.	
ICIP Progress Report		Deputy Director of Transformation	The Committee received an update on the delivery of the ICIP. The Trust is forecasting delivery of the internal Divisional schemes of £9.5m. However the main risk remains around the delivery of the system wide savings. The Committee did agree that the system schemes should remain on the plan because they may be deliverable over a longer period of time. The Committee were assured that there is a detailed monitoring programme in place through the PMO on the ICIP programme.	For noting.
Protocol for Changes to an In-Year Financial Forecast	**N/A**	Director of Finance	The Committee received a paper on the arrangements for changes to the in-year financial forecast. This is relevant in the context of reporting any changes to the original Control Total which given the financial forecast for this year will need to be followed. The FT's forecast outturn as reported to NHSI is being discussed with GMHSCP in view of the current position.	For noting.
Financial Improvement Trajectories and the Financial Recovery Fund	**N/A**	Director of Finance	The financial regime for Trusts from 2020 onwards is to undergo a number of changes. The Committee received a letter from the Regional Director setting out the details of these changes and the likely impact for Bolton NHS Foundation Trust from 2021 onwards. The Control Total has now been replaced by a financial improvement trajectory which requires a surplus of £1.75m for Bolton. The PSF has now been removed and will be used to finance a financial recovery fund. Further updates will be provided as we move towards the new financial year.	For noting.
Planning the 2020/21 ICIP	**N/A**	ICIP Programme Manager	The ICIP Programme Manager, Debbie Tinsley, presented a paper on the opportunities and actions being taken for the 2020/21 ICIP. This is being rolled out to the Divisions in advance of the 2020/21 financial year.	For noting.

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Committee/Group Chair's Report

Model Hospital Use of Resources		Director of Finance	The Committee received an update on the Model Hospital Use of Resources and the four metrics which were identified as requiring further work. Pre-procedure bed days have improved from Q4 in 2017/18 to Q1 of 2019/20. DNAs and Emergency Readmissions have marginally improved, however DNAs are significantly worse than peer and the national average. Further work is being undertaken, in particular the Outpatients Transformation Programme which is focusing on the DNAs.	For noting.
Top-up Insurance		Head of Financial Services	The Committee received an update on the Trust's insurance cover which is arranged through the Trust's insurance broker Griffiths and Armour. The Committee noted the update.	For noting.
iFM Finance Paper		iFM Director of Finance	The Committee received an update on the financial position of iFM as at Month 6. The Finance Director reported that as at September iFM is reporting a profit of £198.0k against a plan of £273.0k. The forecast for the year is a probable outturn of a profit of £627.0k against a plan of £545.0k.	For noting.
BCMS Full Business Case		Director of Finance	The Committee received an update on the proposals for the establishment of the Bolton College of Medical Sciences.	For recommendation to the Board.
Wave 3 Business Case		Director of Finance/iFM Director of Finance	The Committee received the Outline Business Case relating to the transfer of clinical non-pay to iFM. The Committee agreed with the proposal to share the OBC with NHSI to gain their approval to move forward and if this was granted to prepare a Full Business Case for consideration by the Trust.	For approval.
Procurement KPI Report		iFM Director of Finance	The Committee received an update on progress with regard to performance against the key performance indicators for procurement savings. As at the end of September savings of £1.1m representing 34% of the annual target (£3.2m) had been delivered.	For noting.
Chair Report from CRIG		Director of Finance	The Director of Finance provided an update on the work undertaken by the Capital & Revenue Investment Group. In response to a query on the Acute Therapy base it was confirmed that further work was being undertaken to develop this scheme.	For noting.

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Committee/Group Chair's Report

Chair Report from the Strategic Estates Board		Chief Executive	The Chief Executive provided an update on the Strategic Estates Board in particular referencing the work being looked at with regard to the Farnworth area in conjunction with other local partners and how the Trust Estate could benefit potential plans.	For noting.
Tender Update	**N/A**	Director of Finance	There were no schemes that the Trust was currently tendering for.	For noting.
Risks escalated The current financial risk previously reported of 20 (5 x 4) remains unchanged.				

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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:	September, 2019	Date of next meeting:	October, 2019
Chair:	J Bene	Parent Committee:	Trust Board
Members present/attendees:	J Mawrey, F Andrews, E Steele, M Foreshaw, C Sheard, L Gammack , M Costello and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	T Armstrong-Child

Key Agenda Items:	RAG	Key Points	Action/decision
Annual Equality Compliance Report 2018-2019		• The Committee received the annual report. The report included the progress being made on the numerous inclusion work streams.	**Actions agreed:-** • The Committee fully commends the report to the Trust Board.
Workforce & OD Dashboard		• The Committee received the Integrated Workforce Performance Report. The report triangulated key workforce data to support informed discussions. • Members were pleased to hear that over 50 managers had recently been trained to carry out investigations. This will be critical to ensure swift, timely and effective investigation processes. • Workforce & OD metrics positive with the exception of sickness management (albeit in-month improvement). A deeper focus on sickness management was considered later in the agenda. • Committee noted that it would be helpful if the dashboard could set out which changes to headcount should be viewed as positive and which less positive – based on current financial climate and whether changes will increase or decrease run-rate.	**Actions agreed:-** • Review the dashboard to better understand which headcount should be viewed as positive and which less positive – based on current financial climate and whether will increase or decrease the run-rate.

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Sickness absence		• The Committee received a very helpful report, which aimed to better understand the impact Bolton demographics have on sickness rates. • There was a very clear correlation between high sickness rates and Bolton locality areas. • The paper noted that A. The younger generations tended to have a higher number of short term absences. This may indicate that there is more work to do on promoting other types of leave eg flexible working to support staff to stay in work. B. The age group 46+ have a greater incidence of long term absence, rising most to 61+ age group. This may indicate that there is more work in this area – noting the NHS Working Longer Framework helps to better understand enabling actions • The Committee were reminded that the Staff Health and Wellbeing Strategy 2019-2022 and associated action plan was discussed in detail in the last meeting – which supported the Trust holistic approach to Staff Health & Wellbeing.	**Actions agreed:-** • A paper be provided to the December Committee outlining what further steps can be taken to support the findings set out in the paper e.g. liaison with Public Health, implementation plans to improve take-up of other leave and a review of the NHS Working Longer Framework.

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Staff Deal		• The Committee had a helpful paper & presentation on the plans to introduce a staff pledge and refreshed behavioural framework, aligned to a refocused staff recognition approach.	**Actions agreed:-** • The introduction of a staff pledge was supported by the Committee, although there were elements that required greater clarity regarding implementation and the potential re-naming of well-regarded internal awards. • It was agreed that this would remain a standing item until which time the Committee would be able to make final recommendations to the Trust Board.
NHS Staff Survey		• The Trust received an update on the NHS Staff Survey which is currently out and will be closing at the end of November. Currently the Trust's response rate is above the national average. • It is too early to understand whether the EPR 'Go live' will have an impact on the Staff Survey findings. The Committee will receive the Quarter 3 Go-Engage feedback (running concurrently with NHS Staff Survey) in December, which should then provide a helpful indication of NHS Staff Survey results.	**Actions agreed:-** • Verbal update be provided at the next meeting on the response rate for the NHS Staff Survey at both Trust & Divisional level
Workforce Cost Improvement Programme		• The Committee received an update on the Workforce Cost Improvement Programme. It was noted that this remains a regular item on the Financial Recovery Group which reports to the Finance Committee.	**Actions agreed:-** • Report noted

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Committee/Group Chair's Report

Guardian of Safeworking (GOSW) report		• The Committee received an update on the remedial actions that are being taken to improve the poor reports that have been sent to the Committee. • The Committee supported the actions and looked forward to improved reporting moving forward.	**Actions agreed:-** • Report noted
Obstetrics & Gynaecology Trainees Action Plan		• The Committee received little assurance again from the presented action plan that the appropriate actions were being taken. It was noted that significant work is required before submission to Health Education England (HEE) in November.	**Actions agreed:-** • Divisional Medical Director to urgently review the action plan. Further update to be provided to the Executive team along with follow up to the November Committee.
Developing Workforce Safeguards		• The report set out the requirements of the 'Developing Workforce Safeguards' (NHSI). • The report set out a summary of the current policy against the requirements. Based on this assessment the Committee were satisfied that the Trust was compliant with the guidelines.	**Actions agreed:-** • Report noted
Equality & Diversity Group		• The Chairs report was noted	**Actions agreed:-** Paper noted
Staff Engagement Group		• The Chairs report was noted	**Actions agreed:-** Paper noted
Staff Health & Wellbeing Group		• The Chairs report was noted •	**Actions agreed:-** • Paper noted
Medical Education Group		• The Chairs report was noted	**Actions agreed:-** • Paper noted
Education Governance Group		• The Chairs report was noted	**Actions agreed:-** • Paper noted

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Committee/Group Chair's Report

Risks escalated None – matters being managed within Committee (Obstetrics & Gynaecology) **Recommendations** Annual Equality Compliance Report 2018-2019 is fully commended to the Trust Board. Update on the Staff Deal and behaviours had planned to come to the November Trust Board. Given more discussion required then this will follow in a late Board meeting.			

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Urgent & Emergency Care Board	Report to:	Board of Directors
Date of Meeting:	8th October 2019	Date of next meeting:	12th November 2019
Chair:	Su Long	Parent Committee:	Board of Directors
Members Present:	System representatives present	Quorate (Yes/No):	Yes
		Key Members not present:	Bardoc

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
UECB Work Plan & High Impact Changes		JB/IK	• Presentation received from the Trust updating the Board on the work being undertaken to improve NEL LOS, Discharges by 12 & 4pm, Super Stranded patients and DTOC	• Further work required on streaming
Community and Intermediate Tier Update		JS	• Presentation received from the Trust regarding IMC at Home, Home Support Reablement, LOS in Community beds and Admission Avoidance • Improvements demonstrated in Home support reablement and LOS • Further work required for IMC at Home (referral to start date has increased due to more complex cases being managed at home and staff absence	• Update on Reablement requested for next month's meeting
Locality Progress Update		GB	• Feedback provided from the recent Winter Preparedness Peer Review	• Assurance process in place with regular updates expected to be submitted
Reducing Longer Length of Stay Workshop		MH	• Bolton System had representation at the event in September • Communications team working on information for patients and relatives building on the "Home First" theme	• Team are presenting at GM meeting on 18/10/19

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Committee/Group Chair's Report

High Intensity Users Event		MH	• Bolton system had representation at the recent event where our Frequent Attenders work was held up as good practice • Neighbourhood teams to be made aware of Frequent Attenders for the team to try to prevent further attendances at A&E/GPs	• Share frequent attenders information with Neighbourhood teams
Comments				
Risks escalated **None**				

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Agenda Item No:	
Meeting:	Board of Directors
Date:	31st October 2019

NHS Bolton NHS Foundation Trust

Title:	Infection Prevention and Control Annual Report 2018/19
Purpose	Overview of the provision of Infection Prevention and Control and healthcare associated infection (HCAI) performance
Executive Summary:	This report provides a summary of the activities of the Infection Prevention and Control Team (IPCT) for the year 2018/19. It includes key issues such as; meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* figures, Carbapenemase Producing Enterobactericae (CPE) activity, audit activities and adverse incidents
Previously considered by:	Infection Prevention and Control Committee (IPCC)
Recommendation Please state if approval required or if for information	All recommendations to be overseen by the IPCC

Confidential y/n	N

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

Prepared by:	Richard Catlin, Assistant Director of Infection, Prevention and Control	**Presented by:**	Trish Armstrong-Child, Director of Nursing/Director of Infection, Prevention and Control

Infection Prevention and Control Annual Report

April 2018-March 2019

Our Bolton NHS FT Values

1. EXECUTIVE SUMMARY

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

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

Fig. 1: Summary table of performance of 2018/19 HCAI cases as reported as part of the mandatory surveillance scheme

Organism	Cases Reported		
	All Cases	Hospital Onset Cases[3]	
Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias	3	1	
***Clostridium difficile* toxin cases**	67	20	17 Performance cases[4]
Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias	99	22	
***Escherichia coli* (*E. coli*) bacteraemias**	289	39	
***Klebsiella spp.* bacteraemias**	61	12	
***Pseudomonas aeruginosa* bacteraemias**	10	2	

MRSA Bacteraemia

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

There was one Hospital Onset MRSA case in 2018/19 compared with two cases in the previous year.

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

Clostridium difficile toxin (CDT)

NHS England sets the annual *Clostridium difficile* objectives. The objective for 2018/19 was no more than 19 Hospital Onset cases. There were 20 Hospital Onset cases in total. The Trust has an agreement with Bolton CCG that a decision regarding performance will be discussed at the CDT Harm Free Care Panels; if causal lapses in care are identified, then the case will be considered a performance case and so count against the target of 19 cases. Of the 20 Trust apportioned cases, there were no causal lapses in care in three instances meaning that there were 17 cases where lapses were noted.

Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

There are no national objectives for MSSA cases but these are a good proxy for the delivery of safe care, in particular related to line and wound care which are frequently the root cause of these infections. In 2018/19, there were 22 Hospital Onset cases compared with 15 cases in the previous year.

Gram Negatives

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

Escherichia coli (*E. coli*) Bacteraemia

There were 39 Hospital Onset *E. coli* bacteraemias in 2018/19 compared with 44 cases in the previous year.

Pseudomonas aeruginosa Bacteraemia

There were two Hospital Onset *Pseudomonas aeruginosa* bacteraemias in 2018/19 in comparison with two cases in the previous year.

Klebsiella spp. Bacteraemia

This surveillance includes all species of *Klebsiella* – referred to as *Klebsiella spp.* There were 12 Hospital Onset *Klebsiella spp.* bacteraemias in 2018/19 in comparison with nine cases in the previous year.

Carbapenemase Producing Enterobactericae (CPE)

In 2018/19 there were two outbreaks of CPE; there were three linked cases on one ward and 16 linked cases on a different ward. Both outbreaks were unrelated to each other.

In total there were 34 CPE cases identified at Bolton FT in 2018/19. Of these, 28 cases were from screening samples – indicating CPE colonisation rather than infection – and six clinical samples compared with nine and six respectively in the previous year.

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

2.1 IPC Service Delivery

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

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

2.2 Microbiology Services

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

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

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

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

2.3 Healthcare Associated Infection (HCAI) System

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

3. Healthcare Associated Infections (HCAI) performance

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

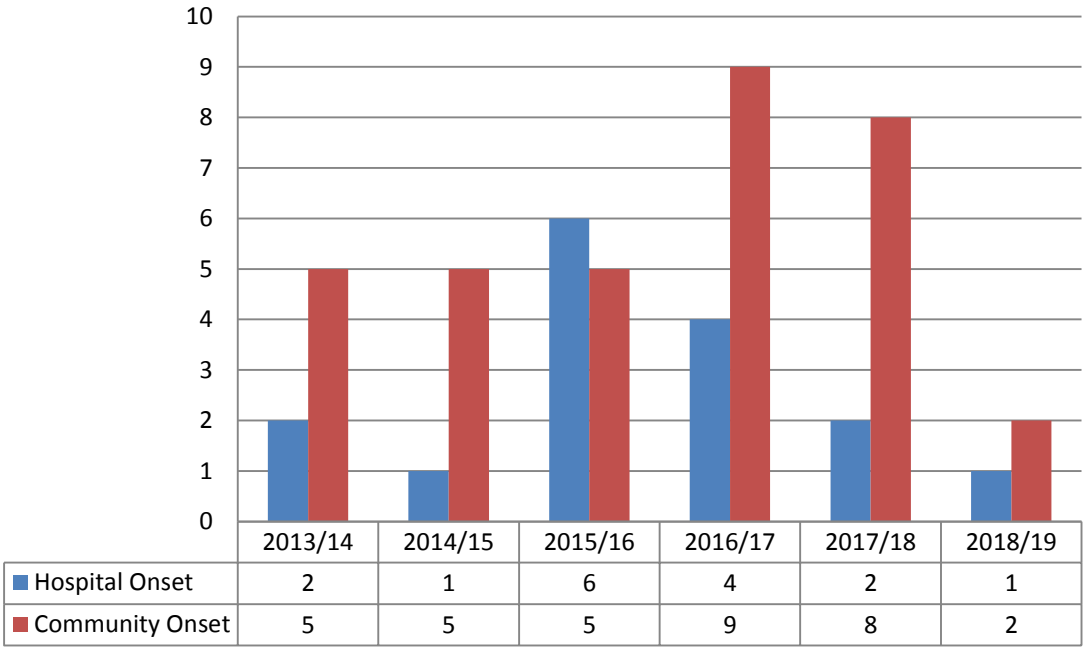
1. MRSA positive blood cultures
2. *Clostridium difficile* toxin positive results
3. MSSA positive blood cultures
4. *E. coli* positive blood cultures
5. *Klebsiella spp.* positive blood cultures
6. *Pseudomonas aeruginosa* blood cultures
7. Surgical Site Infections

3.1 MRSA Bacteraemia

The DH apportions cases to acute Trusts based on date of specimen collection. If blood cultures are collected on the day of admission or the following day then the case is determined to have a Community Onset. Specimens collected after this period are determined to have a Hospital Onset. There is no longer a facility to alter how cases are apportioned following a case review as there was in previous years.

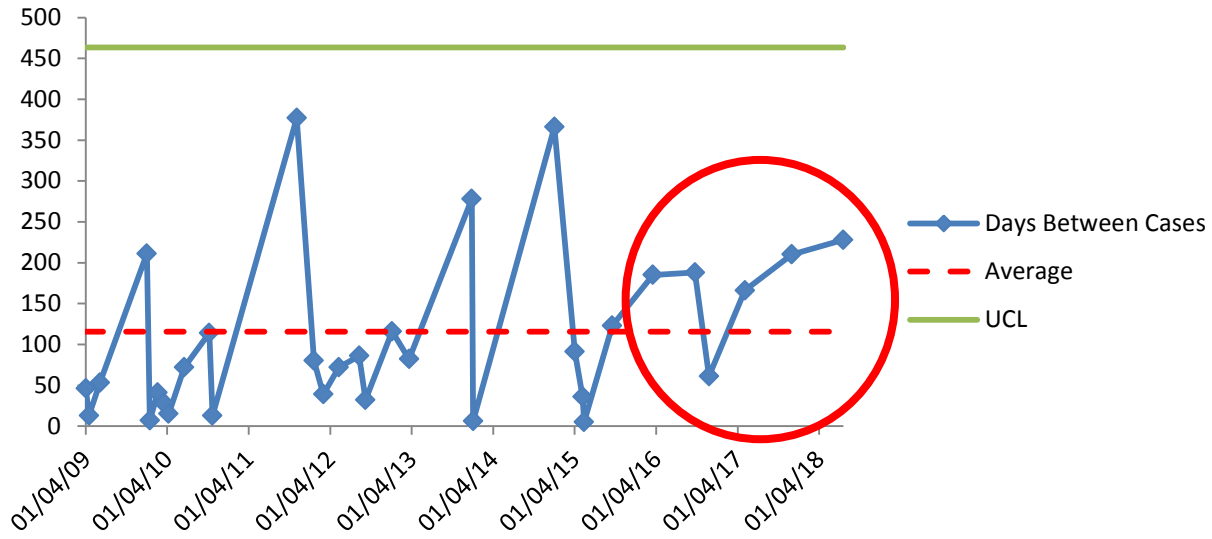
This surveillance only covers MRSA positive blood cultures and excludes results from screening and other clinical sites.

Fig. 2: MRSA Cases



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Hospital Onset	2	1	6	4	2	1
Community Onset	5	5	5	9	8	2

Fig. 3: Hospital Onset MRSA Cases SPC Chart



This chart shows that the period of time between MRSA cases is increasing over time after a period where there were very short durations between cases in the past few years.

3.1.1 Trust Apportioned Cases

NHS England has set a zero tolerance policy for MRSA bacteraemias so every acute provider has a trajectory of zero cases every year. During 2018/19 there was one Hospital Onset case.

3.1.2 Non-Trust Apportioned MRSA Cases

There were two Community Onset cases in 2018/19. These cases have also been reviewed using PIR methodology. In year, the support by Bolton FT for the CCG to undertake these reviews has been strengthened to improve shared learning.

3.1.3 Post Infection Review (PIR) of MRSA Bacteraemia Cases

The Trust follows the mandated NHS England PIR process[5] in conjunction with the CCG. This requires for a case to be reviewed and fed back to a joint Trust/CCG group to agree apportionment. In line with revised guidance published in 2018, there is a threshold above which NHS England requires Trusts to collate their PIR outcomes centrally using the Public Health England (PHE) Data Capture System (DCS) for scrutiny. The threshold is 1.8 cases/100,000 occupied bed days. The Trust ended the year with an MRSA rate of 0.48 cases/100,000 occupied bed days.

3.1.4 MRSA Screening

The Trust has maintained a universal policy to MRSA screening with all elective and non-elective admissions being screened for MRSA on admission to the Trust. Additional screening is undertaken in the critical care departments of the Trust where patients are

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

screened on admission to the relevant unit and on a weekly basis. Elective patients may also be screened as part of their pre-admission pathway to maximise safety prior to surgery or other invasive procedures.

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

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

3.2 *Clostridium difficile*

The DH apportions cases to acute Trusts based on date of specimen collection. If a stool specimen is collected on the day of admission, the following day or the day after that, then the case is determined to have a Community Onset. Specimens collected after this period are determined to have a Hospital Onset.

Every Hospital Onset case is reviewed using root cause analysis methodology. If the Trust can demonstrate that there have been no causal lapses of care then the CCG has agreed to consider these cases as not counting to performance.

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

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

3.2.1 Trust Apportioned Cases

The objective for Bolton FT by NHS England was no more than 19 Trust apportioned cases. The Trust ended the year with 20 Hospital Onset cases in total. In agreement with Bolton CCG three cases were considered to have no lapses in care and so were not considered to be performance cases contributing to the objective of 19 cases.

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

Fig. 4: CDT cases

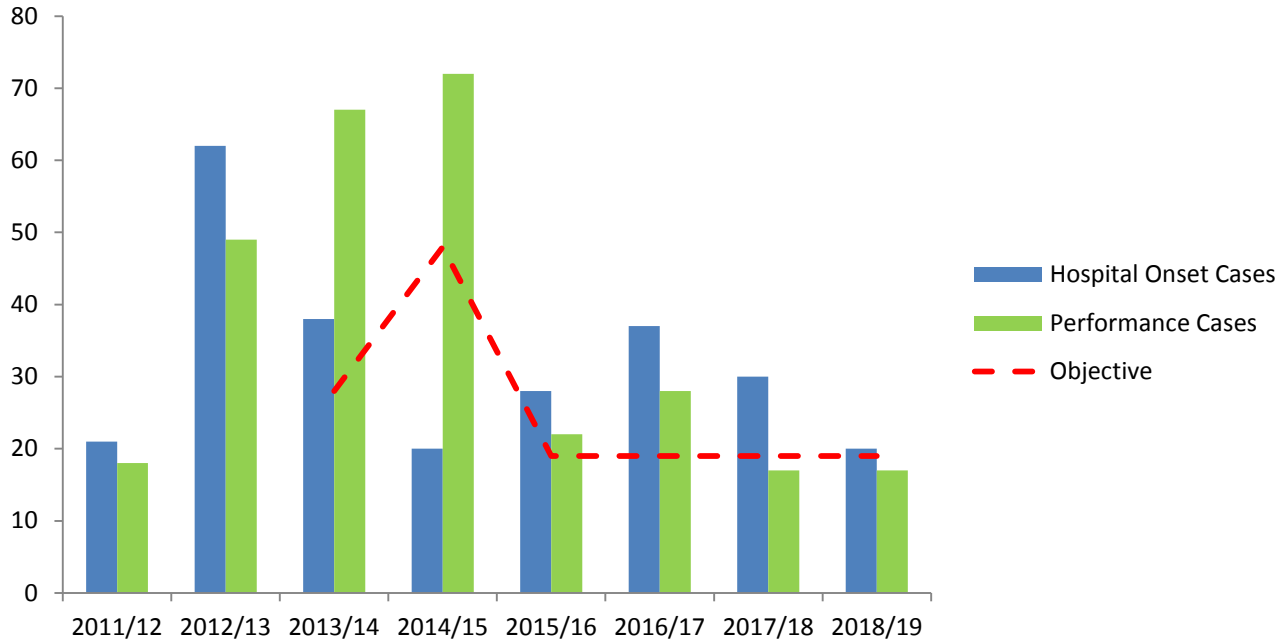
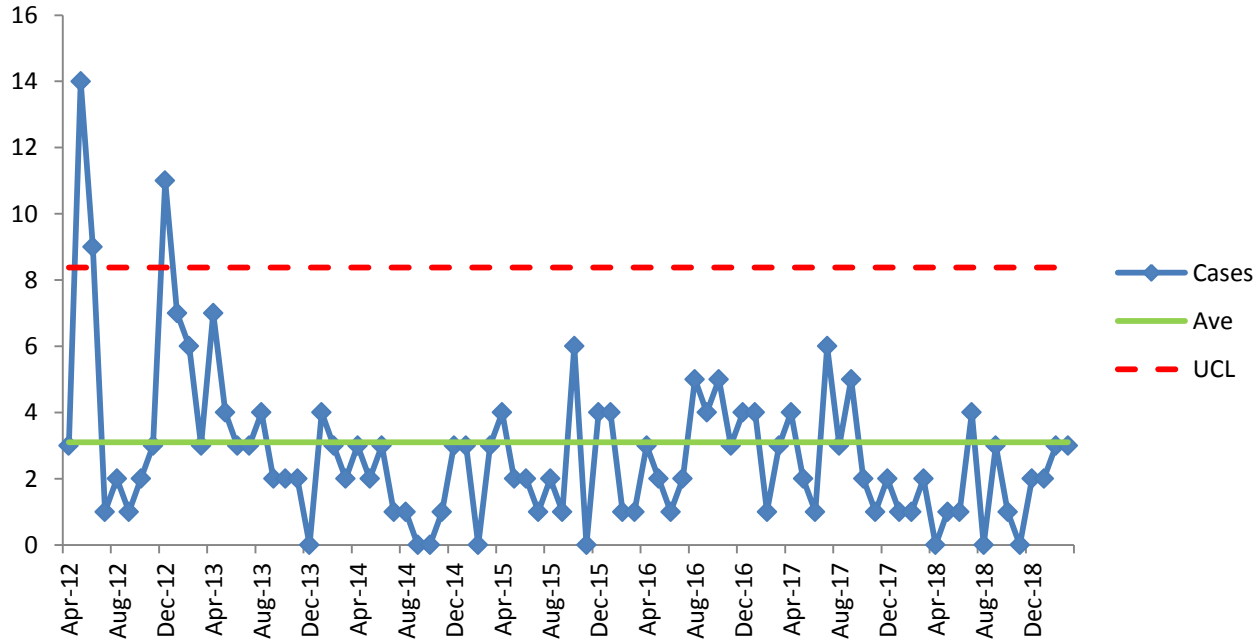


Fig. 5: Hospital Onset CDT Cases SPC Chart



There has been a sustained improvement of Hospital Onset CDT cases since 2009.

Trust apportioned cases are subject to a review which is undertaken using a guided root cause analysis approach. The purpose of these is to review the care provided and assess whether the care delivered was safe and appropriate.

They are reviewed to establish whether care might have contributed to the risk of the patient developing a CDT infection and if this is the case, whether the corresponding policy was followed.

The clinical teams are responsible for the review. On the day of the result, the ward/department management team (patient consultant, ward manager and matron) are notified and given a date for the case to be fed back. The reviews are undertaken by a multidisciplinary team led by the patient's consultant. Feedback is undertaken at a Harm Free Care Panel chaired by the DIPC or Medical Director attended by the ADIPC and/or IPC matron, IPC doctor or Consultant Microbiologist and antimicrobial pharmacist. The cases are presented by senior doctor and a senior nurse from the department.

3.2.1.2 Outbreaks

There were no outbreaks *Clostridium difficile* infection in 2018/19.

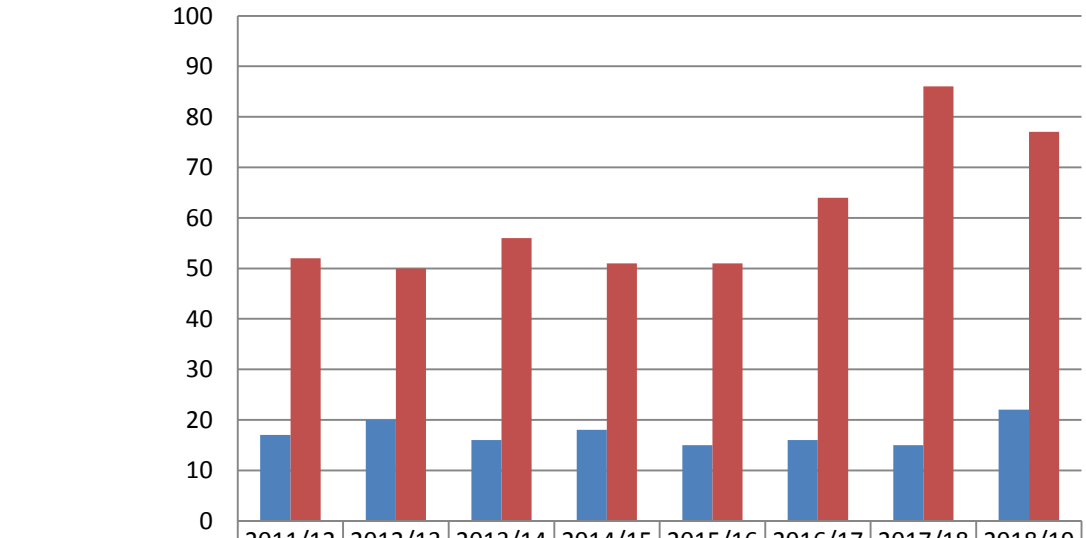
3.3 MSSA Bacteraemia

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

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

There was an increase in MSSA cases in 18/19 with no clear cause and with no clear themes that would account for the increase from 15 cases in 17/18. Three of the 22 hospital onset cases (14%) were related to cannula site infections. In response to this, the IPC facilitated a Trustwide review of cannula care and rolled out a cannula care awareness campaign entitled 'Time and Place' advising staff on core principles of cannula care (see **Appendix 2**).

Fig. 6: MSSA cases



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Hospital Onset	17	20	16	18	15	16	15	22
Community Onset	52	50	56	51	51	64	86	77

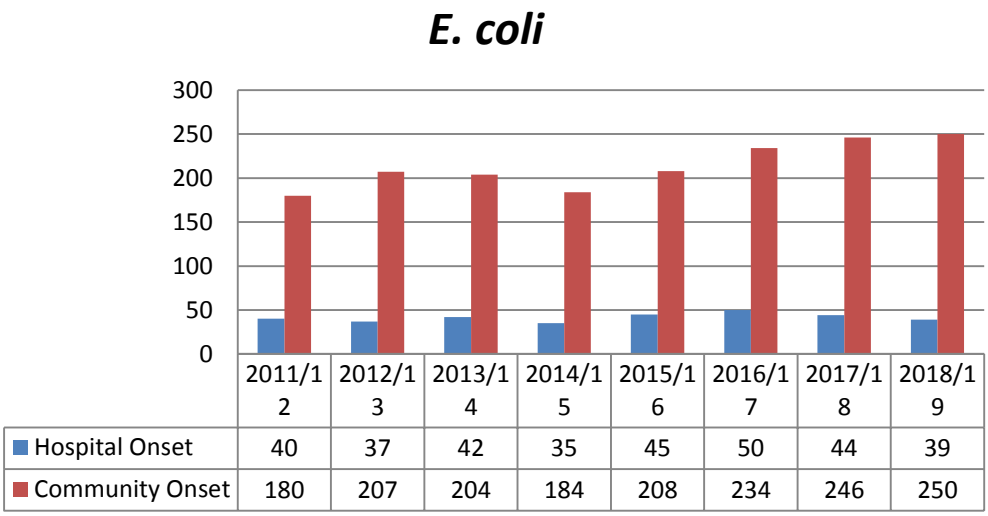
Gram Negatives

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

3.4 *E. coli* Bacteraemia

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

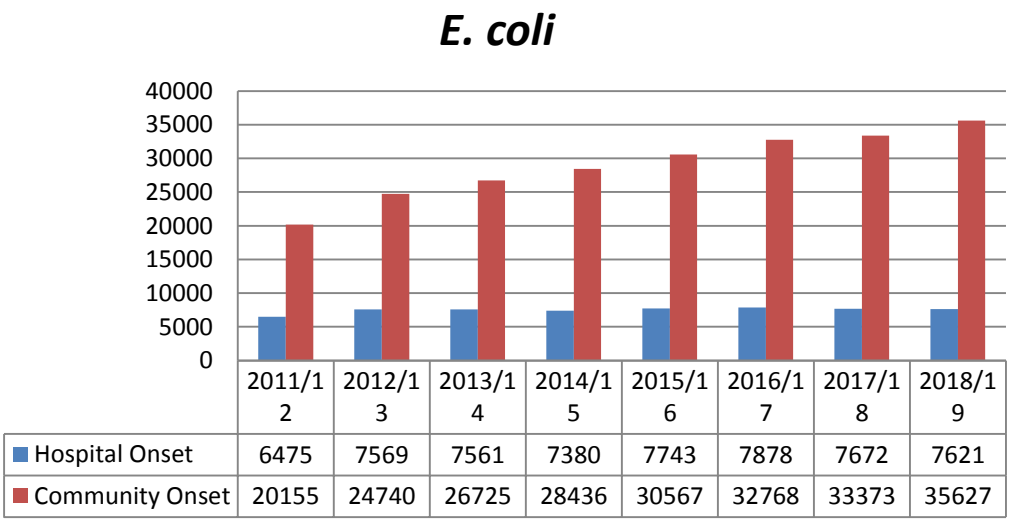
Fig. 7: *E. coli* cases



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Hospital Onset	40	37	42	35	45	50	44	39
Community Onset	180	207	204	184	208	234	246	250

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

Fig. 8: *E. coli* cases – UK



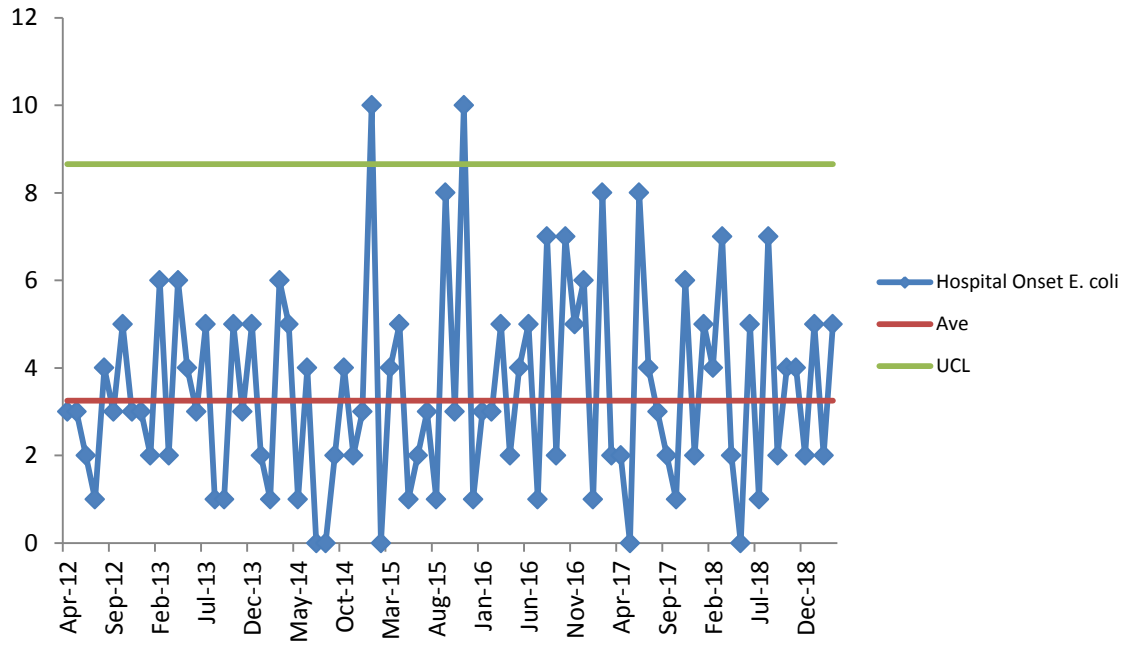
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Hospital Onset	6475	7569	7561	7380	7743	7878	7672	7621
Community Onset	20155	24740	26725	28436	30567	32768	33373	35627

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

Nationally, there continues to be an increase in cases – an increase of more than 5% from year to year and a slightly larger increase in Hospital Onset cases – an increase of more than 6.5%. Bolton has continued to see reduction in Hospital Onset cases by 11% whilst all cases in Bolton has remained largely unchanged from year to year (289 cases in total in 2018/19 compared with 290 cases in 2018/18).

These outcomes continue to be driven by continued improvements in improved fluid balance monitoring and a focus on hydration.

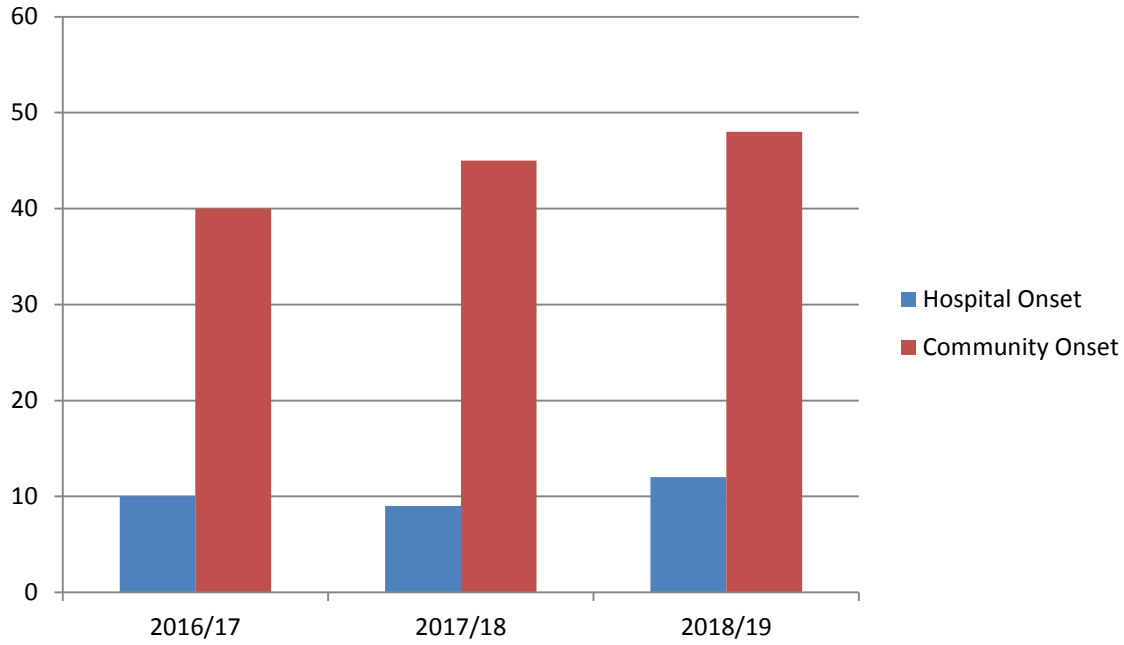
Fig. 9: *E. coli* SPC Chart



3.5 *Klebsiella spp.* Bacteraemia

Mandatory surveillance of bloodstream infections caused by all species of *Klebsiella* started in 2017. There were 60 cases in total of which 12 were apportioned to the Trust. This compares with 54 cases in total in 2017/18 of which nine were apportioned as Hospital Onset.

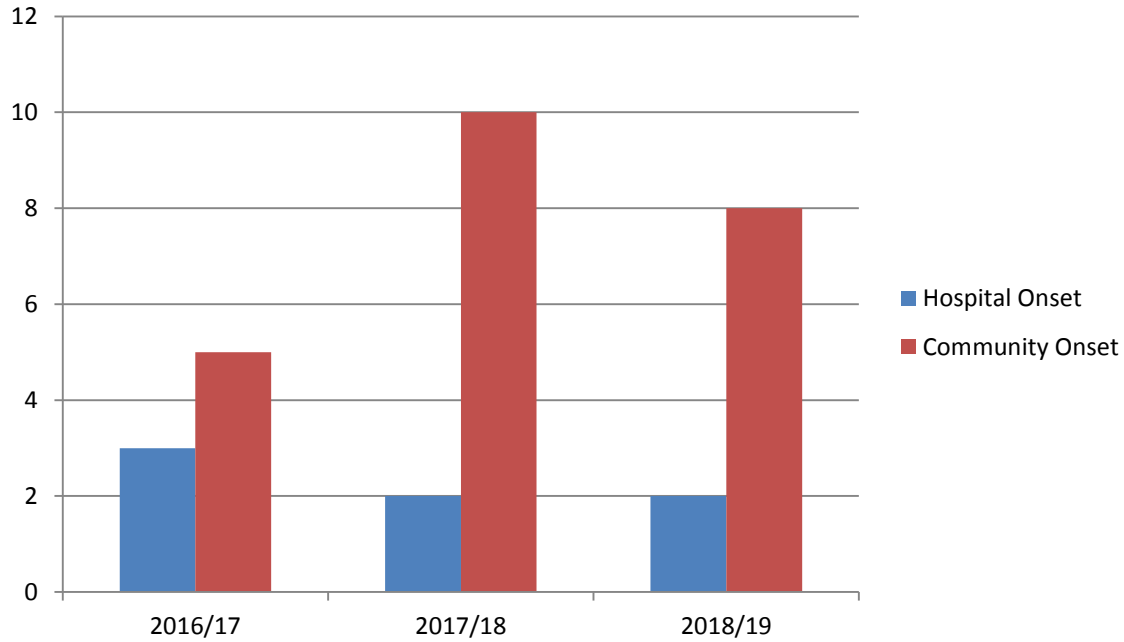
Fig. 7: *Klebsiella spp* Cases



3.6 *Pseudomonas aeruginosa* Bacteraemia

Mandatory surveillance of bloodstream infections caused by *Pseudomonas aeruginosa* started in 2017. There have been no significant changes with eight cases in total of which two were apportioned as Hospital Onset this compared to 10 and two respectively in 2017/18.

Fig. 8: *Pseudomonas aeruginosa* Cases



3.5 Glycopeptide Resistant Enterococcus (GRE) Bacteraemia

There was one GRE bacteraemia in 2018/19.

3.6 Additional Surveillance

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

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

3.7 Surgical Site Infection Surveillance (SSIS)

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

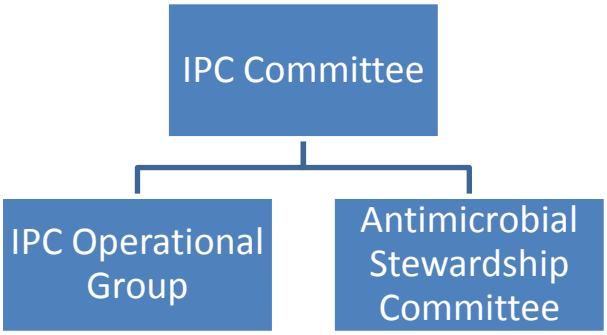
Table 1: Reported SSI

	Total Knee Replacement		Total Hip Replacement		Repair of Neck of Femur	
	RBH	National Average[7]	RBH	National Average	RBH	National Average
No. of procedures	35	225,912	41	200,415	98	33,744
No. of infections	0	3,530	1	1,935	0	405
Incidence of infection	0%	1.6%	2.4%	1%	0%	1.2%

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

4. Infection Prevention and Control Governance

IPC assurance continues to be provided by the following:



4.1 Infection Prevention Control Committee (IPCC)

The committee meets monthly and is chaired by the DoN/DIPC. This committee provides assurance to the DIPC to be reported to the Board where required and provides a strategic direction for the provision of IPC. The committee covers the following on a regular basis plus other topics by exception:

- HCAI surveillance
- Outbreaks/periods of increased incidence
- Antimicrobial stewardship
- Policy approval
- Emerging issues
- Divisional concerns

The revised Terms of Reference are available on request.

4.2 Infection Control Operational Group

This group also meets on a monthly basis. The purpose of this group is much more operational and covers agenda items such as:

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

The revised Terms of Reference are available on request.

4.3 Antibiotic Stewardship Committee (ASC)

The antimicrobial stewardship committee is chaired by the Trust Antimicrobial Stewardship lead – who is a consultant medical microbiology – and includes representation from each of the clinical divisions.

The remits of the group are to provide assurance on the following:

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

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

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

Trustwide Compliance with Each Standard:

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

Fig. 9: Antimicrobial stewardship compliance

Quarter	Compliance
Quarter 1	86%
Quarter 2	Not undertaken
Quarter 3	85.2%
Quarter 4	85%
Average	**85.4%**

4.4 Representation at other Trust wide groups

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

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

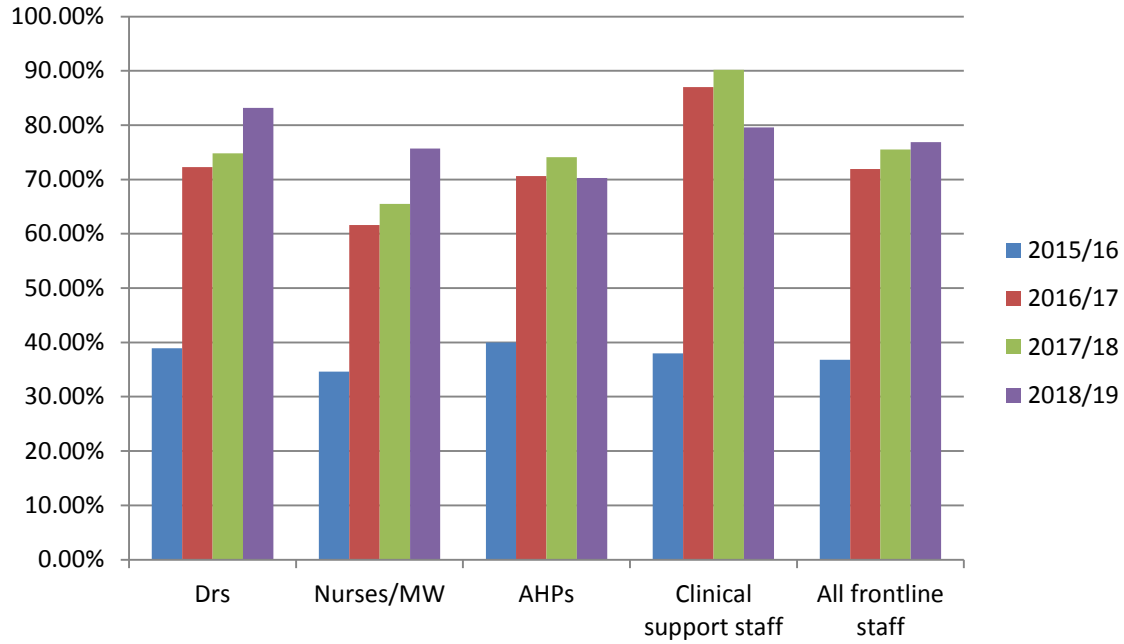
8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF

5. Flu

5.1 Staff Flu Vaccination Campaign

The IPCT led on a successful flu vaccination programme for frontline staff in 2018/19[9]. Uptake in all frontline staff groups increased based on the previous years. Overall uptake for the Trust for frontline healthcare staff was 76.97% representing 3475 frontline staff up from 3446 staff in the previous year.

Fig. 10: Flu Vaccine Uptake



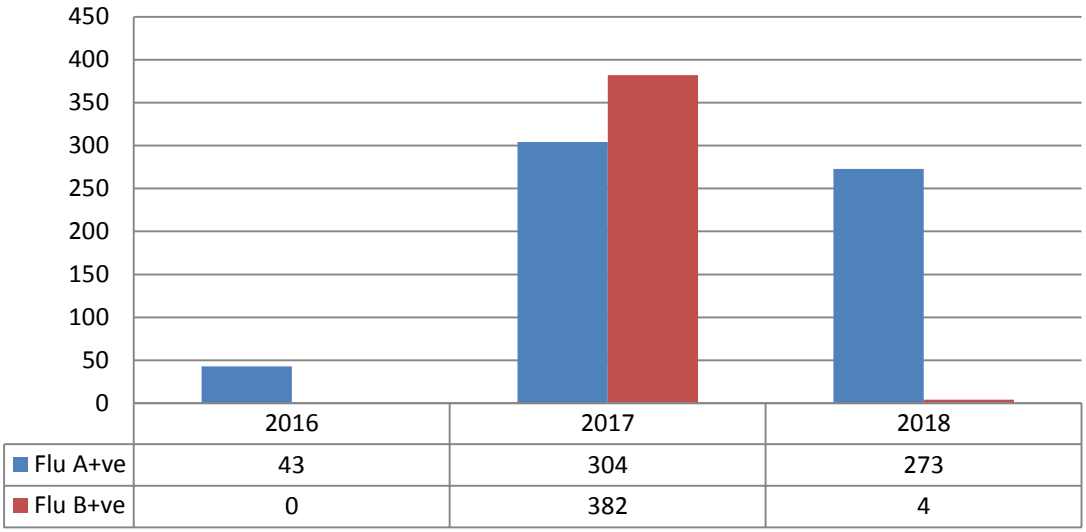
5.2 Seasonal Flu

The 2018 was severe although less severe than during the previous flu season. The impact of flu was felt keenly across Bolton and the disease had a significant impact on patient admissions.

In the 2017 there were 2109 flu samples collected of which 304 patients were Flu A positive and 382 were Flu B positive. In 2018 there were 273 Flu A positive samples and four Flu B positive samples.

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

Fig. 11: Flu Testing



	2016	2017	2018
Flu A+ve	43	304	273
Flu B+ve	0	382	4

The community IPC team managed 20 outbreaks of influenza like illness over the flu season affecting more than 185. Flu was confirmed in three of these outbreaks and other organisms in a further three:

- *Pneumococcus spp.*
- Rhinovirus
- Metapneumovirus

6. Outbreaks

6.1 CPE Outbreak 1

During 2019 there was an outbreak of CPE on a ward that was closed in January. There were three patients who tested positive for CPE – one initial clinical sample and two cases who were positive for CPE in response to the first patient being CPE positive.

This outbreak was closed shortly after being noted following four weeks of CPE screens on admission to the ward and weekly CPE screens of patients on the ward. No further cases were identified from the screening.

6.2 CPE Outbreak 2

There was a second outbreak of CPE that started in January 2019 and closed in August. There were 16 patients who tested positive for CPE as part of this outbreak – predominantly screen samples. There were 14 patients identified from screens and a further two (including the index case) who were positive from clinical samples. No patient came to harm due to this outbreak.

The outbreak control team (OCT) concluded that transmission was likely to have been largely person-to-person transmission. There was universal CPE admission screens on the ward and weekly surveillance screens of patients on the ward. There were extensive screens taken of the environment.

Environmental samples were largely negative for CPE with the notable exception of hand wash basin drains. Some drains were noted to be positive on an intermittent basis. Attempts were made to remove the contamination, including replacing the water traps of each drain with mixed results. Some drains remained free from CPE whereas others became re-colonised with CPE. PHE noted that they had undertaken non-clinical studies at one of their facilities to investigate how to remove colonisation of sink drains with limited success. What they did find was that using hand wash basins for other fluids than soap and water exacerbated the problem. All clinical hand wash basins now have posters advising staff to only use hand wash basins for cleaning hands. What impact these drains had on the outbreak is unclear.

The outbreak was confirmed over in August after four weeks with no new cases from admission and weekly screens after the discharge of the last known CPE positive patient.

Public Health England were consulted for both of these outbreaks for support and guidance.

7. Community IPC

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

The team have worked with care homes, schools and nurseries around the importance of reporting and appropriately managing outbreaks of infection - including diarrhoea and vomiting, and influenza. They have visited schools and carried out education sessions with the smallest of children, and also liaised with the local authority neighbourhood teams to encourage the 'Making Every Contact Count' approach to infection prevention and control with a view to this message being shared with the wider community.

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

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

7.1 Care Homes

The team continue to work consultatively with care homes to ensure that they are safe and improving. The average compliance with an overarching audit of facilities and practice is now more than 86%.

7.2 Training

IPC mandatory training for staff in ICSD predominantly remains face-to-face delivered by the CIPCT. In addition to delivering this, the team have provided 23 training sessions to care staff, monthly training at IPC link meetings, training for schools and education staff. The team has made efforts to provide IPC awareness sessions to hard to reach groups like parents with children with long-term health conditions and vulnerable adults who are homeless or who are injecting drug users.

7.3 Outbreaks

The team dealt with 83 outbreaks in care homes and 29 outbreaks in schools in 2018/19:

Table 2: Summary of care home outbreaks (note that some homes had more than one outbreak at the same time**)**

Setting	Cause	Number/Proportion
Care Home	Diarrhoea/Vomiting	49 (59%)
	Flu like illness	27 (32.5%)
	Scabies	7 (8.5%)
Schools	Diarrhoea/Vomiting	18 (62%)
	Scarlet Fever	8 (27.6%)
	Flu like illness	1 (3.5%)
	Hepatitis A	1 (3.5%)
	Scabies	1 (3.5%)

7.4 Other Functions

The team also take queries by phone, contribute to RCAs of Trust and non-Trust related infections. The team continue to lead on work in the Bolton population in raising awareness of infections related to injecting drug use such as MRSA and Group A *Streptococcus*.

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

8. Environmental Sampling

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

Environmental screening was used as part of the investigation and assurance related to the CPE outbreak (see **Section 6**).

9. Cleaning and Decontamination

9.1 Decontamination across the Trust

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

9.2 Cleaning Service

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

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

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

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

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

9.3 Infection Control audits

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

- ICU
- HDU
- A&E Dept
- Ward D1
- Ward D2
- CDU
- NICU
- Main Theatres

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

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

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

9.4 Hand Hygiene Audits

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

9.5 Bolton System of Care Accreditation (BoSCA)

The IPCT participate in the review of wards as part of BoSCA. The IPCT undertake elements 1, 10 and 13 of the BoSCA:

1. First Impressions: 15 Step Challenge
10. Infection Control
13. Environment

This is another opportunity for the IPCT to work with the ward staff to review and improve the care standards on their ward related to cleanliness and infection prevention and control.

The team work supportively with the ward staff to resolve any issues identified which helps to improve understanding and standards.

10. Education and Training Activities

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

Table 3: IPC Mandatory Training Compliance

Division	Training Compliance
Acute Adult Care	89.6%
Elective Care	93.8%
Family Care	92.2%
Integrated Care Services	95.2%
Total	**92.8%**

Face to face training continues to community staff.

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

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

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

10.1 Student Nurse Placements

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

10.2 IPC Link Meetings

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

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

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

11. Objectives for 2018/19

During the next 12 months the IPCT aims to ensure a high quality and effective service across the whole Trust with an aim of preventing infection by the application of clean, safe care.

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

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

The trajectories set by NHS England remain challenging:

- **MRSA Bacteraemia**: zero, no avoidable cases of MRSA bacteraemia

CDT Cases

The objectives and classification of CDT cases has been changed in advance of 2019/20. Historically cases were classified as Community Onset or Hospital Onset cases:

1. Community Onset: GP samples, outpatient samples or samples collected on the day of admission, the following day or the day after that
2. Hospital Onset: samples collected after the first three days of admission (the day of admission is classified as day 1)

This has now been expanded to four classifications based on earlier admissions to the Trust[10]:

10 https://improvement.nhs.uk/documents/808/CDI_objectives_for_NHS_organisations_in_2019_12March.pdf

1. **Hospital Onset Hospital Associated (HOHA)** – cases from samples collected on day three of admission and after
2. **Community Onset Hospital Associated (COHA)** – community cases and samples collected on day one and two of admission where the patient has had an admission to Bolton FT in the preceding four weeks
3. **Community Onset Intermediate Association (COIA)** – community cases and samples collected on day one and two of admission where the patient has had no admissions to Bolton FT in the preceding four weeks but has had an admission in the preceding 12 weeks
4. **Community Onset Community Associated (COCA)** – community cases and samples collected on day one and two of admission where the patient has had no admissions to Bolton FT in the preceding 12 weeks

Trust objectives will now include HOHA and COHA cases combined. The objective for 2019/20 is no more than 32 HOHA and COHA cases. For context, using these definitions, there would have been 38 HOHA and COHA cases for the 2018 calendar year.

As there had been a significant rise in MSSA cases, the IPC committee has set an objective to improve MSSA cases to be improved to better than 2017/18 figures – no more than 15 Hospital Onset cases.

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

- ***E. coli*** **Bacteraemia:** no more than 35 Trust apportioned cases
- ***Klebsiella spp.*** **Bacteraemia:** no more than 10 Trust apportioned cases
- ***Pseudomonas aeruginosa*** **Bacteraemia:** no more than one Trust apportioned case

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

Patient Engagement

The IPC team has expressed an ambition to gain the expertise of patients with infections such as *E. coli* bacteraemias to understand what strategies might reduce the likelihood of new cases.

The Trust will be engaging in a concerted campaign to improve patient hydration. Dehydration is the single most correlated risk factor with the development of Gram negative urinary tract infections. Improved hydration has other associated benefits such as

reduction in falls, less acute confusion and improved cognitive function in patients with dementia.

Antimicrobial Stewardship

The Government published its five year plan related to antimicrobial resistance: Tackling antimicrobial resistance 2019–2024; The UK's five-year national action plan (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784894/UK_AMR_5_year_national_action_plan.pdf).

This plan outlines a number of planned actions to reduce the likelihood of further antibiotic resistance that can be applied in acute settings (including but not limited to):

- Infection prevention – preventing infections reduces the need for antibiotics which in turn reduces selective pressure which helps bacteria to develop resistance
- Improved stewardship of antibiotics – using antibiotics only when needed and stopping them once no longer required (particularly in secondary care)
- Improved use of diagnostics – better use of diagnostics can stop or shorten antibiotic courses or allow narrow spectrum agents to be used which reduces the selective pressure for antibiotic resistance

Practically, this will mean, the introduction of methods to increase the ease by which prescribers can access antibiotic guidelines (introduction of a prescribing App based on the Trust guidelines and consolidating all of the antibiotic guidelines into a single document).

Appendix 1: Bristol Stool Chart

Bristol Stool Chart

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

Appendix 2: Time and Place

NHS Bolton NHS Foundation Trust

Guide to Optimal Line Care – TIME & PLACE

Every cannula must:

Be dressed with a transparent dressing

Have an extension with a needlefree device

Check and document VIP scores three times a day

Avoid bandages where possible

Time:

- The risk of infection goes up for every hour a cannula is in situ
- **ONLY** use cannula when necessary
- **ALWAYS** remove cannula as soon as the patient no longer needs it
- Remove/change cannula after 96 hours – even if there are no signs of infection
- If lines must remain and the patient has poor IV access – clearly document the need for continued IV access and review every 24 hours

Place:

- Avoid the antecubital fossa – this site is most likely to become infected
- Aim for the lowest point of the arm as possible – this reduces the risk of infection and maintains the veins in the arm
- Preferred order ***(unless clinical necessity indicates an alternative preference- only in emergency situations)***

1. Dorsum
2. Forearm
3. Antecubital fossa

Agenda Item No:	
Meeting:	Board of Directors
Date:	31st October 2019

Title:	Safeguarding Children and Adults and Looked After Children Annual Report 2018-19
Purpose	This annual report outlines the arrangements to safeguard and promote the welfare of children and adults; the Trust's safeguarding activity and also arrangements to provide services for Looked after Children
Executive Summary:	The report provides a summary and overview of activity and arrangements in place within children and adult safeguarding across Bolton NHS Foundation Trust
Previously considered by:	Safeguarding Committee
Recommendation Please state if approval required or if for information	Recommendations to be overseen at the Safeguarding Committee Confidential y/n: n

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

Prepared by:	Fiona Farnworth, Named Nurse Safeguarding Children Sandra Crompton, Lead Nurse Safeguarding Adults	**Presented by:**	Trish Armstrong-Child, Director of Nursing

NHS
Bolton
NHS Foundation Trust

Safeguarding Adults, Children and Looked after Children Annual Report 2018-2019

Everyone's Responsibility

VISION OPENNESS INTEGRITY COMPASSION EXCELLENCE

Contents

Introduction

Bolton NHS Foundation Trust is committed to ensuring that safeguarding is a part of core business and recognises that safeguarding children, young people and adults at risk is a shared responsibility with the need for effective joint working between services and with partner agencies.

This annual report outlines the arrangements to safeguard and promote the welfare of children and adults; the Trust's safeguarding activity and also arrangements to provide services for Looked after Children.

This report is based on the Trust values to provide a clear outline of key areas of practice and responsibilities and demonstrates commitment to ensuring that those who are at risk of or have suffered abuse are at the centre of care delivery.

There is a clear line of accountability for safeguarding and Looked after Children (LAC) within the Trust from the Chief Executive to staff members.

Safeguarding is a complex area of practice with a wide potential cohort. There are groups that research tells us are additionally vulnerable to abuse and those whose vulnerability may be short term or within a specific context.

The Think Family agenda promotes the importance of a whole family approach to securing better outcomes for children, young people, and their families. This approach is supported by the co-location of Trust safeguarding adults and children specialist staff. There are a number of safeguarding issues that cross between adults and children – examples include domestic abuse, modern slavery, and contextual safeguarding.

Safeguarding activity for both staff and those in a safeguarding or LAC specialist role has increased with higher numbers of those identified to be suffering abuse or at risk and increasing complexity. This is due to a number of factors including improved recognition and embedding of adult safeguarding practice across the Trust as all agencies work together to meet the requirements of the Care Act 2014.It is recognised that legislation for children has been in place for considerably longer to support safeguarding practice and legislation for adults is now becoming more recognised and embedded in practice. Increasing activity for children is evident in rising numbers of children subject to a Child Protection Plan and increasing numbers of Looked after Children.

The Safeguarding and LAC team have continued to provide a responsive service despite increased demands by facilitating and leading a range of activities to support safeguarding work, respond to emerging and new areas of practice and to develop practice across the Trust. The Safeguarding Team continue to operate an 'open door' policy for staff to allow easy access when they need support

Summary

Bolton NHS Foundation Trust holds statutory duties in relation to the following:

Safeguarding Children in line with Section 11 of the Children Act (2004) and Working Together to Safeguard Children 2018.

Duties and responsibilities outlined in the "Statutory Guidance for Promoting the Health of Looked after Children"

Safeguarding Adults at risk in line with the Care Act 2014, the Mental Capacity Act 2005 and Depravation of Liberty Safeguards amendment 2007.

Assurance about safeguarding arrangements across the Trust is reviewed and updated by the adult and children safeguarding leads by completing a number of submissions provided every year to the

CCG including standards for safeguarding adults and children and Looked after Children and in relation to the Prevent duty. Action plans are developed where there is additional work to complete and these are monitored through the Trust Safeguarding Committee.

Vision – delivering excellent care, care for future generations, working with partners, decisions that support best outcomes

Since the inception of the role of Lead Nurse For Safeguarding Adults , The Trust has striven to ensure that service provision continually develops to ensure the needs of 'Adults at Risk' are met in respect of promoting safe outcomes and ensuring all staff understand their responsibilities in regard to Safeguarding Adults. Throughout 2018-2019, training programmes have continued to ensure the safeguarding process will continue to be embedded within the ethos of service delivery. A Level 3 programme of training in respect of Safeguarding Adults will be rolled out from September 2019 in accordance with the guidance from the Intercollegiate Document 'Adult Safeguarding: Roles and Competencies for Health Care Staff'(2018). The training will include provision from The Trust's partners of the Safeguarding Board with a view to forging stronger working relationships and a better understanding of service provision, roles and responsibilities. This will be a significant investment in developing staff skills and knowledge in respect of supporting not only victims but Trust staff also.

The Trust has a number of staff in safeguarding children specialist roles to meet the requirements of the Intercollegiate Guidance for safeguarding and Looked after Children. This includes Named Professionals – Doctor, Nurse and Midwife and Specialist roles.

An example of a specialist role is the secondment from Health Visiting to the MASSS (Multi-agency Safeguarding Screening Service).This has been in place to meet the requirements of a distinct Service Specification until the end of March 2019 and is now part of the 0-19 specification

The post holder works closely with the Trust Safeguarding Team and is managed by the Named Nurse. Initial priority areas of work of the role included the establishment of the health practitioner role, support to the MASSS duty team in child protection enquiries, to ensure that agencies are supported in using the Early Help process and to build more effective working relationships with all health providers.

The role has been embedded and developed by the current post holder by ensuring the health role is fully integrated in the duty team. Examples of this in practice include:

- Attending the daily Domestic Abuse triage meeting with the police and Social Work manager
- Supporting the early help and complex families panel
- Providing and interpreting health information for Social Workers and the Police
- Supporting strategy meetings
- To be a point of contact to provide advice and guidance for all health providers
- To review referrals made to the MASSS
- To support multi-agency audit activity for safeguarding
- This role supports effective communication across the health economy and is recognised to have strengthened partnership working.

Contribution to High risk multi-agency panels

The Safeguarding Team support a number of high risk panels locally at operational/practice level and as part of strategic groups.

This includes:

- Specialist Safeguarding Nurse attendance at bi-monthly MARAC meetings (MARAC - Multi-agency Risk Assessment Conference for high risk Domestic Abuse cases).
- Named Nurse Safeguarding Children attendance at MARAC Steering Group and Domestic Abuse Partnership.
- Named Nurse attendance at monthly and ad-hoc MAPPA meetings – these include high risk violent or sexual offenders.
- Safeguarding Specialist Nurse Attendance at bi-monthly SEAM meetings. (SEAM –Sexual Exploitation and Missing. The remit of this meeting now includes complex safeguarding/exploitation also)
- Adult Lead Nurse or Named Nurse Safeguarding Children attendance at CHANNEL (Multi-agency panel to consider adults or children/young people who are at risk of radicalisation).

Looked after Children (LAC)

There is a continued upward trend of children who are in care locally and while this is comparable with areas across Greater Manchester rates are higher than the national average. In UK law, a Looked after Child is a child who is accommodated by the Local Authority for more than 24 hours. Legally, this could be when they are subject to planned or emergency Care Orders, in a secure children's home or youth offender institution, unaccompanied asylum seeking children or Looked After with their parents' agreement. A child will cease being "Looked After" when they are adopted, return home or reach the age of 18 years. Social care responsibilities for Care Leavers over the age of 21 has now changed under the recently published Children and Social Work Act (2017), which enables care leavers to request support up to the age of 25, regardless of whether or not they are in education.

The health and well-being of looked after children remains a national, regional and local priority. Looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers in part due to the impact of poverty, abuse, neglect and trauma.

Trust provision for LAC is closely aligned with arrangements for safeguarding children .This includes oversight of LAC performance, practice issues including themes and trends and statutory requirements through the Trust Safeguarding Committee and by the Named professionals, Specialist medical and nursing staff, Family Division service managers and staff.

The service provided to LAC includes:

- Delivery of initial and review health assessments
- Ensuring immunisations, dental and developmental checks are completed
- Teaching and training to foster carers
- Contribution to fostering and adoption panels and processes

In addition to specific requirements it is recognised that LAC may come into contact with a wide range of services both in the hospital and community setting. Training for staff who are responsible for completing LAC Health Assessments and awareness raising of LAC across other key services continues with examples in practice that show better understanding of the needs of LAC in general and sensitivity to the needs of individual children who are seen. Good practice identified includes consideration within assessments of the child's presentation after a short time in a new foster placement and for other children better understanding of concerns and difficulties based on the child's background/experience and journey prior to becoming LAC.

It is a statutory requirement that children and young people who are looked after receive a health assessment at specified points during their time in care. The purpose of these health assessments is

to identify health needs promptly so that the appropriate care and treatment can be arranged. The statutory requirements include:

- That all LAC should receive an initial health assessment (IHA) within 20 working days of child becoming looked after this includes booking and completing assessment as well as completion of the Health Action Plan (IHA).
- Children under 5 years receive a review health assessment (RHA) every 6 months.
- Children and young people over 5 years will receive review health assessments (RHA) every 12 months. Children in this age group include children who are resident locally with complex health and medical needs who attend special schools or are in a local specialist placement.RHA for this group of children are completed by the Community Paediatric Nurses for special schools. The remaining Children aged 5-19 had services from another provider until the end of March 2019.

LAC data and compliance

Monthly LAC data is captured and reported using an agreed template and submitted to the CCG.

The numbers of health assessments required each month can vary.

Data collected includes the overall figures for children in area (for which robust systems are in place for Health Assessments) and also children who are the responsibility of Bolton LA but are resident out of area. Ensuring that this group of LAC receives their health assessments within timescales and of suitable quality requires contact from both administrative and specialist staff, This is a significant amount of work as contact with other areas may be required more than once and also as part of a review and follow up of a list of children who have not had health assessments completed out of area every month.

There has been an improvement in the number of IHA completed within timescales – 74%.It should be noted that 93% of appointments were offered on time.

Appointments and assessments completed in month is also captured and provides assurance that where notification of a child coming into care is late or the child is not brought to an appointment there is prompt action to offer a clinic appointment within month.

There has also been an improvement in the number of RHA completed within timescales – 82%.There is fluctuation in monthly compliance (for example 94% one month and 71% another).Lower levels of compliance may indicate small numbers however ultimately timescales are important to ensure that there are good outcomes for children.

The annual report for 2017/18 described systems in place for Looked after Children in relation to statutory health assessments and these have been effective in ensuring that the majority of health assessments are carried out within timescales and are of a high quality. There are however challenges in meeting statutory timescales and on monthly basis compliance is collated, reviewed within the Trust and submitted to the CCG.

There is a focus on reducing and eliminating any issue that may impact on meeting timescales for health assessments for Looked after Children. The reasons for health assessments not being completed on time is collected and reported within the monthly report – the largest number is due to late notification of a child coming into care (41%). Other reasons include the child is not brought to the appointment (43%) and staff issues(8%),other (8%).The timeliness of health assessments includes a reliance on the Local Authority to share information about children coming into care and for Bolton LAC who move out of area. There are close working relationships with colleagues in the Local Authority to reduce and prevent delays in the provision of health assessments and use of prompt escalation where delays in sharing information has had an impact on meeting timescales.

Areas of good practice:

The quality of health review assessments undertaken by all professionals continue to be maintained to a high standard. Quality assurance processes in place include Health Visitor Team Leader review of completed HA and an audit programme to review and benchmark samples of all Health Assessments.

As part of an increasing focus on the Voice of the Child a bi-annual VOTC audit of assessments was and health records for LAC was completed. Part of this process is feedback to staff and sharing of examples of good practice.

Expertise and knowledge of medical staff in completing IHA shows a focus on the needs of the child and analysis of their journey into care.

Following discussions at the LAC Health Group it was identified that capturing health needs of LAC locally would assist in understanding of difficulties and would support service planning. It was agreed that 2 groups should be compared as anecdotally it was considered that children remaining at home with parents on a Care Order may have different health issues than children who were in a care setting or foster home. This work commenced in June 2018 with an agreed sample size of 50 for Bolton FT and 50 for 5-19 provider. Analysis of the samples were based on scores of the number of health needs identified with 21% of the sample having a score of between 9-14 indicating a high level of health needs identified. The findings have been of some benefit – for example identifying that dental health is significant compared to vision or hearing concerns. It was difficult to capture the differences in health needs for the two groups of children identified and also it was felt that different data would need to be captured in relation to emotional health and behaviour, general health issues including BMI and for children with complex health needs the level of care they require. LAC specialist staff continue to consider ways to gain a better understanding of health needs locally with opportunities to consider all children in the family as part of the 0-19 service.

Areas for development:

There are significant opportunities to improve services to LAC due to the Trust being the provider of the 0-19 service. This includes a focus on continuity of worker, ways to reduce and avoid duplication where there are a number of children in the family or placement and to strengthen work on Voice of the Child across the Trust to include LAC.

A review of support provided to Care Leavers including transitions to adult health services.

Use of a Tracker to ensure follow up and escalation to the Social Worker manager where children do not have health assessments within statutory timescales or are not brought for appointments.

It is important to maintain high compliance with completion of health assessments and those of a good quality within 0-19 service. Consideration of a “perfect month” in early 2020 to ensure a focus on LAC Health Assessments and to test tracking and escalation processes.

Unaccompanied Asylum Seeking Children

Children often become looked after as a result of urgent concerns or a crisis so it is not possible to plan or predict the number of children or young people who will require an IHA. One group of LAC where the number of young people alone does not highlight the complexity of providing a service is unaccompanied asylum seeking children (UASC). An unaccompanied asylum-seeking child (UASC) is an individual, who is under 18, who has applied for asylum in his/her own right, is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.
There have been a number of UASC seen for IHA within the timeframe of this report. Their circumstances and health concerns can be described an unique based on their experience in country of origin, in transit to the UK and their experience on arrival

The health needs of UASC are often very complex and this has been seen in children who have had an IHA within the timeframe of this report. Many suffer from post-traumatic stress related to their often tragic experiences and separation from their families. They will often have undiagnosed and untreated health conditions when they arrive and details regarding immunisations and past medical history is frequently missing.

The complexity of health needs of UASC and the other contextual factors identified above will often mean that their assessments take more time and are more resource intensive than those involving LAC from within the UK. Interpreters are provided for all UASC who require this support during their health assessments.
For this group of children and young people it is important to identify what currently works well and to identify areas for development to ensure services are responsive to their needs.

Safeguarding training remains a priority to develop a competent and skilled workforce in the identification and management of safeguarding concerns. This includes LAC training for specific staff groups. Training compliance is reviewed with prompt action taken where concerns arise.

Both the safeguarding adult and children agenda are dynamic in relation to themes and trends, recognition of risk and responding to practice issues that may arise. Training content is updated regularly and opportunities are identified to increase learning and understanding of safeguarding issues.

Safeguarding training is reviewed in a number of ways – through Divisional oversight of mandatory training, through BOSCA at ward or service level, through individual case reviews and at the Trust Safeguarding Committee.

Adult Safeguarding Training compliance

As of March 2019 the Trust was fully compliant with Mandatory, Adult Safeguarding Training.

Level 1 – 96.7% (1243 staff of 1286) Target 95%

Level 2 – 95.3% (3664 staff of 3844) Target 95%

There is a planned review and overhaul of the Level 2 e-learning package in 2019 to ensure compliance with the new Intercollegiate Guidance on Adult Safeguarding Training.

A training plan has been agreed and implemented for the Trust's Safeguarding Team to provide face to face, Level 1 Adult Safeguarding training for all IFm employees. All employees will have received training by August of 2019.

Safeguarding Children training compliance– end March 2019

Level 1 – 96.7%

This represents 1244 staff trained from 1287.

Level 2 – 96%

This represents 3690 staff trained from 3843

Level 3- 1418 staff trained from identified staff groups. This is a higher number than the cohort identified at the beginning of a 3 year programme that started in November 2016.Additional numbers of staff who have attended the training are from therapy, specialist and adults services.

Level 3 LAC – 96% staff trained from Health Visiting and Paediatric Nursing staff.

Openness – communicate clearly with patients, families and staff. Feedback to drive improvements

Effective safeguarding relies on joint working and effective relationships across teams and agencies Bolton NHS Foundation Trust is a key partner agency and this is achieved by a contributing to wider safeguarding arrangements. This is demonstrated by:

The Deputy Director of Nursing, Lead Nurse for Adult Safeguarding and Named Professionals for Children continue to represent the Trust on the Adult and Children's Safeguarding Board and subgroups.

The Lead Nurse for Adult Safeguarding also chairs the Effective Practice subgroup with members from Local Authority Safeguarding, Legal and Quality Assurance Team, Police, GMMH, Housing and CCG.

There are safeguarding practice issues that can be described as on-going priority areas of work and also concerns that are identified as emerging safeguarding issues. The following priority areas for multi-agency partnerships and Board are supported by safeguarding activity across the Trust.

The priorities for the Adult Safeguarding Board are:-

1. **Ensure our safeguarding processes are effective-** with assurance being gathered from all partner agencies in respect of their safeguarding policies, process and incidence.
2. **Embed making safeguarding personal into all service delivery across the partnership –** The Trust over the past year has incorporated these principles into both policy and all adult safeguarding training provision
3. **Improve Engagement with Service-Users and the wider community to promote Safeguarding**
4. **Workforce Development and Effective Practice**-The Trust has contributed to the standardising of safeguarding training provision across Bolton and will be offering training places to managers of partner agencies, as part of a multi-agency response to Safeguarding in Bolton, on the Level 3 training initiative that the Safeguarding Team will be rolling out from September 2019.
5. **Strengthen collaboration between our Safeguarding Boards and the Community Safety Partnership.-** The Community Partnership has already started providing bespoke training for Trust Staff , especially in respect of Human Trafficking and Slavery

The safeguarding children agenda at national, regional and local level includes a number of practice areas that are significant for the Trust – this includes the exploitation of children and families, children and families affected by gun and knife crime, FGM, Child Sexual Exploitation. The term complex safeguarding is used and highlights that children may suffer harm from parents and carers or those in a position of trust but also from those outside the family or through contact online or through social media.

Bolton Safeguarding Children Board's business plan for 2018/19 was developed with priority areas listed below. The priority areas highlight where large numbers of children may be at risk of or suffering significant harm and also emerging areas of concern.

There are a number of additional strategies and areas of work that are under review (CSE, Missing, Neglect, Early Help, and LAC))

The identified priority areas are used to raise staff awareness and update safeguarding children training.

Priority 1 – Children are protected from the impact of living with Neglect-

Priority 2 – Children affected by organised crime

Priority 3 – Children's whose experiences are hidden – refugees, Home Educated, Domestic Abuse and Violence and children with a disability

Priority 4 – Child Protection Processes are used effectively to manage and reduce the risk of significant harm

There are planned changes to the Safeguarding Children Board arrangements based on recommendations in the Wood Report and Children and Social Work Act 2017 with implementation from September 2019.

Serious Adult Review (SAR) / Domestic Homicide Review (DHR)

In 2019, The Adult Safeguarding Board commissioned their first Serious Adult Review in respect of a gentleman who died following a house fire. The formal report is awaited but no concerns were identified in respect of care delivery by Bolton NHS Foundation Trust. A second SAR has now been jointly commissioned alongside a Domestic Homicide Review, following the death of a lady in March 2019. Bolton FT will be contributing to the joint review as the Trust was providing care for the victim along with a number of other agencies.

Partnership working

The Safeguarding team work closely with all partners of the Safeguarding Boards and other agencies on a National Level e.g. National Crime Agency, The Home Office, Counter Terrorism Units. These relationships have been developed over a number of years and facilitate best practice and timely response to concerns raised. Partnership working has proven to be beneficial for numerous victims especially where positive outcomes have been achieved by a multi-agency approach.

Integrity –demonstrate fairness, respect and empathy, take responsibility for actions, speaking out and learning from mistakes

LeDeR (Learning Disability Mortality Review Programme)

The national LeDeR programme supports local reviews of people with a learning disability.
The hospital Learning Disability Nurse is a member of the local steering group which monitors the progress and quality of the LeDeR reviews.

There has been an increased number of staff who have undertaken the LeDeR reviewer training which will help to increase the response time for reviews. Further to that there is a local recovery plan in place which widens the reviewer pool to assist the LeDeR reviews.

Feedback from the LeDeR project and local area contact has been consistently positive in regards to the quality of reviews, detailed information and family involvement.

Learning and improvement -Reviews for children and young people.

Serious Case Reviews (SCRs) are undertaken when specific circumstances are identified – where a child has been abused or suffered neglect resulting in serious harm or death and there is cause for concern as to the way in which agencies or services have worked together to safeguard the child.

Bolton NHS Foundation Trust has contributed to local reviews and reviews held in other areas where services were provided to the child and/or their family.

Contribution to any review includes participation on the review panel by the Named Nurse for Safeguarding Children, providing a comprehensive chronology of services provided and an Internal Management Review (IMR) report.

Review panels meet to review information provided by all agencies and this is an opportunity to consider practice, wider consideration of safeguarding systems as a whole and reflect, challenge and provide analysis to support recommendations and actions from each review.

Practitioner events are held to enable staff to meet with the reviewer to consider the multi-agency chronology and identify learning. Practitioner events are important to ensure that the child remains central to the review process.

Progress and findings from all reviews are shared at the Trust Safeguarding Committee and with service managers and staff .To support continuous learning and improvement it is important to identify both areas of concern and what works well.

Contribution to reviews in 2018/19 by safeguarding children team

Serious Case Reviews 2 Trust wide reports,6 Panel meetings ,3 Practitioner events	2
Rapid reviews 4 Trust wide reports ,1 updated report	4
Practice/Learning reviews 2 Trust wide reports ,3 Panel meetings	2
DHR with children in the family 2 Trust Wide reports, 4 Panel meetings	2

Summary of Actions/Recommendations/Learning from reviews

- The importance of routine enquiry about domestic abuse during ante-natal period and opportunities for staff to use routine enquiry in post-natal period.
- Recognition of coercive control as a risk to vulnerable adults and children.
- Supporting children to disclose abuse and recognition of sexual abuse within the family.
- Risks of co-sleeping including where there is adult substance use.

Mental Capacity Act 2005

In February 2019, independent Solicitors were commissioned by the Trust to provide 2 MCA/MHA training workshops for Consultants and Senior Clinicians. The workshops, supported by the Medical Director, Lead Psychiatrist for GMMH and the Lead Nurse for Safeguarding Adults were attended by over 70 Consultants.

Bespoke training for departments such as Urology, Ophthalmology, Orthopaedics, Community Nursing and Therapy Teams has been delivered in respect of completion of Mental Capacity Assessments and the Best Interest Process.

In conjunction with the 'End of Life Care Team' and Consultants a review of mental capacity assessments undertaken to underpin decision making in respect of DNR CPR is being undertaken to ensure adherence to legislation and best practice. This is work on-going led by the End of Life Care Team.

Mental Health Act 2007

The Service Level Agreement with GMMH has been renewed which supports the Trusts registration with the CQC to detain patients to the Trust under the Mental Health Act 2007 and to ensure legitimate process of detention in accordance with the Mental Health Act code of Conduct. On recent CQC inspection, The Trust's governance and imposition process was reviewed and commended. No concerns were raised in respect of any elements of the process. The Deputy Director of Nursing and the Lead Nurse for Adult Safeguarding have attended the Mental Health Act Steering and

Governance committee meetings chaired by the Director of Nursing for GMMH on an agreed basis of twice a year to monitor process and promote excellent partnership working.

An audit of document compliance in respect of detentions continues to be completed on a bi-annual basis to ensure legal process is being followed to reduce risk of illegal detention and to maintain CQC registration requirements.

Compassion – person centred approach, provide compassionate care, helpful and caring to colleagues

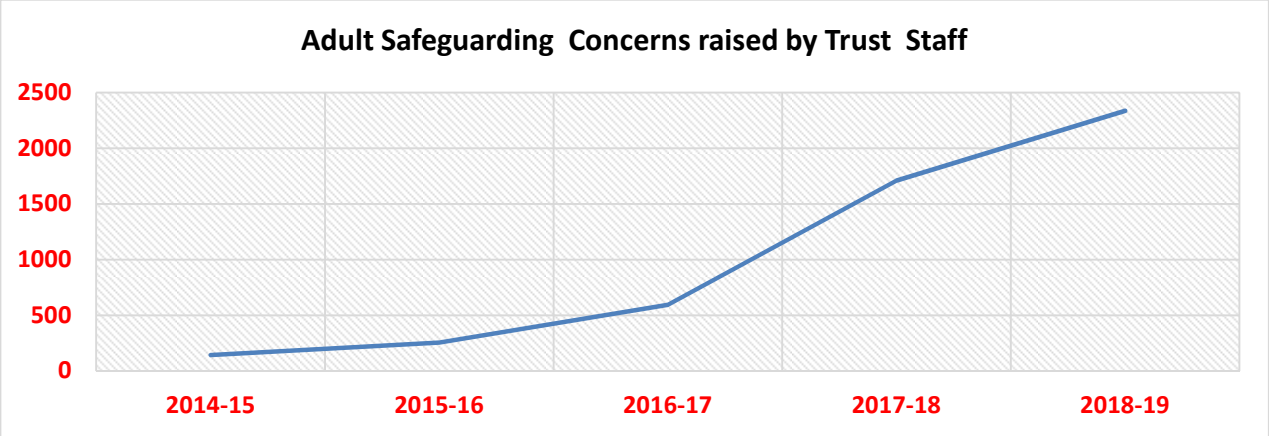
Activity/Referrals

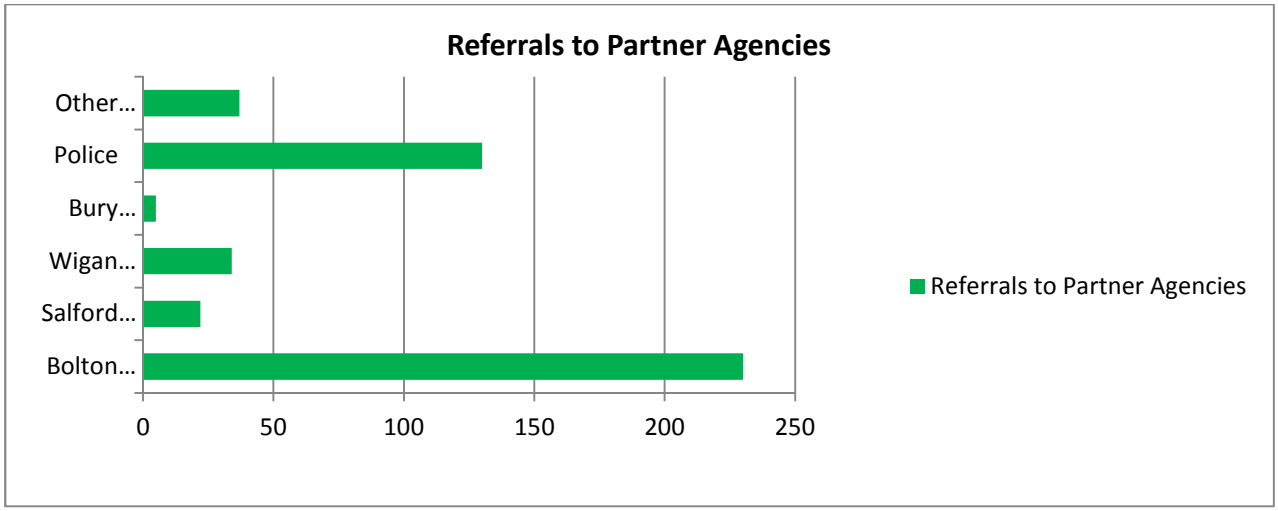
Working with the Adult Safeguarding Board, the Trust and partner agencies have now implemented the principles of Making Safeguarding Personal as described in The Care Act, being embedded within Trust policy and Safeguarding training provision. The principles ensure that Staff support and empower a victim to achieve outcomes they want as opposed to agencies dictating what a victim should accept.

Staff clearly demonstrate that Safeguarding is integral to the assessment and support process with referral rates steadily climbing year on year. Trust staff have been faced with some very complex safeguarding cases especially within community settings and now have very clear pathways in which they can raise safeguarding concerns, taking a multi-agency approach to ensure optimal care delivery and outcomes for victims of abuse.

The CQC noted on recent inspection reported that -

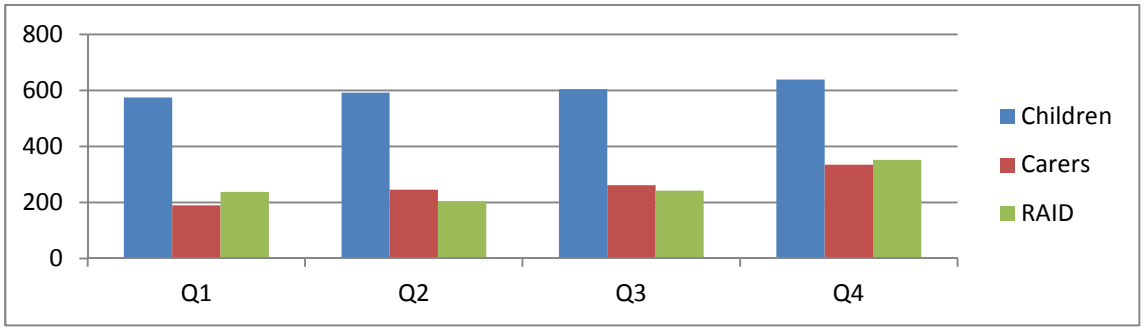
'staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had access to training on how to recognise and report abuse and they knew how to apply it. Staff were aware of how to make a referral and could give examples of referrals made'





It is possible to track individual cases but not all referrals due to the number of referrals and the number of agencies involved in care plans.

Referrals to safeguarding children team from A&E April 2018 –March 2019



Referrals relating to children have been reviewed within the timeframe of this report in a number of ways. The number of referrals to the safeguarding children team from A&E has increased by 41% since 2017.The table above shows referrals within the Trust from A&E where the highest number of concerns are raised about children but a significant and increasing number of concerns raised where adults attend and there are concerns identified as they are parents or carers. In these cases the children are not seen by staff however there is sufficient concern about their care or parenting capacity based on information about the adult.

Concerns about adults attending that may have implications for the care of children include physical or mental health issues, victim or perpetrator of violence and aggression and substance use. This results in establishing the identity of children in the family and a number of actions may be taken – some are for no further action, information may be shared with health professionals who know the family or who can review the health and well- being of the children or contact with Children's Social Care to request information or make a referral.

All referrals are notified to the Specialist Nurse in the MASSS who supports decision making and provides feedback to health staff where required.

Section 47 medicals service evaluation 2018-2019

There is an established pathway in place for Child Protection medicals where the Social Worker makes direct contact with the Consultant Paediatrician on hot week to discuss prior to the child

attending the hospital. Referrals for section 47 medicals are from Social Care (GP/HV) and A&E when concerns arise regarding neglect or physical abuse.

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

The total number of medicals for 2018-19 = 100
This represents a slight increase compared with the previous year (94 in 2017-18), but overall remains lower than preceding years. All of these were seen either same or next day (within 24 hours).

77/100 (77%) were seen by a Consultant, the remainder by ST3-ST8 Paediatric trainees under supervision of Consultant. This represents a slight increase in those seen by Consultant compared with previous years (2017-18 = 69%).

Section 47 medicals continue to place significant demands on the acute service, particularly out of hours and over the winter months. They are currently performed by the hot-week Consultant who is also managing a high acute work load. Various options including a 2 Consultant hot week system and clinic based section 47 medical examinations are currently being explored.

Following a previous SCR Trust medical staff complete an immediate response form that is given to the Social Worker at the time of the medical. This highlights findings and supports effective communication and understanding and is an example of good practice.

Learning Disability Specialist Nurse Provision

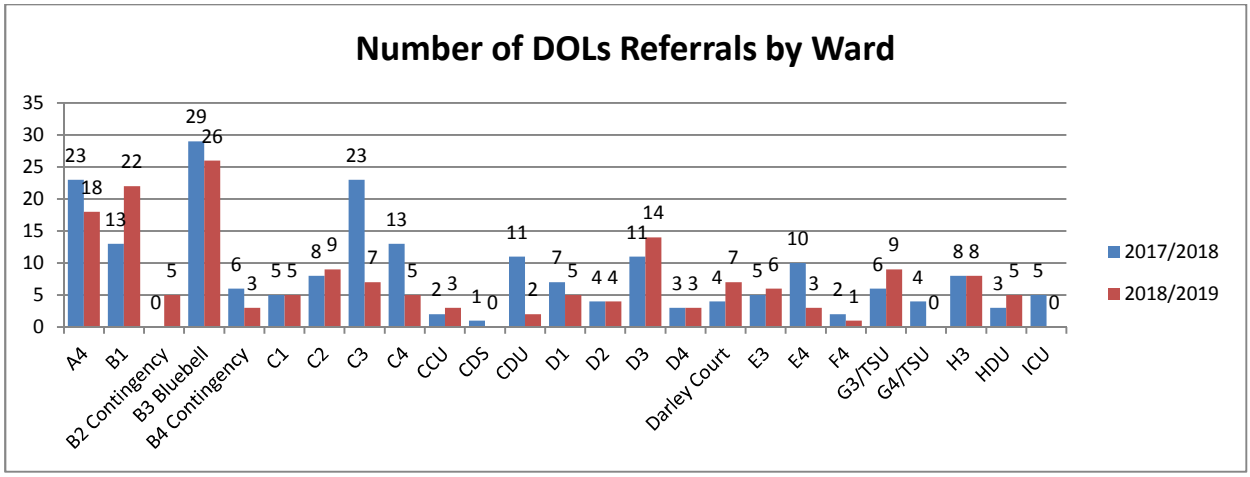
Learning Disability Awareness Training
The Learning Disability Nurse has delivered training to a wide range of hospital staff which includes medical staff, newly qualified nurses, trainee nurse associates and specialty staff.
Hospital staff has access to bespoke learning disability training pertinent to their specialty and area of work.

Hospital Learning Disability Link Champions
In our endeavour to continually improve the quality of care we provide to people with a learning disability who access hospital services and intermediate care we have a network of over 50 Learning Disability Link Champions throughout the hospital wards, departments and intermediate care facility.

The Learning Disability Link Champions commitment includes:
To work in partnership with the hospital Learning Disability Nurse to provide a high quality service that appropriately meets the needs of people with a learning disability and their carers and maximises successful health outcomes.
VOTC

Excellence – focus on quality and safety, continuously improve practice

Safeguarding patients whilst in our care also includes the application of numerous legal frameworks including Deprivation of Liberty Safeguards as previously mentioned. The Trust's process was reviewed by the CQC on recent inspection and found to be appropriate with no concerns raised.



The data reflects the higher incidence on complex care and orthopaedic wards where there can be sizeable cohorts of patients with cognitive impairments who may require enhanced care.

The Spring of 2020 will see the implementation of the New 'Liberty Protection Safeguards' (LPS) which received assent in May 2019. LPS will replace 'Deprivation of Liberty Safeguards', following review of the Metal Capacity Act 2005 legislation. It is envisaged that the Trust will become autonomous in respect of the imposition process without having to apply for overarching authorisation from the Supervisory Body i.e. the Local Authority. This transition will incur considerable change in policy, practice and training provision with a 6 month implementation window as the Trust will be required to be able to adhere to the revised legislation by October 2020.

BOSCA

The safeguarding team contribute to the BOSCA schedule in the areas of Patient care and satisfaction, safeguarding adults and children and vulnerable patients. This provides regular scrutiny and oversight of services and ward areas and the opportunity to monitor staff skills and knowledge and also compliance with safeguarding procedures.

Standard discussions include staff knowledge of referral processes, the identification and reasonable adjustments for vulnerable patients and feedback from patients and relatives in relation to care received.

This has proved an effective way to ensure that issues identified and included in safeguarding policies are understood and implemented by staff.

National Prevent Agenda

Prevent forms part of the Counter Terrorism and Security Act 2015 and one aim is to work to ensure that children and vulnerable adults are not radicalised to carry out terrorist activity. The Trust is mandated as per the NHS contract to adhere to the National Prevent Agenda which is a strand of the National 'Contest' Strategy which is the National overarching counter terrorism strategy.

As of March 2019:-

92.1% (3847 staff) of identified staff have completed the level 3 Prevent training. The NHS England target to be achieved is 85%.

93.9% (4911 staff) of all employees have completed the awareness training which has to be repeated every 3 years. The awareness training is now incorporated in both Level 1 and 2 Adult Safeguarding e-learning packages.

Training compliance is reported on a quarterly basis, as mandated to both NHS England and the CCG. The Trust is represented at the North of England Regional Prevent Forums by the Trust's Safeguarding Leads.

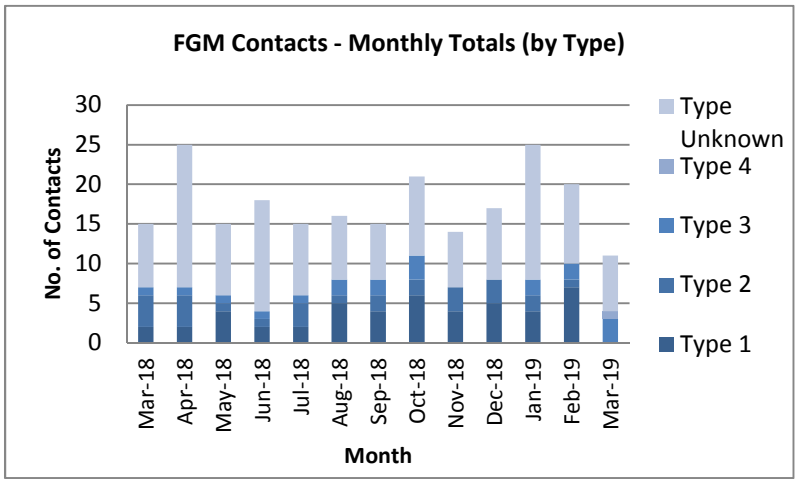
Prevent referrals to Local Counter Terrorist Unit and the Channel Panel remains low with only 6 referrals having been made throughout the year. This reflects the fact that Bolton is regarded as a low risk area. Both the Adult and Children's Lead nurses represent the Trust on the Channel Panel, which meets on a monthly basis where potential cases are reviewed and multi-agency action plans collated.

The prevent training provision is currently under review by NHS England and The Home Office with a new provider having been commission to revise training packages to be implemented Nationally. These are not expected until late 2019. Lord Carlisle has been commissioned to undertake a complete review of the 'Prevent Agenda' by the Home Office as since inception, trends in terrorist activity have changed with the emergence of significant right wing concerns but the main concern remains international terrorism.

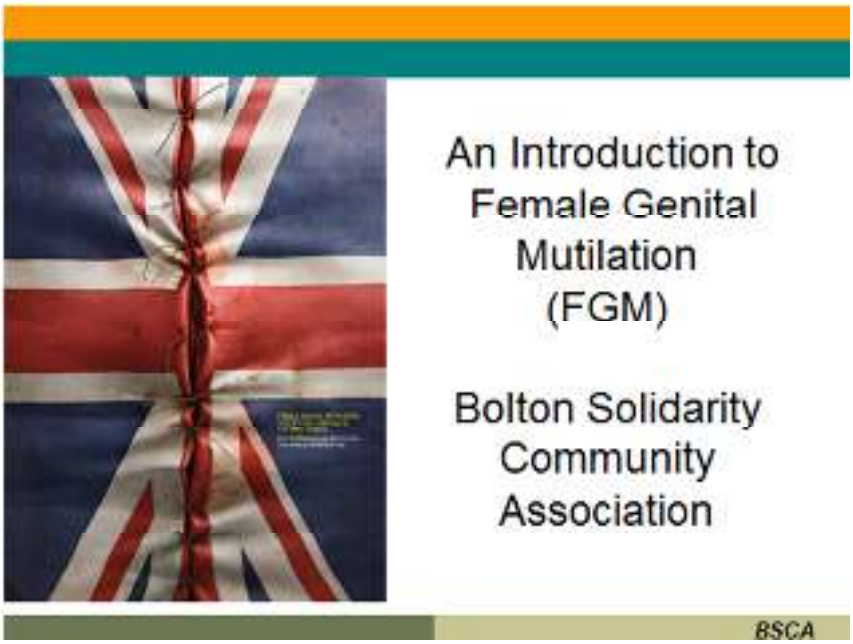
Female Genital Mutilation FGM

Monthly data about FGM is collected and submitted to the Department of Health. All the cases identified within the timeframe of the report were of adults who disclosed having FGM in country of origin.

The numbers of cases and type each month varies and most cases are identified within maternity for Bolton residents. See table below



Trust staff in key services (Maternity, Health Visiting, Sexual Health, and Asylum Nurses) have the skills and knowledge to work with families where there is FGM and use nationally approved risk assessments.



In March 2019 the Trust hosted an FGM workshop organised by the Named Nurse Safeguarding Children on behalf of the Bolton FGM Steering Group. This was open to Trust staff and partner agencies and attended by 55 people. Speakers were from Border Agency, local community groups (Bolton Solidarity Community Association above) an FGM charity in Greater Manchester and from University of Bolton. Positive feedback was provided about all the speakers and topics covered on the day including raising staff confidence in asking questions about FGM in the family, understanding of services in Bolton and across GM, findings from Border Force interventions at airports and the research in progress at the University about mental and emotional health impact of having FGM.

The Trust has signed up to and implemented a new information sharing system known as FGM –IS.

This is a National web based system for sharing information on the NHS Spine/Summary Care Record which:

- Highlights a family history of FGM to protect and safeguard a girl under 18
- Shares information on the record of a girl under 18
- Prompts clinicians treating a girl that she has a family history of FGM

The FGM- IS:

- Does not change or replace professionals responsibility
- Is used alongside existing local and national safeguarding frameworks
- Provides an opportunity to strengthen/ review existing local safeguarding policies and procedures
- Should already be sharing family history of FGM with GP and health visitor

It is proposed that nationally for all maternity units to implement FGM-IS and to start adding the FGM indicator to baby girls' records.

The advantages are that FGM information can then be seen by practitioners or GPs/Practice Nurses, it will start appearing when open a girl's record.

Future Priorities 2019-2020

2019 will see the implementation of the Trust's Electronic Patient Record. The Safeguarding Team has designed the new referral pathway with the EPR Team to ensure the least diusruption as possible and to ensure the pathway is ready for the implementation. It is envisaged, in time this will improve communication between the team and Trust Staff as information in respect of cases will be readily available at all times as well as reducing administration workloads.

Adult Safeguarding

1. To commence rolling programme of Level 3 Adult Safeguarding Training to which partner agencies will also have access to with a view to an improved understanding of multi/inter-agency working partnerships
2. Implement Liberty Protection Safeguards legislation and process
3. Develop further training provision in respect of care for those with Learning Disabilities
4. Respond to and support the business plan of the Adult Safeguarding Board

Safeguarding Children and LAC

1. To develop safeguarding pathways and practice within 0-19 service
2. Establish a Trust wide Voice of the Child Forum
3. Update Level 3 safeguarding children training package
4. Contribute to work-streams under new safeguarding children partnership arrangements

Agenda Item No:	
Meeting:	Trust Board
Date:	31st October 2019

NHS Bolton NHS Foundation Trust

Title:	Learning from deaths Quarter 2 report for 2019-2020
Purpose	Trusts are required to collect and publish on quarterly basis specified information on deaths via board. This data includes the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care, and be accompanied by relevant qualitative information and interpretation. This paper describes the (Q1) &Q2 summary from the learning from deaths programme at Bolton NHS FT
Executive Summary:	
Previously considered by:	N/A
Recommendation Please state if approval required or if for information	The board are asked to approve the paper

Confidential y/n	n

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

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

Introduction

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

Methodology

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

Results

These are shown in table 1 and 2 below. Data from quarter one is included for comparison. Of concern is the poor completion of cases for September-this will be raised at the next learning from deaths committee meeting to determine the reasons why. Of particular note is that some consultants have expressed concerns about the time taken for reviews in an already full job plan. On a more positive note, the advent of the EPR means that there should be no delays in getting patient notes as these will be available immediately online which may offset some of the delays to completion.

Table 1: numbers of deaths per month

Total number of inpatient deaths	**June**	**July**	**August**	**Total for quarter**
number	100	107	105	312

Table 2. Details of cases by source and score

	Pilot	Quarter 1			Quarter 2		
	Mar	April	May	June	July	Aug	Sept
Number Cases (Sample)	23	29	35	32	26	27	25
COMPLETED	22	26	30	27	18	16	3
Outstanding Cases	1	3	5	5	8	11	22
Not Yet Received - Within Deadline	0	0	0	0	0	0	0
Outstanding -Surpassed Deadline	1	2	3	4	6	11	22
Missing notes unable to find	0	1	2	1	2	0	0
%	**95.7**	**89.7**	**85.7**	**84.4**	**69.2**	**59.3**	**12.0**
Source							
Mandated Death (Alert Diagnosis)*	22	18	25	21	4	2	8
Unexpected Death	0	1	7	2	6	6	9
LD Death	0	0	0	1	0	0	0
Mental Health Death	1	6	1	4	7	9	1
5% sample	0	4	2	4	9	9	7
Requested by cons/matron	0	0	0	0	0	1	0
Total	23	29	35	32	26	27	25
Overall Score							
1 (Very Poor)	0	0	0	0	0	0	0
2 (Poor)	3	4	3	2	3	1	2
3 (Adequate)	5	9	8	3	8	4	0
4 (Good)	13	11	15	18	6	7	1
5 Excellent	1	2	4	4	1	4	0
Total	22	26	30	27	18	16	3

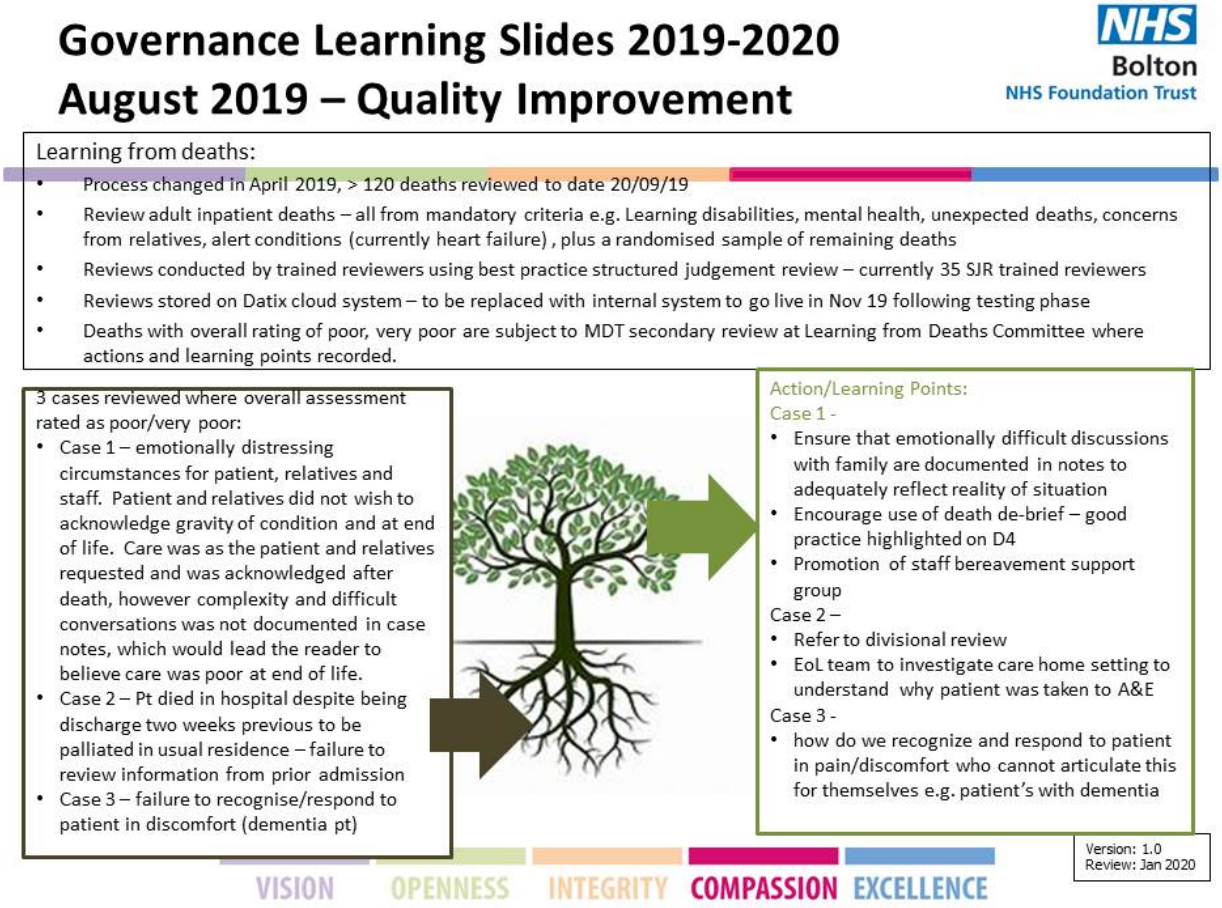
*Mandated diagnoses were pneumonia to June 2019, then congestive cardiac failure from July 2019.

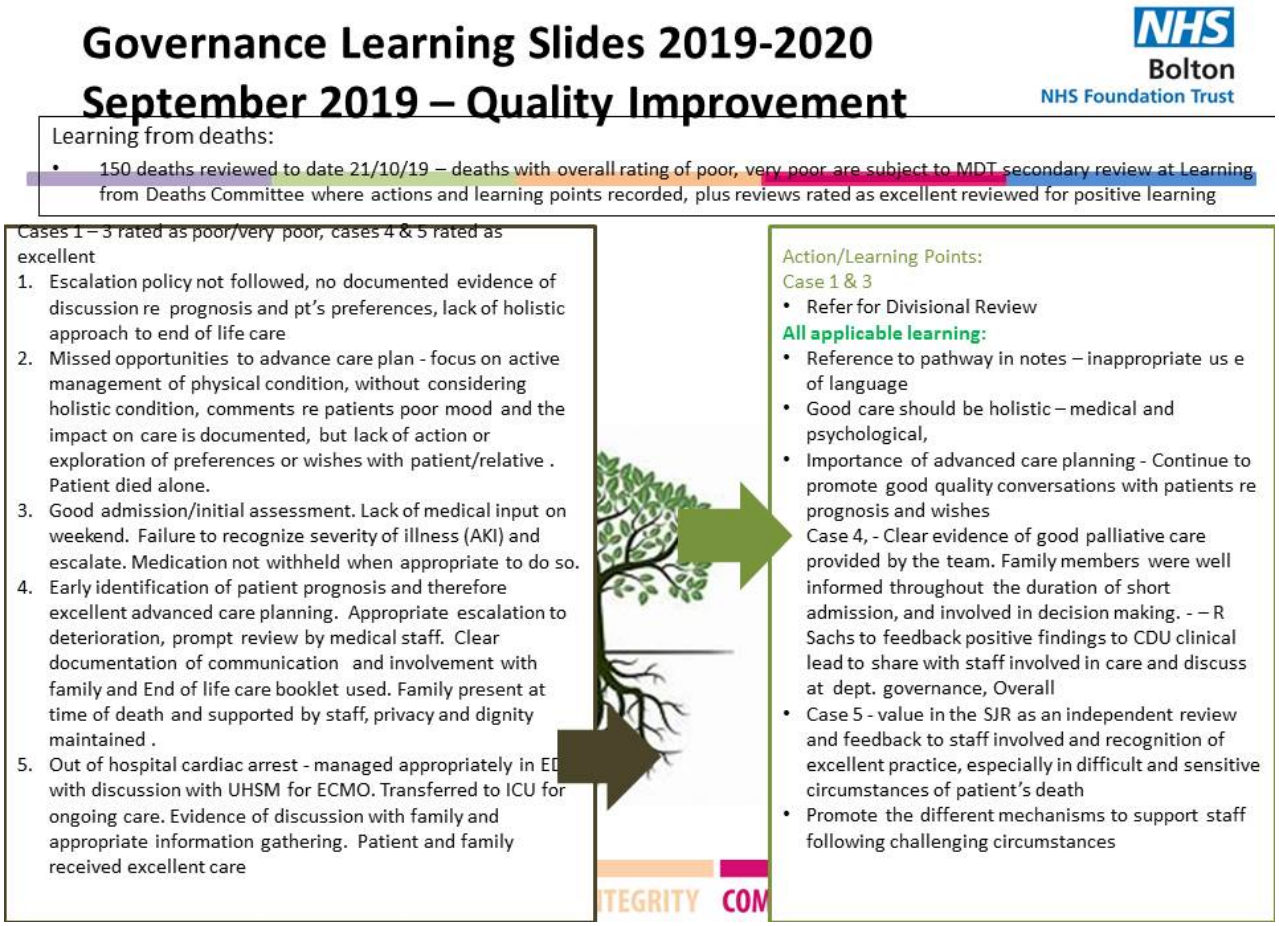
Total number of cases where death was more than likely to have occurred due to problems with care

Of the 37 cases that so far for quarter 2 have been rated as poor, 1 was classed as a death more than likely due to problems in care and was referred for a Serious Incident investigation. Estimate therefore 3% all deaths more than likely due to problems with care

Learning

At each learning from deaths committee, for each case where the care was judged to be poor or very poor, a secondary review is completed by the committee and learning points are collated in and disseminated via a learning slide from clinical governance to clinical governance and quality assurance committee and the divisions for circulation.





The learning slides are distributed each month via the Better care together group email for cascade and distribution at ward level. Copies of the learning slides are then made available to everyone via the Governance page on BOB. This process commenced in August. As can be seen, some cases at learning from deaths committee are highlighted for excellent care and this learning is also fed back.

Further issues

Consideration is being given to raising the number of cases randomly selected to 10% of reviews. A limiting factor is the poor completion rate for September which needs to be examined for explanation. Those deaths categorized as 'unexpected' are currently based on the judgement of the clinician in acute cases and this is often not borne out given the frailty and comorbidities of many of these patients and should be replaced by deaths occurring in patients who have been admitted for elective procedures, in line with national recommendations.

Agreement has been reached with Greater Manchester Mental Health (GMMH) Trust that they will be notified of any SJRs where patients had severe mental health problems for their own review. GMMH have done a similar exercise with Salford culminating in useful learning points for the acute Trust and the intention is to replicate this at Bolton.

Conclusion

The learning from deaths programme continues to evolve with evidence of lessons learned now being circulated, and links with the GMMH being forged around learning from deaths. Timely completion of SJRs and clinician capacity to do them is becoming a concern which will be addressed at the next learning from deaths meeting.

Report ends

Integrated Summary Dashboard - September 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		4
Organisational Development		6
Agency		3
Finance		
Finance		5
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
Pressure ulcers acquired in the hospital have remained low and within plan for September with only three Category 2 pressure ulcers identified. In the community, the number of Category 2 pressure ulcers has increased to eight, which is one above trajectory. One of these pressure ulcers developed in a paediatric patient. The number of Category 3 and Category 4 pressure ulcers developing in the community has remained below plan. The number of pressure ulcers attributed to lapses in care across the trust has increased by one since August, but continues to remain below trajectory, at three.

Falls
Falls per 1000 bed days for September is under our target of 5.3 and shows an improving position from August. YTD we are also maintaining performance at under 5.3 falls per 1000 bed days.
Falls with harm remain red but again show an improving position from August. Wards with falls levels outside the 5.3 target, have increasing repeat falls or falls with harm will be supported from November with the introduction of a new, targeted ward review process.

	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%	95.5%	Sep-19			>= 95%	97.4%	Aug-19		>= 95%	96.9%		95.5 - 97.6%	
9 - Never Events	= 0	1	Sep-19			= 0	0	Aug-19		= 0	1		0 - 1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.24	Sep-19			<= 5.30	6.19	Aug-19		<= 5.30	5.21		3.60 - 6.19	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	2	Sep-19			<= 1.6	3	Aug-19		<= 9.6	10		0 - 5	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	3.0	Sep-19			<= 6.0	3.0	Aug-19		<= 36.0	29.0		1.0 - 8.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Sep-19			<= 0.5	0.0	Aug-19		<= 3.0	0.0		0.0 - 2.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Sep-19			= 0.0	0.0	Aug-19		= 0.0	0.0		0.0 - 0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	8.0	Sep-19			<= 7.0	5.0	Aug-19		<= 42.0	45.0		2.0 - 12.0	

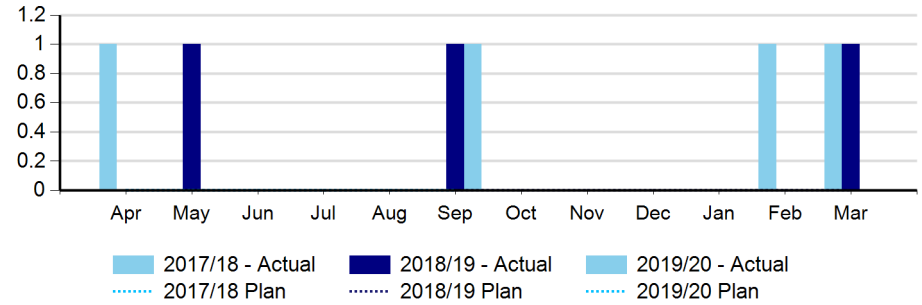
Integrated Summary Dashboard - September 2019

NHS Bolton NHS Foundation Trust

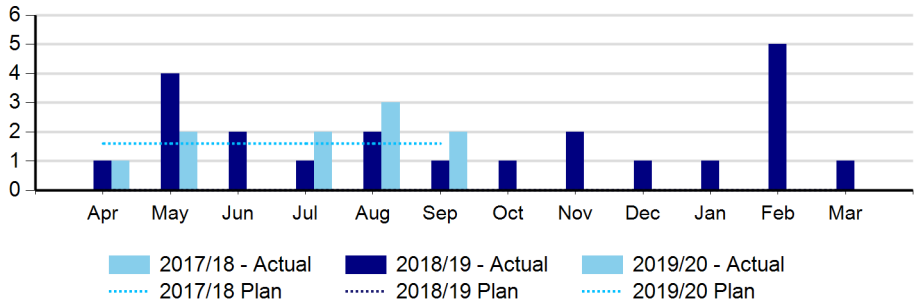
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	2.0	Sep-19			<= 4.0	3.0	Aug-19		<= 24.0	16.0		0.0 - 8.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Sep-19			<= 1.0	0.0	Aug-19		<= 6.0	2.0		0.0 - 2.0	
21 - Total Pressure Damage due to lapses in care	<= 6	3	Sep-19			<= 6	2	Aug-19		<= 34	18		0 - 8	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	94.3%	Q4 2018/19			>= 90%	92.5%	Q3 2018/19		>= 90%			92.5 - 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%			91.7 - 100.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 80%	81.0%	Sep-19			>= 80%	80.0%	Aug-19		>= 80%	79.0%		75.2 - 81.0%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	68.6%	Sep-19			>= 72.5%	72.2%	Aug-19		>= 72.5%	61.5%		50.1 - 79.3%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	66.7%	Sep-19			= 100%	100.0%	Aug-19		= 100%	86.8%		33.3 - 100.0%	
88 - KPI Audits linked to Bolton System of Accreditation (BOSCA)	>= 85%	91.6%	Sep-19			>= 85%	92.2%	Aug-19		>= 85%	92.3%		91.6 - 94.0%	
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	0.0%	Sep-19			= 100%	100.0%	Aug-19		= 100%	142.9%		0.0 - 100.0%	

Exceptions

9 - Never Events



14 - Inpatient falls resulting in Harm (Moderate +)

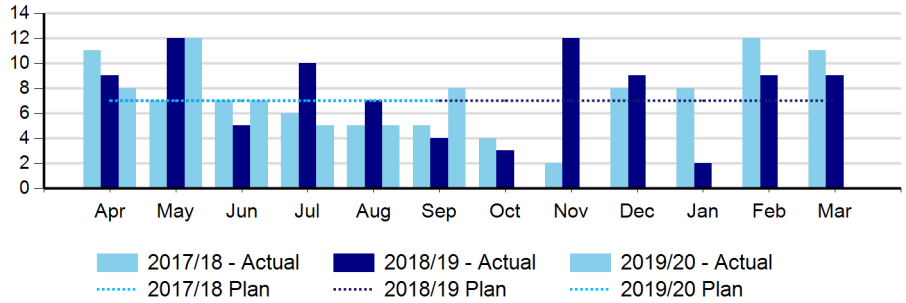


Bolton NHS Foundation Trust

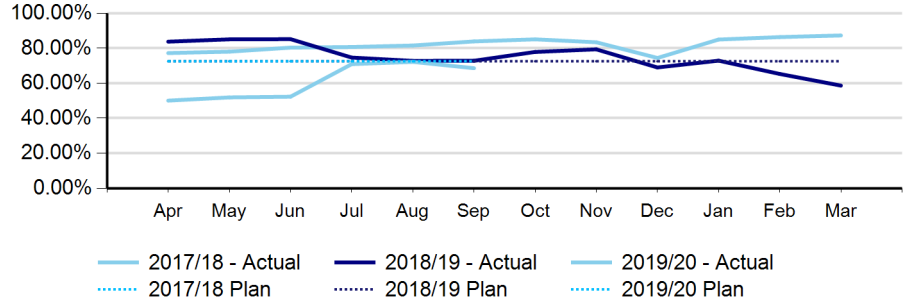
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	0	0	0	0	0	0	0	0	0	1	1
18/19	0	1	0	0	0	1	0	0	0	0	0	1
19/20	0	0	0	0	0	1						

	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	0	2	3	2						

18 - Community patients acquiring pressure damage (category 2)



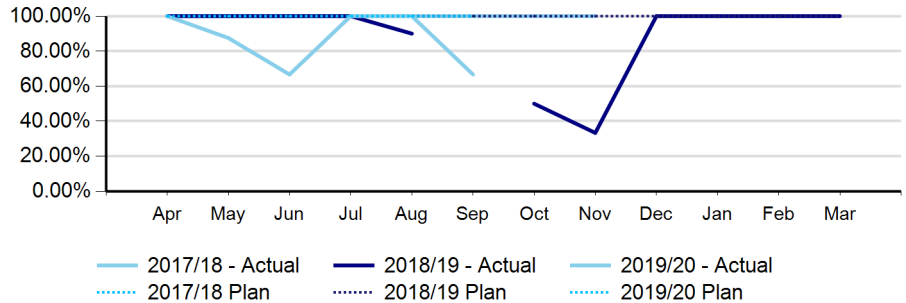
31 - Clinical Correspondence - Outpatients %<5 working days



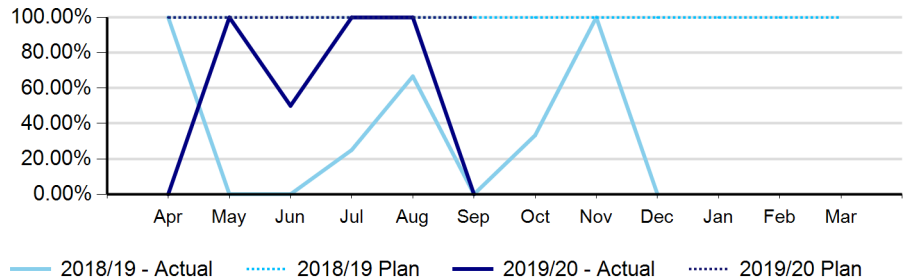
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	11.0	7.0	7.0	6.0	5.0	5.0	4.0	2.0	8.0	8.0	12.0	11.0
18/19	9.0	12.0	5.0	10.0	7.0	4.0	3.0	12.0	9.0	2.0	9.0	9.0
19/20	8.0	12.0	7.0	5.0	5.0	8.0						

	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%	52.3%	70.9%	72.2%	68.6%						

86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days



	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%	66.7%	100.0%	100.0%	66.7%						

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	100.0%	0.0%	0.0%	25.0%	66.7%	0.0%	33.3%	100.0%	0.0%		100.0%	
19/20	0.0%	100.0%	50.0%	100.0%	100.0%	0.0%						

Bolton NHS Foundation Trust

Infection Prevention and Control

There number of CDT cases has reduced since August from 12 to six . Trust Board received an update last month on the approaches taken regarding back to basics in light of not being able to determine a single root cause.

Blood culture contaminants continue to reduce to 3.7%.

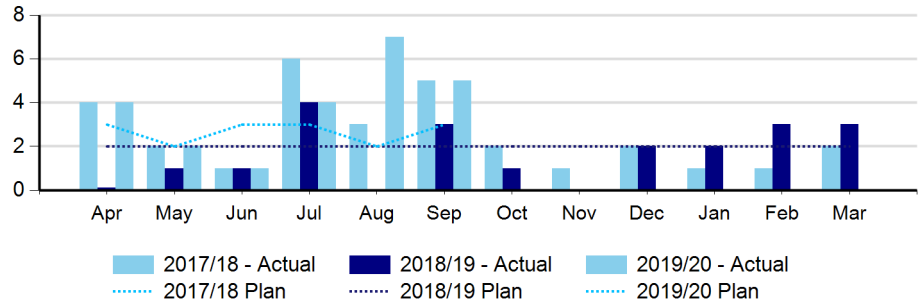
There have been no new MRSA cases, there has been a year on year decrease in MSSA cases.

	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	<= 3	5	Sep-19			<= 2	7	Aug-19		<= 16	23		0 - 7	
346 - Total Community Onset Hospital Associated C.diff infections	<= 2	0	Sep-19			<= 1	5	Aug-19		<= 7	19		0 - 7	
347 - Total C.diff infections contributing to objective	<= 3	6	Sep-19			<= 3	12	Aug-19		<= 16	37		2 - 12	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Sep-19			= 0	0	Aug-19		= 0	1		0 - 1	
218 - Total Trust apportioned E. coli BSI	<= 4	5	Sep-19			<= 4	4	Aug-19		<= 24	20		0 - 6	
219 - Blood Culture Contaminants (rate)	<= 3%	3.4%	Sep-19			<= 3%	4.5%	Aug-19		<= 3%	3.9%		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	1.0	Sep-19			<= 1.3	0.0	Aug-19		<= 7.8	3.0		0.0 - 4.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	<= 1	1	Sep-19			= 0	1	Aug-19		<= 5	6		0 - 3	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	= 0	0	Sep-19			= 0	0	Aug-19		<= 1	1		0 - 1	

Bolton NHS Foundation Trust

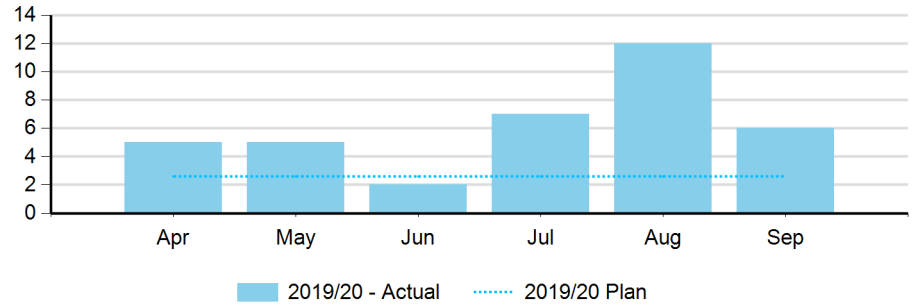
Exceptions

215 - Total Hospital Onset C.diff infections



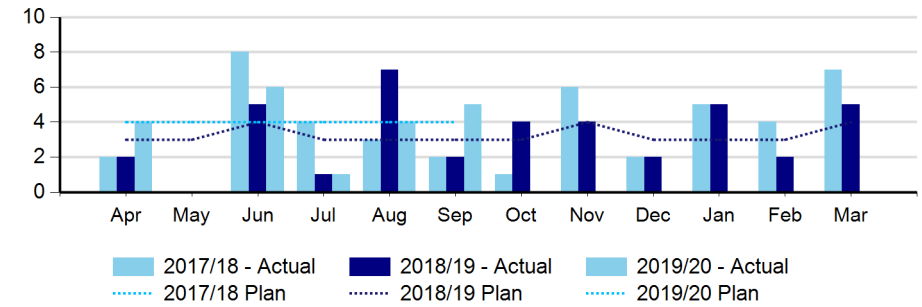
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4	2	1	6	3	5	2	1	2	1	1	2
18/19	0	1	1	4	0	3	1	0	2	2	3	3
19/20	4	2	1	4	7	5						

347 - Total C.diff infections contributing to objective



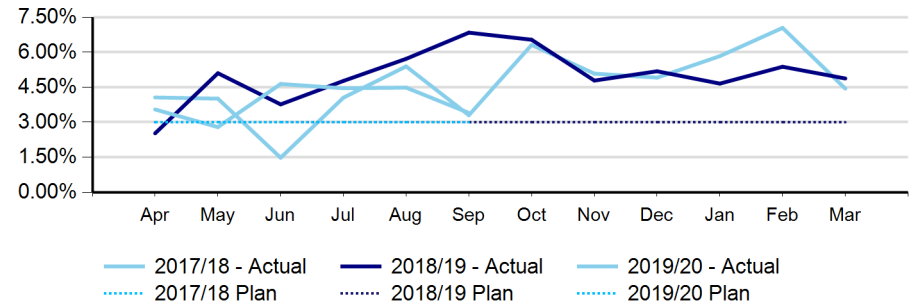
	Apr	May	Jun	Jul	Aug	Sep
19/20	5	5	2	7	12	6

218 - Total Trust apportioned E. coli BSI



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	0	8	4	3	2	1	6	2	5	4	7
18/19	2	0	5	1	7	2	4	4	2	5	2	5
19/20	4	0	6	1	4	5						

219 - Blood Culture Contaminants (rate)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4.1%	4.0%	1.5%	4.1%	5.4%	3.3%	6.3%	5.1%	4.9%	5.8%	7.0%	4.4%
18/19	2.5%	5.1%	3.8%	4.8%	5.7%	6.8%	6.5%	4.8%	5.2%	4.7%	5.4%	4.9%
19/20	3.5%	2.8%	4.6%	4.5%	4.5%	3.4%						

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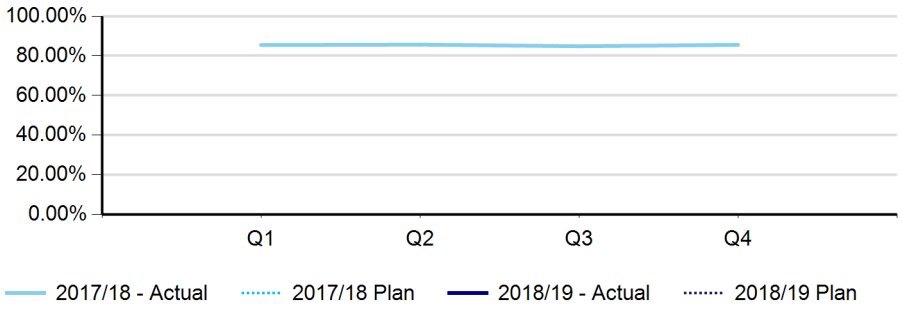
NHS Foundation Trust

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%	

Bolton NHS Foundation Trust

Mortality

Crude rate has fallen slightly to 1.9% with total deaths in month of 86. Heart failure, pneumonia and A&E deaths continue to be monitored via the 'Learning by Deaths' Committee.

SHMI has fallen to 116 for the period April 2018 to March 2019 although this figure is still significantly higher than the England average.

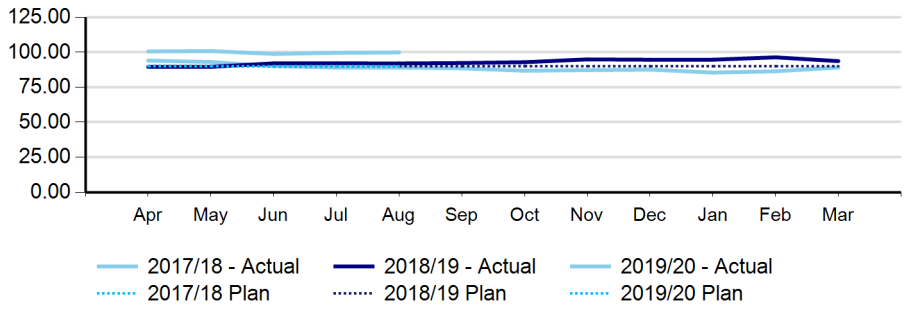
The rolling 12 month average figure for RAMI has increased slightly in the 12 months to August 2019 but this is not significant

	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%	98.8%	Sep-19			>= 85%	100.0%	Aug-19		>= 85%	96.2%		87.1 - 100.0%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	99.8	Aug-19			<= 90	99.5	Jul-19		<= 90	99.8		92.2 - 100.8	
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.00	116.00	Q4 2018/19			<= 100.00	119.00	Q3 2018/19		<= 100.00			116.00 - 119.00	
12 - Crude Mortality %	<= 2.9%	1.9%	Sep-19			<= 2.9%	2.0%	Aug-19		<= 2.9%	1.9%		1.7 - 2.7%	

Bolton
NHS Foundation Trust

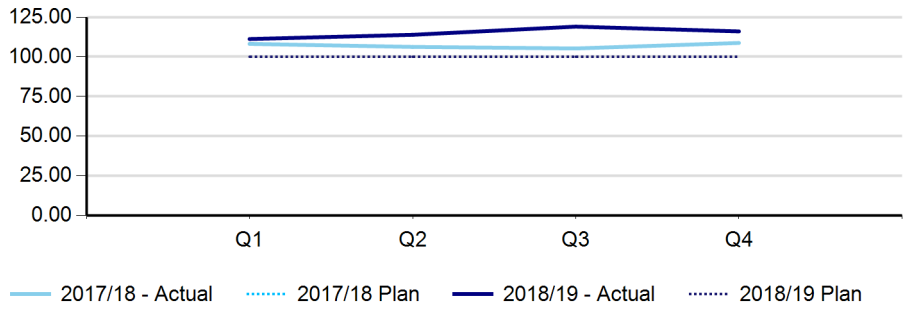
Exceptions

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
19/20	100.5	100.8	98.7	99.5	99.8							

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	116.00

NHS Bolton NHS Foundation Trust

Patient Experience

A&E FFT
Although there has been a slight dip, the response rates for September remain at the 20% trajectory for a second month.

In-Patient FFT/Maternity
The recommendation rates for in-patients and Maternity are below the 95% trajectory. Matrons and Ward Managers continue to review the negative feedback and act to improve services as a result.

Complaints
There was one complaint that was not acknowledged within the 3 days target. This is as a result of the pressures the patient experience team has been under due to sickness.

	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%	20.0%	Sep-19			>= 20%	23.4%	Aug-19		>= 20%	18.7%		15.1 - 23.4%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	90.7%	Sep-19			>= 90%	92.3%	Aug-19		>= 90%	91.3%		88.9 - 92.3%	
80 - Inpatient Friends and Family Response Rate	>= 30%	29.9%	Sep-19			>= 30%	28.6%	Aug-19		>= 30%	29.7%		25.7 - 32.7%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	95.3%	Sep-19			>= 90%	96.6%	Aug-19		>= 90%	96.6%		95.3 - 97.9%	
81 - Maternity Friends and Family Response Rate	>= 15%	30.2%	Sep-19			>= 15%	36.6%	Aug-19		>= 15%	31.7%		25.0 - 40.0%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	94.2%	Sep-19			>= 90%	96.0%	Aug-19		>= 90%	95.7%		92.4 - 97.3%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	20.8%	Sep-19			>= 15%	23.5%	Aug-19		>= 15%	22.3%		7.3 - 43.4%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	99.1%	Sep-19			>= 90%	96.7%	Aug-19		>= 90%	98.6%		95.9 - 100.0%	
83 - Birth - Friends and Family Response Rate	>= 15%	27.0%	Sep-19			>= 15%	28.1%	Aug-19		>= 15%	33.2%		26.1 - 50.2%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	90.1%	Sep-19			>= 90%	91.5%	Aug-19		>= 90%	92.7%		88.7 - 97.6%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	28.1%	Sep-19			>= 15%	58.0%	Aug-19		>= 15%	33.6%		17.7 - 58.0%	

Integrated Summary Dashboard - September 2019

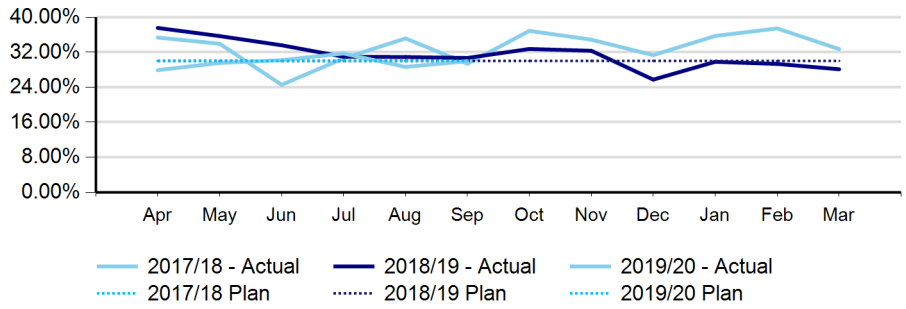
Bolton NHS Foundation Trust

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	89.6%	Sep-19			>= 90%	96.7%	Aug-19		>= 90%	93.3%		88.1 - 96.7%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	47.7%	Sep-19			>= 15%	44.6%	Aug-19		>= 15%	40.6%		28.8 - 51.4%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	97.0%	Sep-19			>= 90%	98.3%	Aug-19		>= 90%	98.1%		93.2 - 99.5%	
89 - Formal complaints acknowledged within 3 working days	= 100%	96.8%	Sep-19			= 100%	100.0%	Aug-19		= 100%	99.4%		96.8 - 100.0%	
90 - Complaints responded to within the period	>= 95%	95.5%	Sep-19			>= 95%	95.7%	Aug-19		>= 95%	97.2%		90.0 - 100.0%	

Bolton NHS Foundation Trust

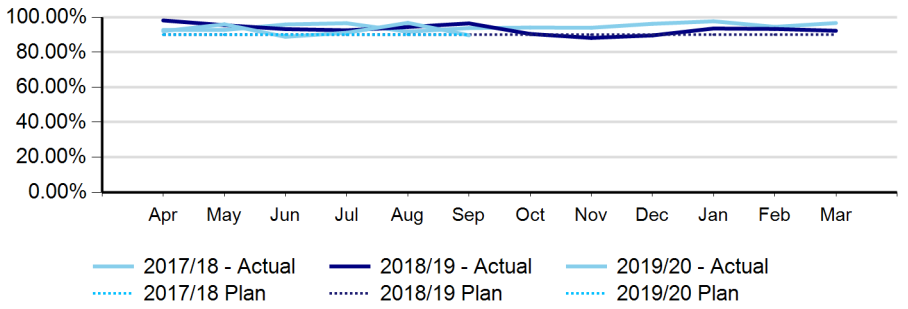
Exceptions

80 - Inpatient Friends and Family Response Rate



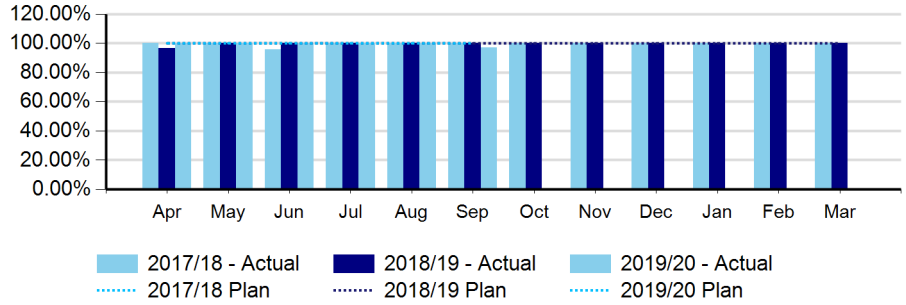
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	35.3%	33.9%	24.5%	30.6%	35.1%	29.3%	36.9%	34.9%	31.3%	35.7%	37.4%	32.7%
18/19	37.5%	35.7%	33.6%	31.0%	30.9%	30.7%	32.7%	32.3%	25.7%	29.8%	29.3%	28.1%
19/20	27.9%	29.5%	30.2%	31.7%	28.6%	29.9%						

244 - Hospital Postnatal Friends and Family Test - Satisfaction %



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.7%	92.7%	95.8%	96.5%	91.7%	93.8%	94.0%	93.9%	96.2%	97.6%	94.4%	96.6%
18/19	98.1%	95.4%	93.2%	92.5%	94.4%	96.4%	90.4%	88.1%	89.6%	93.5%	93.2%	92.2%
19/20	92.0%	95.9%	88.8%	91.1%	96.7%	89.6%						

89 - Formal complaints acknowledged within 3 working days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
18/19	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
19/20	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%						

NHS Bolton NHS Foundation Trust

Maternity

Maternity stillbirths per 1000 births 5.99 (this month 3 stillbirths) - 1 woman came to us from another Trust looking for confirmation and went on to birth with us, she had not previously been under our care. 1 woman had Type 1 diabetes at 38/40. 1 woman was 26 weeks and 5 days. None were unexpected stillbirths in labour that meet the HSIB criteria.

Maternity -3rd/4th degree tears 2% (improved again on last month 2.3%).

Booked 12+6 BI calculated figure was 88.9%, maternity are keeping a log of the activity and had attained 91.50%, attributed to late bookers and repeat

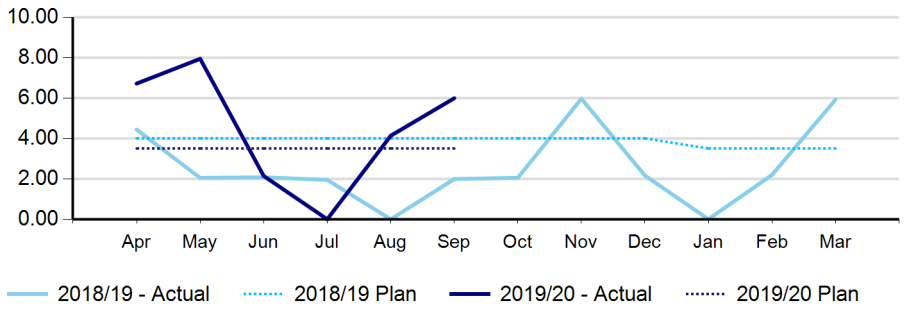
Rate of preterm births. This is for information only as this is a regional QI work supported by the LMS.

	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	5.99	Sep-19			<= 3.50	4.13	Aug-19		<= 3.50	4.46		0.00 - 7.94	
23 - Maternity -3rd/4th degree tears	<= 2.5%	2.0%	Sep-19			<= 2.5%	2.3%	Aug-19		<= 2.5%	2.4%		1.3 - 3.3%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.3%	Sep-19			>= 95.0%	98.8%	Aug-19		>= 95.0%	98.8%		97.8 - 99.8%	
203 - Booked 12+6	>= 90.0%	88.9%	Sep-19			>= 90.0%	89.4%	Aug-19		>= 90.0%	88.7%		82.9 - 90.7%	
204 - Inductions of labour	<= 35%	40.9%	Sep-19			<= 35%	40.4%	Aug-19		<= 35%	41.9%		37.6 - 45.0%	
208 - Total C section	<= 29.0%	30.8%	Sep-19			<= 29.0%	25.7%	Aug-19		<= 29.0%	27.8%		24.6 - 31.4%	
210 - Initiation breast feeding	>= 65%	69.86%	Sep-19			>= 65%	65.76%	Aug-19		>= 65%	68.77%		63.30 - 72.60%	
213 - Maternity complaints	<= 5	4	Sep-19			<= 5	6	Aug-19		<= 30	19		0 - 8	
319 - Maternal deaths (direct)	= 0	0	Sep-19			= 0	0	Aug-19		= 0	0		0 - 0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	10.2%	Sep-19			<= 6%	9.3%	Aug-19		<= 6%	9.7%		7.6 - 11.4%	

Bolton NHS Foundation Trust

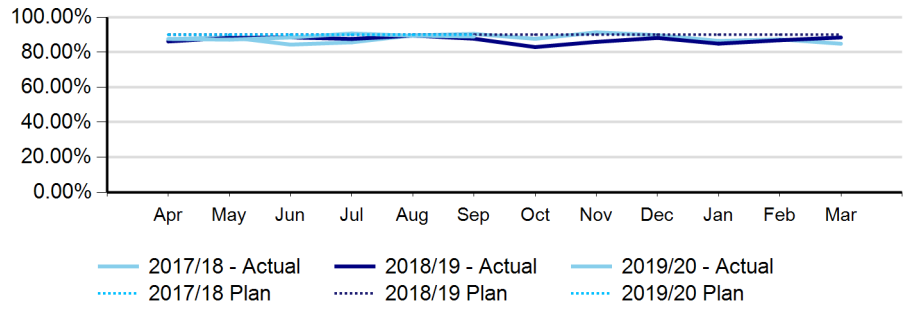
Exceptions

322 - Maternity - Stillbirths per 1000 births



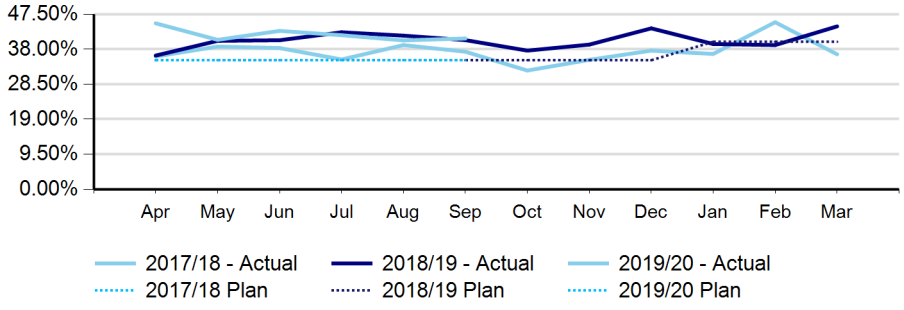
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	4.43	2.04	2.07	1.95	0.00	1.99	2.05	5.96	2.16	0.00	2.19	5.92
19/20	6.71	7.94	2.14	0.00	4.13	5.99						

203 - Booked 12+6



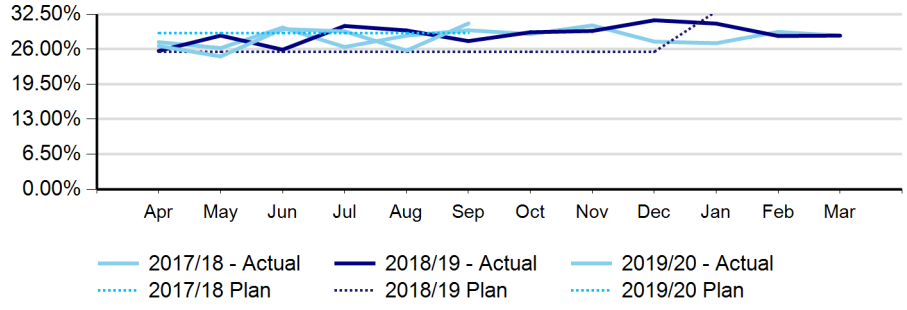
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	87.4%	88.5%	84.3%	85.6%	89.6%	90.4%	87.6%	91.3%	89.7%	86.4%	87.3%	84.8%
18/19	86.1%	88.1%	88.4%	87.5%	89.4%	87.7%	82.9%	85.9%	88.1%	84.8%	86.8%	88.4%
19/20	87.5%	87.1%	88.4%	90.7%	89.4%	88.9%						

204 - Inductions of labour



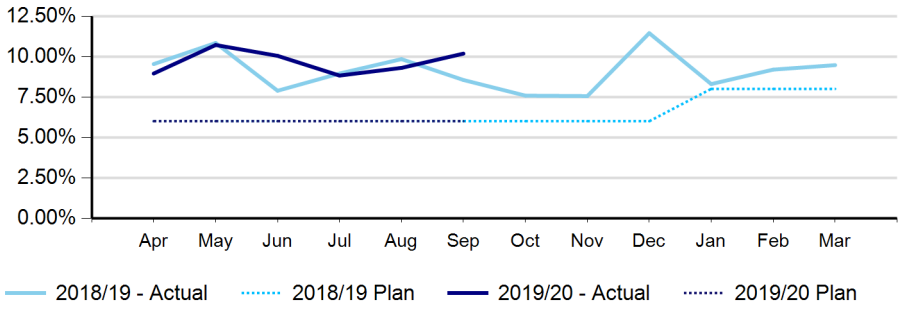
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	36.0%	38.7%	38.3%	35.2%	39.1%	37.3%	32.2%	35.1%	37.6%	36.7%	45.3%	36.6%
18/19	36.3%	40.3%	40.4%	42.6%	41.7%	40.4%	37.6%	39.2%	43.6%	39.4%	39.1%	44.2%
19/20	45.0%	40.5%	43.0%	41.8%	40.4%	40.9%						

208 - Total C section



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	27.3%	26.2%	30.0%	26.4%	28.5%	29.5%	28.8%	30.4%	27.4%	27.1%	29.2%	28.5%
18/19	25.7%	28.5%	25.9%	30.3%	29.5%	27.5%	29.1%	29.4%	31.4%	30.7%	28.4%	28.5%
19/20	26.6%	24.6%	29.7%	29.3%	25.7%	30.8%						

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%	10.0%	8.8%	9.3%	10.2%						

Bolton NHS Foundation Trust

Operational Performance

Access

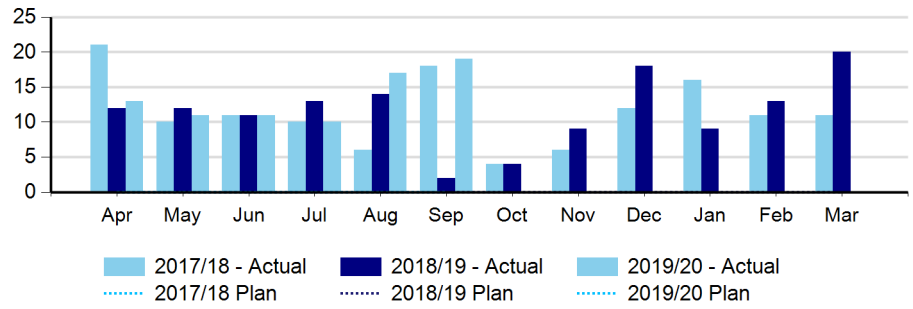
4 hour Standard
There has been significant pressure on bed availability towards the end of September which saw performance fall behind for the first time compared to the previous period last year.
This has been exacerbated with the launch of EPR through October. The knock on effect on ambulance turnaround due to congestion in the department has seen turnaround times deteriorate, although remaining better than any point in the previous year. Recovery with the launch of EPR is not expected until November.

	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)	<= 30	29	Sep-19			<= 31	36	Aug-19		<= 183	167		13 - 42	
8 - Same sex accommodation breaches	= 0	19	Sep-19			= 0	17	Aug-19		= 0	81		2 - 20	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	68.8%	Sep-19			>= 75%	63.9%	Aug-19		>= 75%	70.5%		56.8 - 90.6%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	84.8%	Sep-19			>= 92%	84.4%	Aug-19		>= 92%	85.4%		84.4 - 89.4%	
42 - RTT 52 week waits (incomplete pathways)	= 0	6	Sep-19			= 0	6	Aug-19		= 0	34		1 - 9	
314 - RTT 18 week waiting list	<= 22,812	26,705	Sep-19			<= 22,812	25,184	Aug-19		<= 22,812	26,705		22,554 - 26,705	
53 - A&E 4 hour target	>= 95%	84.5%	Sep-19			>= 95%	85.2%	Aug-19		>= 95%	85.3%		78.9 - 91.3%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	6.1%	Sep-19			= 0.0%	3.1%	Aug-19		= 0.0%	4.0%		3.1 - 9.7%	
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	2.70%	Sep-19			= 0.00%	0.81%	Aug-19		= 0.00%	1.44%		0.35 - 3.50%	
72 - Diagnostic Waits >6 weeks %	<= 1%	0.7%	Sep-19			<= 1%	0.9%	Aug-19		<= 1%	1.0%		0.4 - 3.2%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	77.0%	Sep-19			= 100%	83.3%	Aug-19		= 100%	70.9%		0.0 - 100.0%	

Bolton NHS Foundation Trust

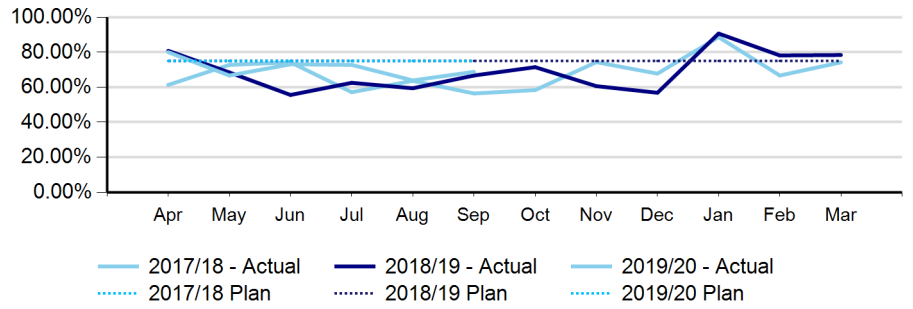
Exceptions

8 - Same sex accommodation breaches



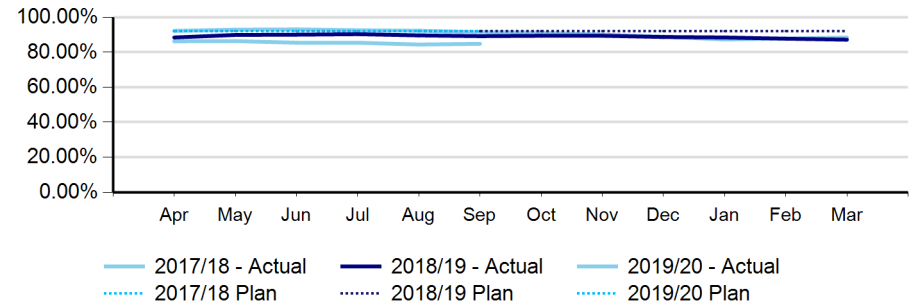
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	21	10	11	10	6	18	4	6	12	16	11	11
18/19	12	12	11	13	14	2	4	9	18	9	13	20
19/20	13	11	11	10	17	19						

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



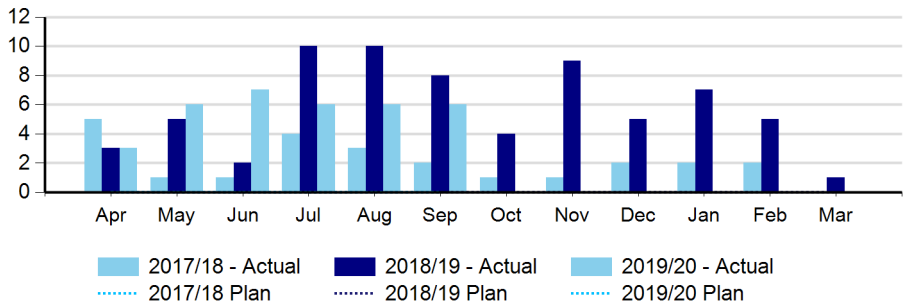
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	61.3%	72.7%	74.2%	57.1%	63.6%	56.4%	58.3%	74.3%	67.7%	88.6%	66.7%	74.2%
18/19	80.8%	68.4%	55.6%	62.5%	59.4%	66.7%	71.4%	60.6%	56.8%	90.6%	78.1%	78.4%
19/20	80.0%	66.7%	73.1%	72.7%	63.9%	68.8%						

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%	85.4%	85.4%	84.4%	84.8%						

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	7	6	6	6						

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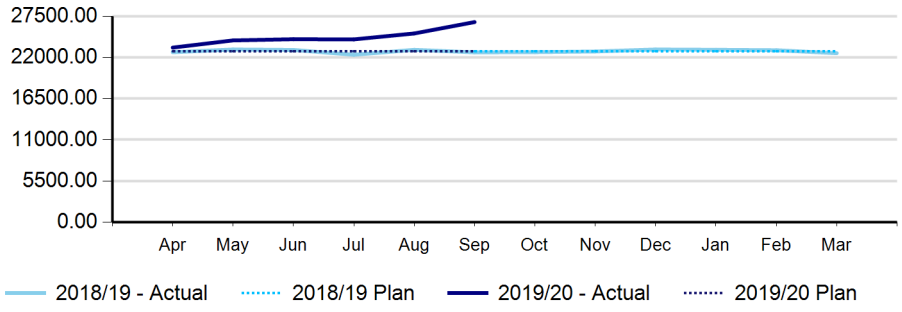
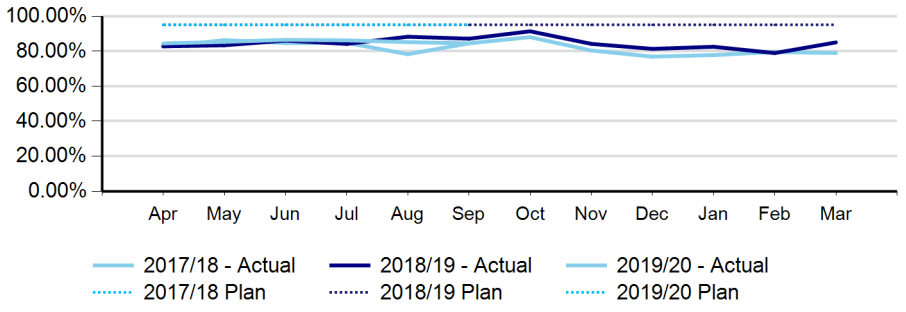
314 - RTT 18 week waiting list



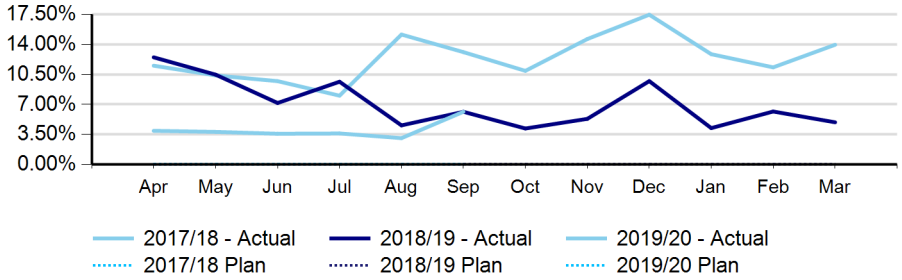
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	22,675	23,052	22,985	22,344	23,003	22,663	22,691	22,783	23,050	23,004	22,949	22,554
19/20	23,298	24,259	24,416	24,394	25,184	26,705						

53 - A&E 4 hour target



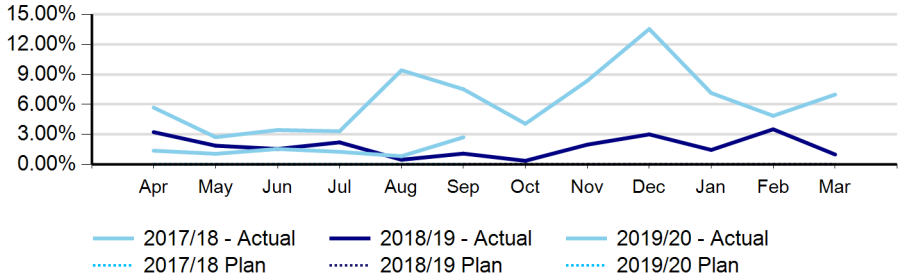
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	82.5%	86.3%	84.6%	84.7%	78.3%	84.5%	88.0%	80.4%	76.9%	77.8%	79.5%	78.9%
18/19	82.7%	83.4%	86.0%	84.1%	88.2%	87.1%	91.3%	84.2%	81.3%	82.5%	78.9%	85.0%
19/20	84.4%	85.3%	86.5%	86.2%	85.2%	84.5%						

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	11.5%	10.4%	9.7%	8.0%	15.1%	13.1%	10.9%	14.6%	17.5%	12.9%	11.3%	14.0%
18/19	12.5%	10.5%	7.2%	9.6%	4.5%	6.1%	4.2%	5.3%	9.7%	4.2%	6.2%	4.9%
19/20	3.9%	3.8%	3.6%	3.6%	3.1%	6.1%						

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%	1.53%	1.25%	0.81%	2.70%						

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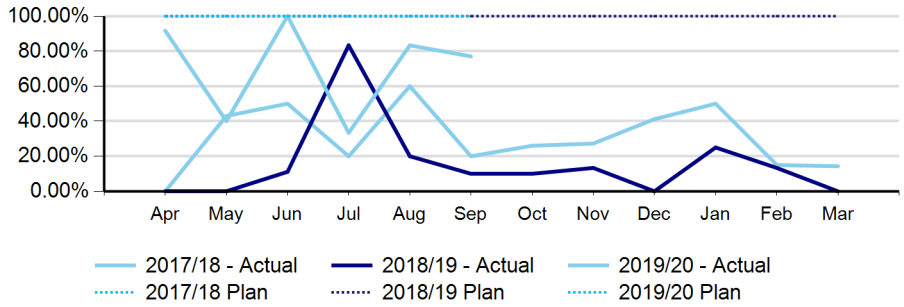
27 - TIA (Transient Ischaemic attack) patients seen <24hrs



	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%	100.0%	33.3%	83.3%	77.0%						

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Productivity

Stranded
Towards the end of September the number of patients over 21 and 7 days did rise above thresholds which in part explains the challenging 4 hour standard and increased in procedures cancelled on the day. Focussed actions say that improve towards the end of September and into October.

	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	234	Sep-19			<= 200	230	Aug-19		<= 200	234		199 - 269	
307 - Stranded Patients - LOS 21 days and over	<= 69	77	Sep-19			<= 69	91	Aug-19		<= 69	77		68 - 100	
57 - Discharges by Midday	>= 30%	27.9%	Sep-19			>= 30%	28.2%	Aug-19		>= 30%	28.9%		26.2 - 33.1%	
58 - Discharges by 4pm	>= 70%	69.7%	Sep-19			>= 70%	68.7%	Aug-19		>= 70%	67.9%		63.4 - 70.0%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	11.3%	Aug-19			<= 13.5%	12.0%	Jul-19		<= 13.5%	11.4%		10.8 - 12.0%	
60 - Daycase Rates	>= 80%	90.0%	Sep-19			>= 80%	90.6%	Aug-19		>= 80%	89.5%		87.1 - 90.6%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	3.3%	Sep-19			<= 1%	2.1%	Aug-19		<= 1%	2.0%		1.4 - 3.3%	
62 - Cancelled operations re-booked within 28 days	= 100%	94.9%	Sep-19			= 100%	93.2%	Aug-19		= 100%	89.5%		70.8 - 97.1%	
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	2.3%	Aug-19			<= 3.3%	2.8%	Jul-19		<= 3.3%	2.5%		1.1 - 2.8%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.46	Sep-19			<= 2.00	2.39	Aug-19		<= 2.00	2.47		2.06 - 2.90	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.80	Sep-19			<= 3.70	4.97	Aug-19		<= 3.70	4.74		4.09 - 4.97	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	90.9%	Aug-19			>= 80%	95.2%	Jul-19		>= 80%	92.0%		78.6 - 95.2%	

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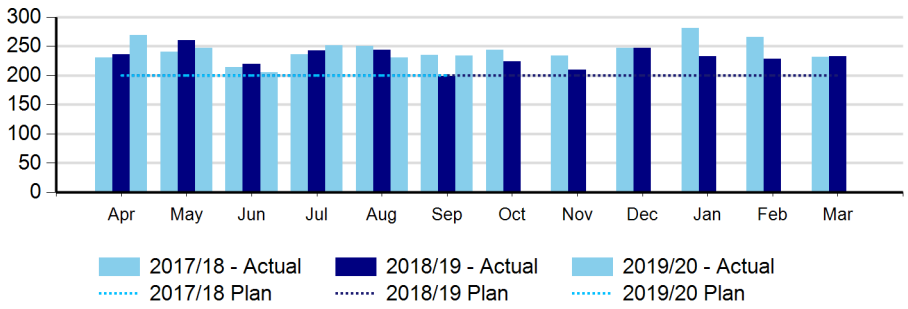
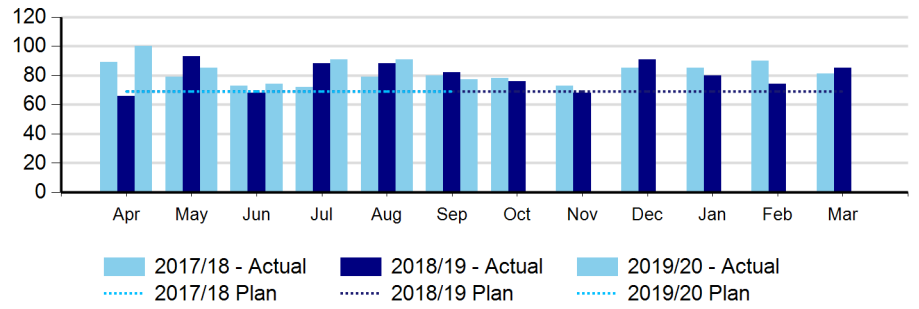
Exceptions

56 - Stranded patients



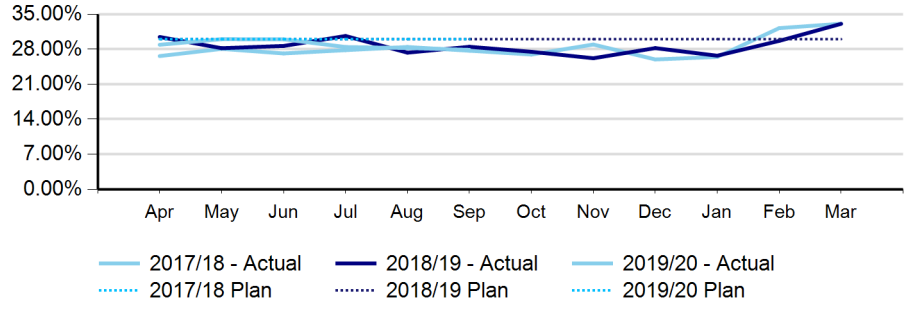
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	230	240	214	236	250	235	244	234	247	281	265	232
18/19	236	260	219	242	243	199	224	210	247	233	228	233
19/20	269	247	205	251	230	234						

307 - Stranded Patients - LOS 21 days and over



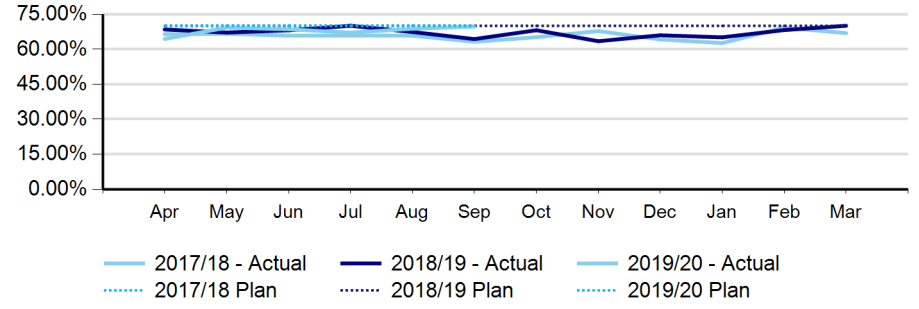
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	89	79	73	72	79	80	78	73	85	85	90	81
18/19	66	93	68	88	88	82	76	68	91	80	74	85
19/20	100	85	74	91	91	77						

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%	30.0%	28.4%	28.2%	27.9%						

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%	68.5%	67.1%	68.7%	69.7%						

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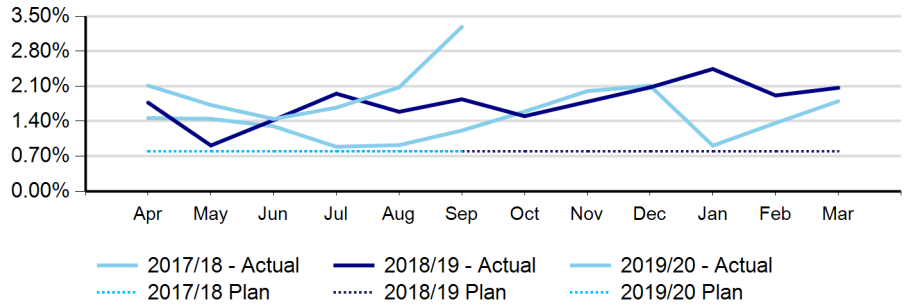
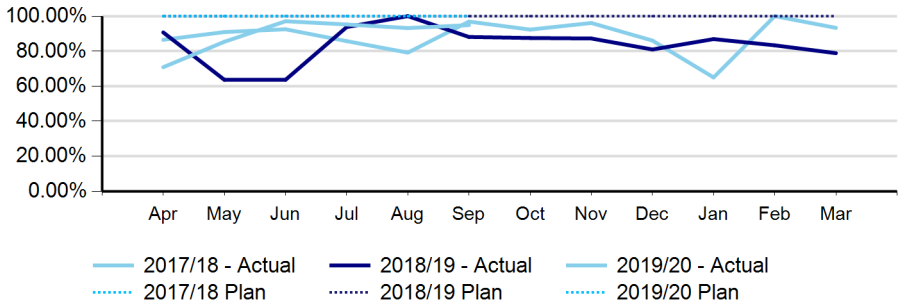
61 - Operations cancelled on the day for non-clinical reasons



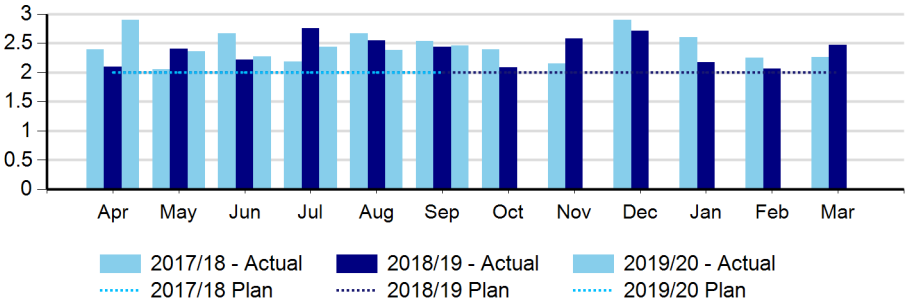
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1.5%	1.4%	1.3%	0.9%	0.9%	1.2%	1.6%	2.0%	2.1%	0.9%	1.4%	1.8%
18/19	1.8%	0.9%	1.4%	2.0%	1.6%	1.8%	1.5%	1.8%	2.1%	2.4%	1.9%	2.1%
19/20	2.1%	1.7%	1.4%	1.7%	2.1%	3.3%						

62 - Cancelled operations re-booked within 28 days



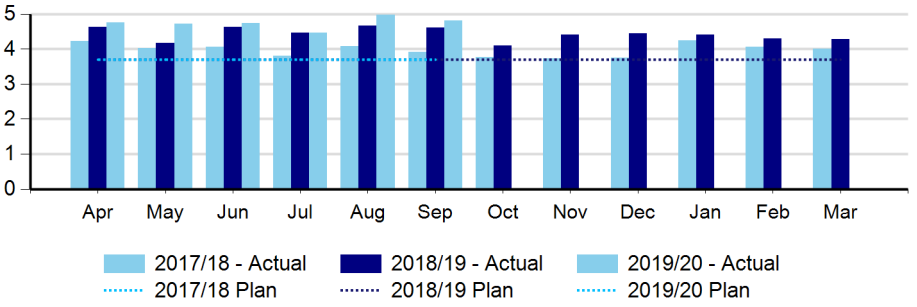
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86.5%	90.9%	92.5%	85.7%	79.2%	96.9%	92.3%	96.1%	86.0%	65.0%	100.0%	93.3%
18/19	90.7%	63.6%	63.6%	93.8%	100.0%	88.1%	87.5%	87.2%	81.0%	86.9%	83.3%	78.8%
19/20	70.8%	85.4%	97.1%	95.2%	93.2%	94.9%						

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	2.27	2.44	2.39	2.46						

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	4.75	4.71	4.74	4.47	4.97	4.80						

Bolton NHS Foundation Trust

Cancer

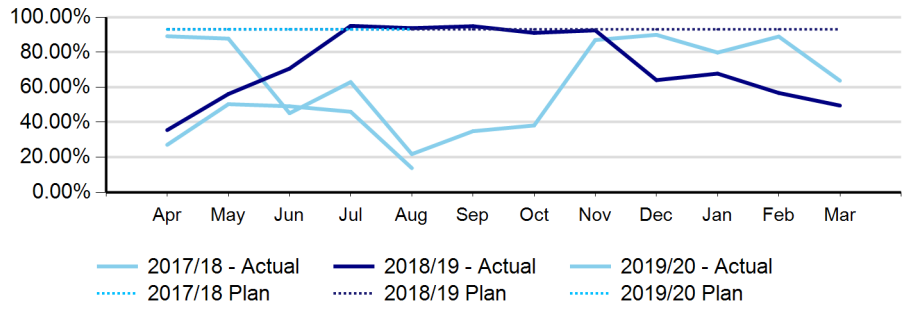
2 week wait
Performance on the 2 week wait for all Breast patients is under considerable pressure due to higher than expected referrals and capacity gaps. A business case has been agreed for further staff and is going through recruitment, extra clinics have been agreed in the short term and monitoring and management of risk continues so that although missing the standard no patients have missed any required treatments.

	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%	90.4%	Aug-19			>= 85%	92.6%	Jul-19		>= 85%	87.6%		80.0 - 92.6%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	96.2%	Aug-19			>= 90%	86.7%	Jul-19		>= 90%	87.1%		75.6 - 100.0%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	97.8%	Aug-19			>= 96%	98.4%	Jul-19		>= 96%	98.6%		97.8 - 100.0%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Aug-19			>= 94%	100.0%	Jul-19		>= 94%	100.0%		87.5 - 100.0%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Aug-19			>= 98%	100.0%	Jul-19		>= 98%	100.0%		100.0 - 100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	96.7%	Aug-19			>= 93%	96.2%	Jul-19		>= 93%	97.0%		93.8 - 98.7%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	13.8%	Aug-19			>= 93%	46.0%	Jul-19		>= 93%	38.3%		13.8 - 94.8%	

Bolton NHS Foundation Trust

Exceptions

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%	50.3%	49.1%	46.0%	13.8%							

Bolton NHS Foundation Trust

Community

The combined deflections from ED by the Home First team and the Admission Avoidance team remains well above the plan. Seasonal resilience schemes will commence in October with the ambition of reaching the stretch target of 600 people deflected from ED per month over winter.

The total length of time people spend in Intermediate Tier services remains within plan and has reduced in September.

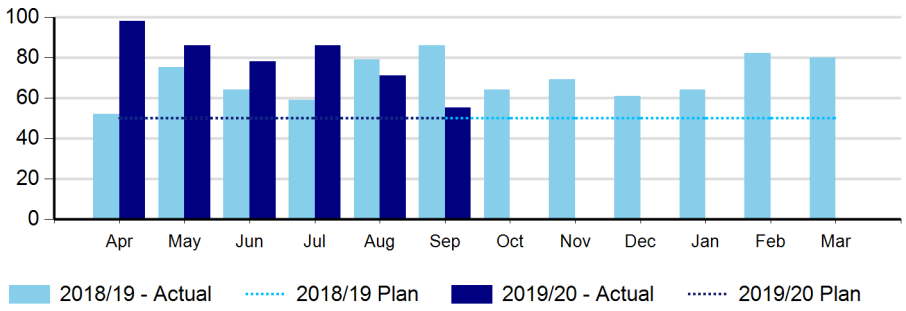
The number of people remaining in hospital once medically optimised has reduced this month and there is now an overall reducing trend since April 2019. The days occupied by people who are medically optimised has reduced this month but remains well above plan. Work to improve the length of stay of people who are medically optimised is underway within the Long Length of Stay reduction workstream.

	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	542	Sep-19			>= 400	558	Aug-19		>= 2,400	3,200		343 - 558	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.14	Sep-19			<= 6.00	5.30	Aug-19		<= 6.00	5.14		3.86 - 5.94	
230 - Medically Optimised Numbers	<= 50	55	Sep-19			<= 50	71	Aug-19		<= 300	474		55 - 98	
231 - Medically Optimised Days	<= 209	554	Sep-19			<= 209	696	Aug-19		<= 1,254	3,616		388 - 790	

Bolton NHS Foundation Trust

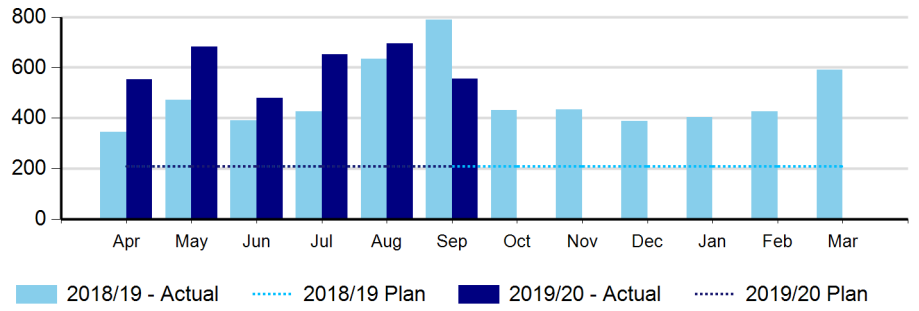
Exceptions

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	78	86	71	55						

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	479	651	696	554						

NHS Bolton NHS Foundation Trust

Workforce

Sickness, Vacancy and Turnover

Whilst the sickness rate has reduced from last month it remains higher than target. Long term sickness continues to be the driver for this high sickness rates, with short term absence pressures remaining at the expected tolerance levels. The Workforce Assurance Committee recently received an update on the clear correlation between higher sickness absence rates and Bolton population demographics – whilst the data proved helpful it was agreed that a further update would be provided on potential enabling actions that could be taken as a result of these findings. The Committee also reviewed the Trust's GM Benchmark position and an improvement in this area was noted. As previously communicated the Committee recently received the Health & Wellbeing Strategy, which sets out the enabling actions that will be taken moving forward.

Performance on the recruitment and retention metrics remains strong. Via the Workforce Dashboard the Workforce Assurance Committee are sighted on the areas within the organisation that remain 'hard to fill', along with the clear set of actions that are in place. Strong partnership working between the Divisional and Workforce Teams is evident which is supporting this positive position.

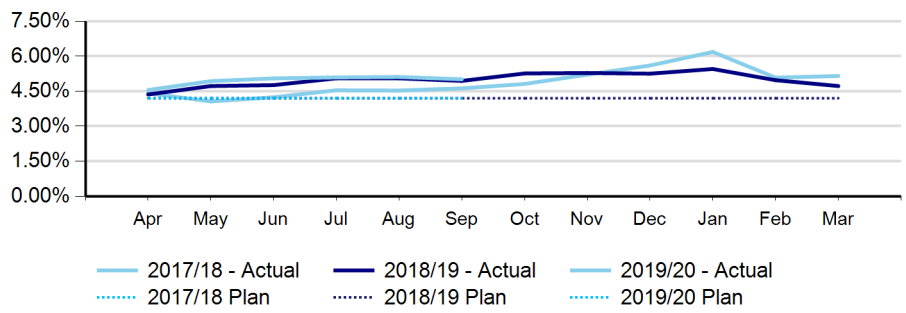
As noted in the previous Board Dashboard colleagues will see that the Dashboard includes the number of investigations over 8 weeks. A KPI will be set during the planned changes to the wider Board Dashboard.

	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%	5.01%	Sep-19			<= 4.20%	5.11%	Aug-19		<= 4.20%	4.96%		4.55 - 5.45%	
120 - Vacancy level - Trust	<= 6%	1.92%	Sep-19			<= 6%	4.17%	Aug-19		<= 6%	4.68%		1.92 - 6.78%	
121 - Turnover	<= 9.90%	9.77%	Sep-19			<= 9.90%	9.88%	Aug-19		<= 9.90%	9.90%		9.16 - 10.65%	
366 - Ongoing formal investigation cases over 8 weeks		7	Sep-19				2	Aug-19			14		2 - 7	

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%	5.05%	5.09%	5.11%	5.01%						

Bolton NHS Foundation Trust

Organisational Development

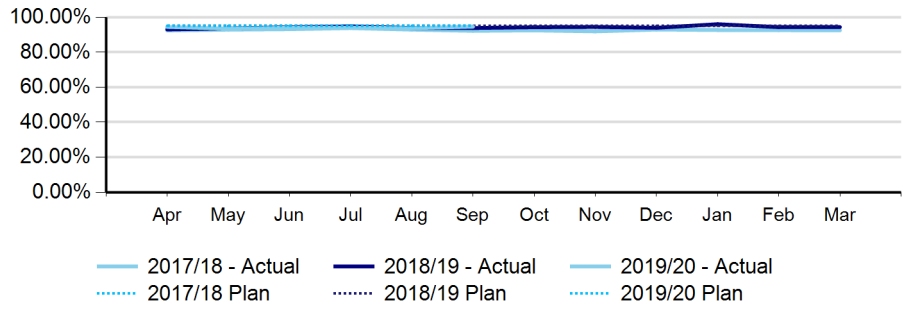
The OD indicators remain strong. The NHS Staff Survey is currently out (closing end of November) and pleasingly the response rate is slightly above the national average. It is too early to understand whether the EPR 'Go live' will have an impact on the Staff Survey findings. The Trust will receive the Quarter 3 Go-Engage feedback (running concurrently with NHS Staff Survey) shortly, which should then provide a helpful indication of NHS Staff Survey results.

	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%	94.5%	Sep-19		↑	>= 95%	93.7%	Aug-19		>= 95%	94.0%		93.4 - 96.0%	
38 - Staff completing Mandatory Training	>= 85%	91.5%	Sep-19		↓	>= 85%	91.7%	Aug-19		>= 85%	91.8%		85.9 - 93.1%	
39 - Staff completing Safeguarding Training	>= 95%	95.66%	Sep-19		↓	>= 95%	95.75%	Aug-19		>= 95%	95.84%		94.80 - 96.19%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	85.8%	Sep-19		↑	>= 85%	84.5%	Aug-19		>= 85%	84.7%		84.2 - 89.4%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	83.0%	Q1 2019/20		↑	>= 66%	68.0%	Q4 2018/19		>= 66%			68.0 - 83.0%	
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	75.0%	Q1 2019/20		↓	>= 80%	82.0%	Q4 2018/19		>= 80%			75.0 - 82.0%	

Bolton
NHS Foundation Trust

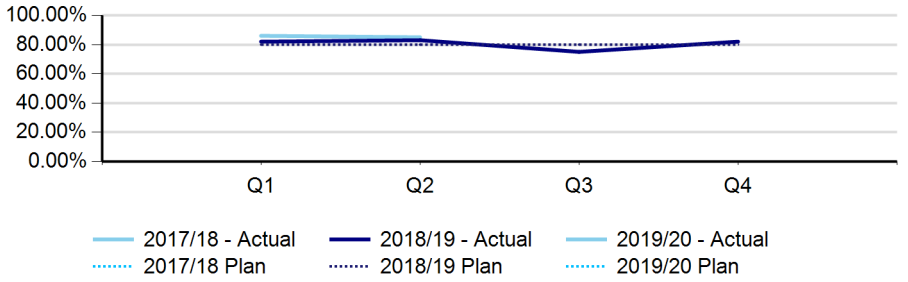
Exceptions

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%	94.0%	94.0%	93.7%	94.5%						

79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)



	Q1	Q2	Q3	Q4
17/18	86.0%	85.0%		83.0%
18/19	82.0%	83.0%	75.0%	82.0%
19/20	75.0%			

Bolton NHS Foundation Trust

Agency

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 continues to benchmark very favourable on Agency spend when compared to peer organisations for % agency spend versus overall pay, that said the Workforce Assurance Committee remains sighted on the multiple actions that are being taken to drive down agency spend to the lowest possible level.

	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)	<= 0.82	0.52	Sep-19			<= 0.66	0.52	Aug-19		<= 4.26	3.56		0.52 - 0.74	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.27	0.17	Sep-19			<= 0.26	0.17	Aug-19		<= 1.80	1.31		0.17 - 0.33	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.36	0.24	Sep-19			<= 0.32	0.25	Aug-19		<= 1.98	1.62		0.19 - 0.31	

NHS Bolton NHS Foundation Trust

Finance

Finance

The September YTD performance against the control total is a deficit of £8.4m, £4.7m 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 £2.9m has been earned year to date compared to a plan of £2.4m. Within the PSF element £1.5m is secured but the remainder is subject to achievement of the finance plan in Quarter 2 or the ICS (GM) achieving its control total. As such this has been accrued on the basis of the system delivering overall.

Overall, the Trust has made a deficit after PSF/MRET and Impairments of £5.5m year to date compared to a plan deficit of £1.4m.

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 YTD performance. The financial recovery plan has been submitted to NHSI/E and the Trust continues to work to achieve the best case forecast as set out in the FRP. The risk range for the forecast is from £3.2m surplus (plan) to a £20.9m deficit; with the most probable being £13.2m deficit. Recovery plan actions have been developed, but it will require external system help to achieve the plan.

The Trust capital plan for the year is £15.0m. The spend YTD was £4.5m which is £0.7m more than plan.

In September there was a net cash inflow of £1.2m with a closing cash balance of £24.8m, which is £11.2m above plan.

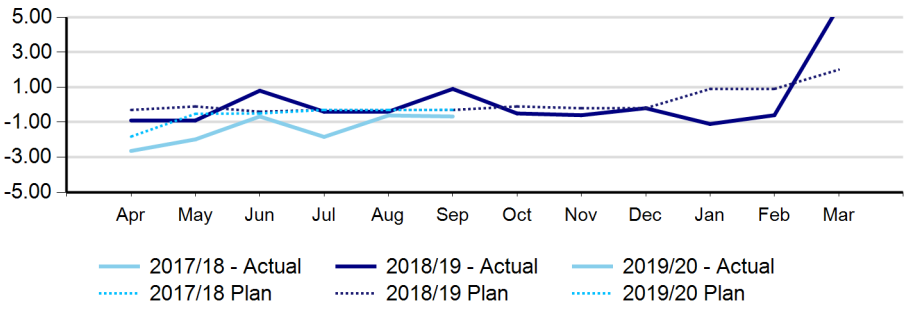
The Trust overall risk rating for Use of Resources was a 3 in September compared to a plan of 2.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
220 - Control Total (£ millions)	>= -0.3	-0.7	Sep-19			>= -0.3	-0.6	Aug-19		>= -3.7	-8.4		-2.6 - 5.6	
221 - Provider Sustainability Fund (£ millions)	>= -0.01	0.02	Sep-19			>= -0.01	-0.01	Aug-19		>= -0.04	-0.04		-0.01 - 1.30	
222 - Capital (£ millions)	>= 1.4	2.2	Sep-19			>= 0.7	0.7	Aug-19		>= 4.3	4.5		0.2 - 4.2	
223 - Cash (£ millions)	>= 13.6	24.8	Sep-19			>= 13.9	23.6	Aug-19		>= 13.6	24.8		6.0 - 27.5	
224 - Use of Resources	>= 2	3	Sep-19			>= 2	3	Aug-19		>= 2	3		2 - 3	

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	-0.7	-1.8	-0.6	-0.7						

NHS Improvement

Model Hospital

Bolton NHS Foundation Trust

Finance & Use of Resources

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

Report Date: 23 October 2019

Generated by: Emma Cunliffe

The Model Hospital website: https://model.nhs.uk

Single Oversight Framework

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

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

Peer group: 'My Region'

The Finance Score	Data period	Trust value	Performance band description
Single Oversight Framework segment	Sep 2019	2 - Targeted support offer	
The finance score	Aug 2019	3	

Financial Sustainability	Data period	Trust value	Performance band description
Capital service capacity - value	Aug 2019	-0.59	In quartile 1 - Lowest 25% (blue)
• Capital service capacity - SOF Score	Aug 2019	4	
Liquidity (days) - value	Aug 2019	10.80	In quartile 4 - Highest 25% (blue)
• Liquidity (days) - SOF Score	Aug 2019	1	

Financial Efficiency	Data period	Trust value	Performance band description
Income and expenditure (I&E) margin - value	Aug 2019	-4.07%	In quartile 2 - Mid-Low 25% (blue)
• Income and expenditure (I&E) margin - SOF score	Aug 2019	4	

Financial Controls	Data period	Trust value	Performance band description
Distance from financial plan - value	Aug 2019	-3.03%	In quartile 1 - Lowest 25% (blue)
• Distance from financial plan - SOF score	Aug 2019	4	
Distance from agency spend cap - value	Aug 2019	29.00%	In quartile 3 - Mid-High 25% (blue)
• Distance from agency spend cap - score	Aug 2019	3	

Use of Resources Framework

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

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

Peer group: 'My Region'

Clinical Services	Data period	Trust value	Performance band description	Peer median	National median
Pre-procedure elective bed days	Q2 2019/20	0.16	In quartile 3 - Mid-High 25% (amber / red)	0.14	0.12
Pre-procedure non-elective bed days	Q2 2019/20	1.21	In quartile 4 - Highest 25% (red)	0.77	0.62
Did not attend (DNA) rate	Q2 2019/20	9.11%	In quartile 4 - Highest 25% (red)	7.95%	7.14%
Emergency Readmission 30 days	Q2 2019/20	5.16%	In quartile 2 - Mid-Low 25% (amber / green)	5.35%	5.36%

Clinical Support Services	Data period	Trust value	Performance band description	Peer median	Benchmark value
Top 10 Medicines - % Delivery of Savings Target Achieved to Current Month	To Nov 2017	73%	Below the benchmark (red)	N/A	100%

Clinical Support Services	Data period	Trust value	Performance band description	Peer median	National median
Overall cost per test	2017/18	£1.70	In quartile 2 - Mid-Low 25% (amber / green)	£1.70	£1.86

People	Data period	Trust value	Performance band description	Peer median	National median
Staff retention rate	Dec 2018	86.9%	In quartile 3 - Mid-High 25% (amber / green)	86.8%	85.6%
Sickness absence rate	Jun 2019	5.13%	In quartile 4 - Highest 25% (red)	4.65%	3.96%
Total pay cost per WAU	2017/18	£2,434	In quartile 4 - Highest 25% (red)	£2,351	£2,180
Substantive Medical staff cost per WAU	2017/18	£412	In quartile 1 - Lowest 25% (green)	£459	£533
Substantive Nursing staff cost per WAU	2017/18	£967	In quartile 4 - Highest 25% (red)	£826	£710
Substantive AHP staff cost per WAU	2017/18	£184	In quartile 4 - Highest 25% (red)	£148	£130

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

Corporate services, procurement, and estates and facilities	Data period	Trust value	Performance band description	Peer median	National median
Estates & Facilities Cost (£ per m2)	2017/18	£292	In quartile 1 - Lowest 25% (green)	£293	£342
Procurement League Table: Process Efficiency and Price Performance Score (scaled 0 to 100)	Q4 2018/19	62	In quartile 2 - Mid-Low 25% (amber / red)	75	69

Finance	Data period	Trust value	Performance band description
Capital service capacity - value	Aug 2019	-0.59	In quartile 1 - Lowest 25% (blue)
Liquidity (days) - value	Aug 2019	10.80	In quartile 4 - Highest 25% (blue)
Distance from agency spend cap - value	Aug 2019	29.00%	In quartile 3 - Mid-High 25% (blue)
Income and expenditure (I&E) margin - value	Aug 2019	-4.07%	In quartile 2 - Mid-Low 25% (blue)
Distance from financial plan - value	Aug 2019	-3.03%	In quartile 1 - Lowest 25% (blue)

Procurement (Supplies & Services)	Data period	Trust value	Performance band description	Peer median	National median
YTD Expenditure - Actual - Procurement	Jun 2019	£7.72m	In quartile 3 - Mid-High 25% (blue)	N/A	N/A
• YTD Expenditure - VarianceToPlan - Procurement	Jun 2019	5%	In quartile 3 - Mid-High 25% (blue)	N/A	0%
Monthly Expenditure - Actual - Procurement	Jun 2019	£2.75m	In quartile 3 - Mid-High 25% (blue)	N/A	N/A
• Monthly Expenditure - VarianceToPlan- Procurement	Jun 2019	16%	In quartile 4 - Highest 25% (blue)	N/A	-1%

Drugs (Medicines)	Data period	Trust value	Performance band description	Peer median	National median
YTD Expenditure - Actual - Drugs	Jun 2019	£5.82m	In quartile 3 - Mid-High 25% (blue)	N/A	N/A
• YTD Expenditure - Variance to Plan - Drugs	Jun 2019	2%	In quartile 3 - Mid-High 25% (blue)	N/A	-1%
Monthly Expenditure - Actual - Drugs	Jun 2019	£2.08m	In quartile 3 - Mid-High 25% (blue)	N/A	N/A
• Monthly Expenditure - Variance to Plan- Drugs	Jun 2019	10%	In quartile 4 - Highest 25% (blue)	N/A	-4%

About the peer group referenced in this report

Peer group

Your trust is benchmarked against the peer group My Region

Trusts in your NHS England and NHS Improvement region

Peer group members

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

Colour meanings

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

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

Board Assurance Heat Map - Hospital

	INDICATOR	Target	ICS				Acute Division																			Elective Division																			Families Division											
			Darley Court	A4	AED-Adults	AED-Paeds	B1 (Frailty Unit)	B2	B3	B4	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DischargeLounge	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
Beds	Total Beds		30	22			23	0	21	0	25	26	25	26	10	14	26	22	27	27	12	24	10	8	25	25	25	24	24	24	16	25	9	11	4	10	7	17	6	26	15	5	4	44	38	762
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	G>=100%, A>80% <99.9%, R =	95.0%	100.0%	100.0%	Non Return	80.0%		90.0%		100.0%	100.0%	95.0%	Non Return	100.0%	100.0%	80.0%	95.0%	95.0%	100.0%	100.0%	95.0%	100.0%	95.0%	90.0%	90.0%	100.0%	100.0%	95.0%	95.0%	95.0%	85.0%	95.0%	100.0%	100.0%	100.0%		100.0%		100.0%						100.0%	38	97.3%
	IPC Rapid Improvement Tool %	R=<80%,A>80% <94.9%=A >95	96.0%	96.0%	91.0%	100.0%	Non Return		96.0%		87.0%	100.0%	96.0%	83.0%	100.0%	100.0%	62.0%	92.0%	100.0%	74.0%	91.0%	92.0%	100.0%	100.0%	96.0%	92.0%	78.0%	100.0%	91.0%	88.0%	96.0%	95.0%	100.0%	92.0%	96.0%		95.0%		96.0%						100.0%	95.0%	94.4%
	Mattress Audit Compliance %	Yes=G, No Return=White	100.0%	Non Return			96%		97%		100%	100%	100%	98%	Non Return	100%	85%	100%	Non Return	100%	100%	100%	100%	100%	100%	100%	Non Return	100%	100%	100%			100%				100%		100%		100%						100%	100%	99.1%
	C - Diff	0	0	0	0	0	0		0		1	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	3
	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	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	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	0
Harm Free Care	Safety Express Programme Harm Free Care (%)	95%	93.1%	100.0%			91.3%		100.0%		91.3%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	96.3%	96.3%	Non Return	95.0%	88.9%	100.0%	95.8%	95.7%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%		Non Return		100.0%	100.0%	100.0%		97.2%	100.0%	97.9%
	All Inpatient Falls (Safeguard)	0	5	3	2	0	7		5		2	3	3	3	0	2	3	8	2	1		2	1	1	0	1	1	1	7	3	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	67
	Harms related to falls (moderate and above)	1.6	0	0	0	0	0		0		0	0	0	0	0	0	1	0	0	0		0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	VTE Assessment Compliance	95%		100.0%			50.0%		Non Return		100.0%	85.7%	94.9%	100.0%	98.3%	94.9%	95.4%	95.7%	100.0%	95.7%		100.0%	100.0%	100.0%	96.9%	96.3%	90.0%	86.5%	94.3%	95.38%	100.0%	98.5%	99.8%	100.0%	100.0%			58.5%	82.4%	99.6%	100.0%	88.9%	93.3%	100.0%		95.5%
	Monthly New pressure Ulcers (Grade 2)	0	0	0	0	0	0		0		0	0	2	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	3
	Monthly New pressure Ulcers (Grade 3)	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0
	Monthly New pressure Ulcers (Grade 4)	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0
	PU due to lapses in care	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	0	0	1
Audit	Monthly KPI Audit %	R=<80%,A>80%<94.9%,G>=95%	97.7%	93.8%	93.1%	87.4%	83.9%		90.3%		94.5%	93.4%	95.7%	80.3%	97.6%	89.3%	91.3%	97.1%	93.8%	90.1%		98.0%	97.3%	100.0%	95.5%	97.1%	91.7%	85.0%	95.2%	95.1%	98.6%	98.9%	100.0%	100.0%	99.1%		98.2%		95.7%		99.1%	100.0%	100.0%		98.3%	99.7%	
	BoSCA Overall Score %	R=<73.9%,B>=73.9%<74.9%,S=>75%<89.9%,G>=90%	92.3%	76.3%	71.7%		59.5%		71.9%		82.1%	80.1%	76.0%	79.3%	91.7%	91.3%	75.3%	81.9%	92.9%	90.0%		90.2%	90.7%	93.9%	72.4%	90.4%	90.4%	81.6%	90.4%	92.5%	93.7%		81.4%		75.6%		90.1%		75.5%		91.9%	90.3%	90.4%		71.4%	90.3%	
	BoSCA Rating	white, bronze, silver, gold, platinum	platinum	silver	bronze		bronze		bronze		silver	silver	silver	silver	gold	gold	silver	silver	platinum	gold		gold	platinum	platinum	bronze	platinum	gold	silver	platinum	gold	platinum		silver		silver		platinum		silver		platinum	gold	gold		bronze	gold	
Patient Experience	Friends and Family Response Rate	**30%**	100.0%	60.9%	17.5%	25.3%	57.1%		47.6%		29.1%	26.9%	28.1%	0.0%	55.2%	43.7%	15.0%	30.5%	12.9%	41.3%		57.5%	100.0%	27.8%	60.5%	33.9%	33.2%	32.8%	0.0%	60.7%	58.0%	28.3%	27.1%	26.9%	28.0%	40.4%	0.0%	16.3%		20.8%	16.7%	37.3%		28.1%	65.6%	29.9%
	Friends and Family Recommended Rate	**97%**	100.0%	100.0%	89.2%	93.1%	95.8%		100.0%		100.0%	94.4%	100.0%	N/A	100.0%	95.2%	92.6%	91.7%	90.9%	86.0%		95.7%	100.0%	100.0%	93.5%	97.6%	97.3%	94.9%	N/A	100.0%	100.0%	91.5%	95.2%	89.4%	71.4%	98.2%	N/A	97.2%		99.1%	88.0%	100.0%		89.6%	100.0%	95.3%
	Number of complaints received	**0**	0	0	2	0	1		1		0	0	2	0	0	0	1	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	1		1		1	1	0	0	0	1	15
Governance	SIs in Month	**0**	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
	Incidents over 20 days, not yet signed off	**0**	2	0	61	1	6		1		7	4	3	6	0	0	1	0	1	8	1	2	0	0	2	0	4	0	4	1	0	0	1	0	0	6	2	32	14	0	2	1	15	61	2		
	Harms related to Incidents (Moderate and above)	**0**	0	0	0	0	1		0		1	0	1	0	0	0	0	1	0	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	9
Staff Development	Appraisals	85%	98.3%	85.7%	90.7%		75.7%		93.2%		90.9%	95.2%	90.7%	86.5%	92.9%	94.4%	87.2%	73.8%	89.2%	87.2%	88.9%	82.9%	95.4%	88.3%	87.1%	86.1%	84.6%	73.3%	93.5%	87.8%	88.9%	93.9%	98.6%	82.4%	100.0%	98.8%		81.5%		72.8%						81.0%	85.8%
	Statutory Training	95%	99.40%	92.40%	96.20%		90.20%		87.61%		91.45%	92.97%	89.64%	91.08%	100.00%	99.07%	87.13%	90.68%	89.34%	91.61%	100.00%	89.31%	96.88%	98.09%	91.36%	90.95%	99.63%	86.81%	95.11%	91.99%	98.47%	96.44%	94.86%	94.48%	97.62%	98.7%		93.91%		91.8%						97.61%	94.5%
	Mandatory Training	85%	99.5%	87.2%	94.87%		85.6%		88.2%		89.2%	92.0%	84.2%	89.3%	91.0%	98.7%	79.8%	85.8%	91.5%	88.0%	100.0%	87.2%	95.7%	97.4%	86.0%	85.5%	99.3%	86.5%	89.8%	89.8%	93.6%	99.3%	93.5%	90.9%	97.1%	98.3%		80.5%		86.3%						93.3%	91.5%
Staffing & Workforce	% Qualified Staff (Day)			99.7%			82.0%		77.0%		82.2%	61.3%	77.9%	91.1%	102.9%				88.7%	95.0%		83.1%	80.8%	80.6%	95.6%	99.5%		96.1%	84.4%	77.0%	90.9%					60.4%		80.6%		93.7%	79.7%	75.1%		66.4%	95.9%	
	% Qualified Staff (Night)			101.7%			100.0%		98.3%		98.3%	98.6%	94.2%	98.6%	100.0%				102.2%	101.1%		98.9%	87.3%	75.2%	100.2%	100.0%		121.0%	100.0%	100.0%	105.0%					67.4%		97.5%		83.6%	74.6%	54.7%		61.5%		
	% un-Qualified Staff (Day)			102.9%			77.7%		94.5%		82.3%	101.1%	77.9%	75.0%	113.6%				75.4%	100.7%		97.7%		127.2%	77.2%	86.6%		104.2%	118.4%	117.7%	105.2%					103.0%		113.1%		86.5%	84.4%	93.3%		80.8%	94.5%	
	% un-Qualified Staff (Night)			102.8%			109.2%		110.8%		105.8%	99.1%	79.9%	76.5%	100.0%				80.6%	107.8%		97.3%			75.4%	81.1%		110.2%	99.2%	100.0%	92.9%					0.0%		110.6%		95.2%	87.2%	96.7%		96.8%		
	Budgeted Nurse: Bed Ratio (WTE)		1.56	1.08			-3.35		-2.67		0.36	-0.64	4.61	-3.62	1.18	-0.39	0.17	-8.03	3.88	-1.74		-1.09	1.66	-1.27	1.05	-4.06	-10.07	-0.99	-3.18	-0.01	-0.77	-2.26	8.81	4.32	0.54	-5.37		3.75							7.08	-9.46
	Current Budgeted WTE (From Ledger)		43.38	32.83	146.55		38.03		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	1407.37
	Actual WTE In-Post (From Ledger)		41.82	31.75	142.81		36.98		43.01		33.35	40.87	38.08	39.31	24.75	20.36	47.65	42.33	34.13	39.71		36.24	36.92	54.68	30.47	31.27	39.02	29.20	43.45	43.50	14.92	29.59	51.58	44.00	15.34	72.02		21.97							99.51	1350.59
	Actual Worked (From Ledger)		41.41	33.06	147.13		42.66		47.33		33.52	45.77	43.80	46.10	24.45	21.56	50.00	43.49	40.27	43.59		43.52	34.95	52.31	32.96	35.58	43.86	35.96	48.60	45.01	17.20	30.16	52.51	44.83	16.38	70.91		23.48							98.44	1430.80
	Sickness (%) (September)	R = >4.75, A = 4.2 - 4.75, G = <4.2	8.37%	4.35%	5.88%		15.18%		12.89%		2.13%	5.14%	9.28%	4.47%	0.51%	3.19%	6.39%	1.99%	5.66%	16.22%	0.00%	13.82%	0.65%	4.36%	2.51%	3.15%	7.16%	12.01%	5.28%	3.17%	8.63%	8.37%	12.79%	5.81%	4.55%	5.63%		7.52%		8.99%					3.09%	5.01%
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)		0.41	-1.31	-9.32		-10.08		-7.32		-0.17	-5.90	-5.72	-11.79	-0.70	-1.20	-5.35	-7.16	-8.14	-5.88	0.00	-8.28	1.97	0.76	-6.49	-7.31	-13.68	-8.76	-9.37	-2.51	-6.20	-2.49	-0.93	-3.42	-1.04	0.11		-1.51							1.07	-153.15
	Pending Appointment				5		4		3			1		5	1		3	6	2	2		1		1.6	4	3	8.84	2	4.22	1	3.92	1.92		2.59		1				5.44							72.94
	Substantive Staff Turnover Headcount (rolling average 12 months)	10%	21.5%	10.6%	4.5%		12.7%		17.3%		21.4%	8.9%	14.4%	20.6%	0.0%	5.0%	7.5%	17.4%	19.8%	6.7%	0.0%	7.4%	0.0%	11.9%	3.0%	18.2%	7.1%	6.1%	9.5%	4.2%	0.0%	7.8%	9.1%	5.5%	0.0%	12.2%		21.4%		8.1%					8.7%	9.8%

Board Assurance Heat Map - District Nursing Domiciliary

	INDICATORS	Target	Avondale and Chorley old Road	Breightmet & Little Lever	Crompton merged with Egerton & Dunscar	Farnworth	Great Lever and Central	Horwich	Pikes Lane (Deane)	Pikes Lane (St Helen's Road)	Waters Meeting	Westhoughton	Evening Service	Treatment Rooms	Total
Harm Free Care	Safety Thermometer Programme Harm Free Care (%)		97.22%	96.61%	100.00%	100.00%	100.00%	100.00%		95.74%	98.04%	93.88%			98.14%
	Total Monthly New pressure Ulcers (Grade 2)(Lapse in Care + No Lapse in Care)		1	2	1	0	1	0	0	1	0	0			6
	Total Monthly New pressure Ulcers (Grade 3)(Lapse in Care + No Lapse in Care)		1	0	1	0	0	0	0	0	0	0			2
	Total Monthly New pressure Ulcers (Grade 4)(Lapse in Care + No Lapse in Care)		1	0	0	0	0	0	0	0	0	0			1
	Total Monthly New Pressure Ulcers - due to lapses in care		0	1	0	0	0	0	0	0	0	0			1
Audit	Monthly KPI Audit % (Revised Buddy Assessed Audit)		99.6%	96.0%	93.1%	84.2%	97.9%	98.3%		98.8%	98.4%	93.9%	96.2%		
	BoSCA Overall Score %		95.7%	94.2%	91.1%	87.1%	96.0%	91.4%	96.2%	94.7%	91.7%	93.4%	95.6%		
	BoSCA Rating		platinum	gold	gold	silver	platinum	platinum	gold	gold	platinum	gold	gold		
Patient Experience	Friends and Family Response Rate %		44.10%											62.50%	
	Friends and Family Recommended Rate %		96.90%											100.00%	
	Number of Complaints received		0	0	0	0	0	0	0	0	0	0	0	0	0
Governance	Total SI's		0	0	0	0	0	0	0	0	0	0	0	0	0
	Incidents over 20 days, not yet signed off		0	1	0	0	0	0	0	0	1	0	0	0	2
Staffing and Workforce	Current Budgeted WTE		11.64	13.72	16.00	18.24	7.11	13.15	17.13		17.26	11.09	19.96	25.39	214.37
	Actual WTE In-Post		10.24	14.00	14.10	15.60	6.11	11.89	16.33		12.41	8.80	17.27	23.17	364.30
	Actual WTE Worked		10.60	14.04	13.19	15.24	6.20	12.04	14.77		13.27	9.18	18.46	22.48	513.76
	Pending Appointment					3.6			1.8						5.40
	Current Budgeted Vacancies (WTE)				1.53			0.40			1.60	1.60			5.13
Staff Development	Sickness (%) August 2019		12.59%	0.58%	10.36%	5.75%	0.00%	1.90%	10.15%		0.14%	4.30%	5.53%	11.83%	6.10%
	Substantive Staff Turnover Headcount (rolling average 12 months)		7.27%	5.45%	17.31%	21.24%	0.00%	6.12%	10.39%		6.12%	19.35%	18.95%	9.35%	13.09%
	12 month Appraisal		91.7%	94.4%	87.5%	66.7%	100.0%	73.3%	81.3%		100.0%	66.7%	90.00%	88.00%	84.7%
	12 month Statutory Training		97.4%	99.1%	87.3%	88.9%	95.9%	97.8%	91.7%		96.9%	96.3%	94.65%	98.72%	93.8%
	12 month Mandatory Training		94.00%	97.37%	89.55%	91.67%	96.88%	96.61%	90.32%		93.75%	94.44%	93.55%	96.00%	93.14%

Agenda Item No:	**16.1**
Meeting:	Trust Board
Date:	31/10/2019

Title:	18 Week RTT Performance
Purpose	
Executive Summary:	To provide information on the current RTT position within the Trust, and the factors impacting performance. The paper outlines the activity needed to reduce the PTL size and an action plan to tackle the current issues.
Previously considered by:	
Recommendation Please state if approval required or if for information	Approve of the outlined action plan

Confidential y/n	

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

Prepared by:	Lianne Robinson - Divisional Director Anaesthetics and Surgical Services Division Madeleine Szekely – Deputy Divisional Director Anaesthetics and Surgical Services Division	**Presented by:**	Andy Ennis - Chief Operating Officer

18 Week Referral to Treatment Performance (RTT)

The purpose of this paper is to provide the Trust Board with information on; performance against the national Referral to Treatment (RTT) standard, the factors influencing the performance, and the actions currently being undertaken.

Background

The 18 week RTT standard applies to consultant led elective pathways (except Genito-urinary medicine and maternity services). The target sets a maximum time of 18 weeks from the point of initial referral up to the start of any treatment necessary for all patients who want it, and for whom it is clinically appropriate.

Until October 2015 there were three RTT standards; admitted performance, non-admitted performance and the incomplete performance. Since the national guidance changed Trusts are only required to report on the incomplete Standard (the admitted and non-admitted standard are still monitored internally). This can be described as: "92% of patients on incomplete pathways to be waiting less than 18 weeks".

Nationally there has been deterioration in the performance of the 18 week incomplete standard. This is as a result of urgent care pressures, workforce challenges and increased demand. In recognition of the challenges faced the recent joint NHS England and NHS Improvement planning guidance does not stipulate adherence to the 92% incomplete standard. Instead it states that the RTT waiting list (PTL) should be no higher in March 2020 than it was in March 2019 and no patient should breach 52 weeks.

Current Position

Incomplete Performance (RTT)

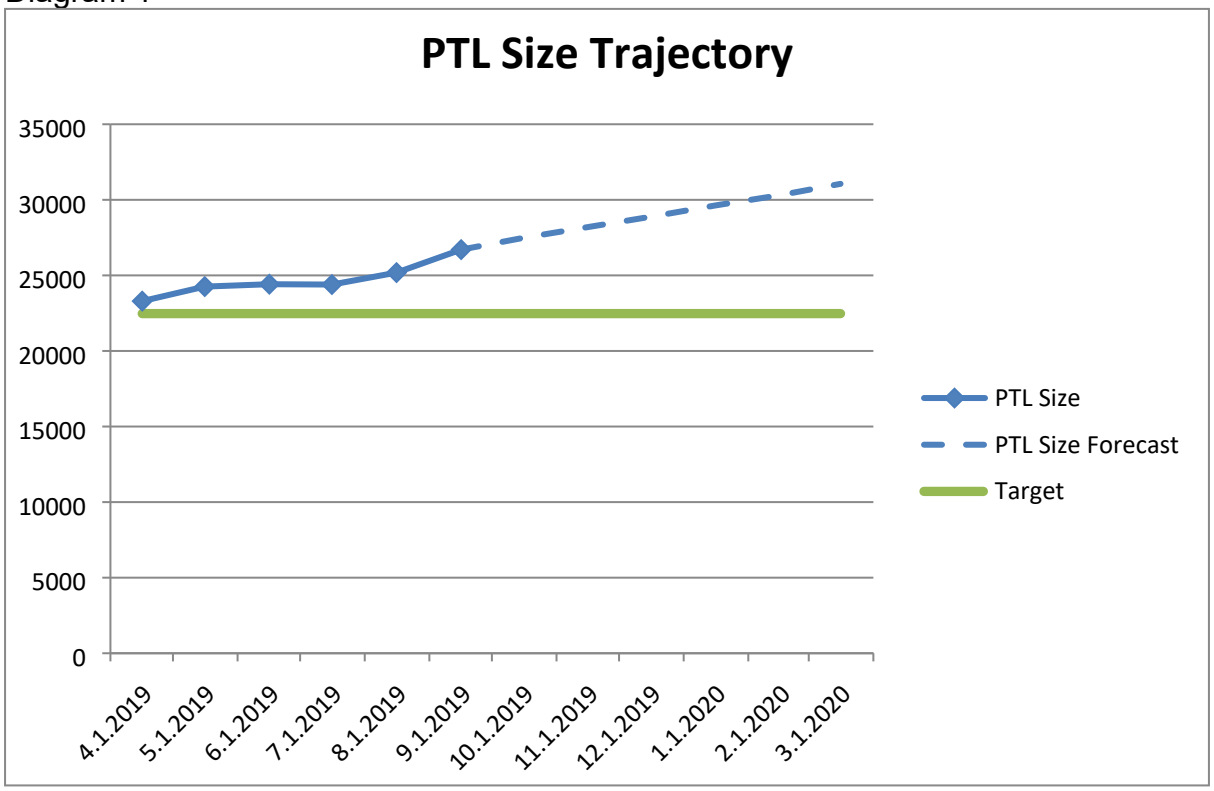
The Trust has failed to deliver the 92% standard since September 2017 with performance gradually deteriorating over time. The Trust position in September 2018 was 84.8%. The below table summarises performance over the past 2 years.

Activity Type	Period	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total RTT Incomplete Performance	2017/2018	92.1%	92.9%	93.0%	92.5%	92.2%	91.4%	91.1%	90.0%	88.8%	87.6%	87.8%	88.3%
	2018/2019	88.4%	89.8%	90.0%	90.3%	89.6%	89.1%	89.4%	89.6%	88.7%	88.4%	87.7%	87.2%
	2019/2020	86.2%	86.3%	85.4%	85.4%	84.4%	84.8%						

PTL Size

The total PTL size in March 2019 was 22,472. Since the start of the financial year the PTL size has grown month on month and is now close to 27,000 at the end of September. The diagram 1 outlines the growth in PTL size over the past 12 months:

Diagram 1



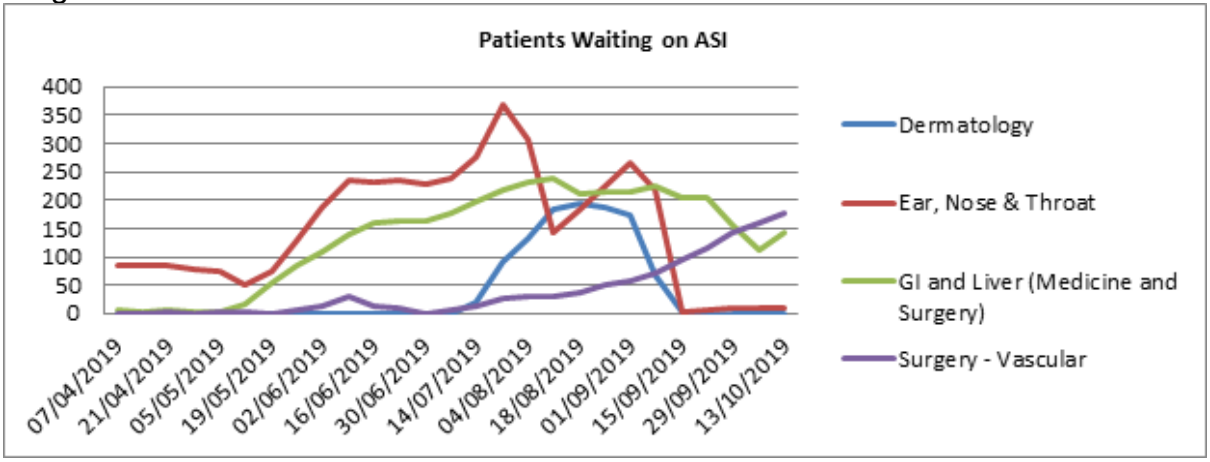
The top five specialities for pure growth in PTL size are ENT, Dermatology, Gynaecology, Ophthalmology and Oral Surgery and need to be the initial target of any backlog or data quality work. It should however be highlighted that Diabetic medicine, Dermatology and Bowel screening have the largest percentage growth compared to their PTL size which is likely indicative of a new capacity gap or issues with data quality.

The growth trajectory has some marked spikes due to bulk additions to the PTL where patients have been on the Appointment Slot Issues list (ASI) holding areas of eReferral. When patients are referred on e-referral and there is no available capacity, the patients are added to the ASI worklist on e-referral.

Due to the way that e-referral interfaces with LE2.2, the referral only generates on LE2.2 at the point that an appointment is booked so for the time that patients are on the ASI worklist they are not visible on LE2.2 and therefore not on the PTL.
At any given time, there will be patients on the ASI worklist and the number of patients will vary dependant on capacity issues in services and the time they spend on the worklist will be determined by how quick the capacity issue can be resolved. There will therefore always be a cohort of patients not on the PTL unless we are ever in a position of having no patients on the ASI.

September's sharp increase was due to the patients in ENT/Dermatology coming onto the PTL in block from the ASI (see below). We may see a sudden increase again in Vascular and Gastro as the patients are booked from the ASI. The diagram 2 below outlines the patients waiting on the ASI.

Diagram 2



With ASI, a recent issue identified following a review of the PTL was the clock start date not always reflecting the date of referral. As explained above the ASI work list and LE2.2 do not have an interface and therefore the date of referral has to be manually changed when patients are moved from the ASI list to an appointment on LE2.2. As part of a recent review of the PTL, it came to light that the clock start date when patients moved from ASI to LE2.2 was not always being changed to reflect date of referral, in total 1900 patients were highlighted where this was the case.

Appendix 1 includes comparison of the waiting list size with time band and specialty breakdown:

- Table 1 includes the waiting list with the ASI issue
- Table 2 includes the waiting list size with corrections to the referral date having being made
- Table 3 includes the changes in number of patients waiting by time band following correction

The impact of the ASI issue has meant patients who had been recorded on PTL waiting between 0-36 weeks, moving up in weeks, biggest change is between 12 and 24 weeks. There has been no increase in 52 week waits and the major impact has been in ENT, Gastroenterology and Dermatology. This will put additional pressure on services as the volume of patients waiting in excess of 18 weeks will increase. This is being discussed with the relevant specialties to enable action to be taken to mitigate patients becoming a 52 week wait risk.

Standard work was undertaken a year ago to ensure booking teams had a consistent approach with ASI patients, patients who are moved from ASI to LE2.2 would be recorded with date of original referral (when the patient went on to ASI). This information was agreed through the RTT steering group (cross Divisional working group) and then cascaded to teams. As part of the investigation to understand the reason why 1900 patients have had the incorrect clock start date recorded, it has come to light that due to turnover of staff, the information had not been seen by all members of the booking team. All teams are now aware of the process and the 1900 patients clocks are being corrected, this piece of work will be concluded by mid-November.

52 Week Waiters

The Trust does not routinely have a waiting list containing patients over 52 weeks; but there have been patients treated beyond their 52 week breach date. In some instances this is due to pathway delays and capacity (time to first appointment, time to surgery). In 2019/20 year to date 34 patients have breached 52 weeks. Some of the patients who have been treated after their 52 week breach date could have been treated before 52 weeks, but declined these earlier treatment dates. The trust is also having particular issues with patients undergoing corneal grafts due to issues sourcing graft material for the procedure. Alternative procedures are being explored and alternative sources of materials.

Productivity & Efficiency

The Trust generally performs well compared to peer, in terms of productivity and efficiency benchmarking. This includes new to follow up ratios, number of cases on a theatre list, number of patients seen in an outpatient clinic. GIRFT reports received for T&O, General Surgery and ENT were all favourable and confirmed the specialties were working productively.

It is accepted that there will be the ability to continue to improve on productivity and efficiency but there are no specialties highlighted as outliers in comparison to peers. This was evidenced through the Capacity & Demand exercise undertaken last year, using benchmarking data from CHKS. NHSI have also fed back that the trust are demonstrate control and efficiency.

Factors Impacting RTT Performance

There are a number of factors impacting the Trust's ability to deliver the RTT standard. Capacity & Demand mismatch and Data Quality are two of the key reasons for this.

Data Quality

Over recent years, the Trust has lost some of its organisational knowledge in relation to RTT. In addition, there is a significant gap in training. As a result, there are data quality issues impacting RTT. These include patients added to RTT pathways that should be excluded, and incorrect clock stops. Both of these issues impact on performance.

These data quality issues result in a need for high volumes of validation activities being required. Validation activities across specialities are very inconsistent and are often reliant on one individual in each area leading to lack continuity of validation in the event of sickness absence or vacancy of roles. The majority of validation resource is currently sat within Anaesthetics and surgery division with limited resource dedicated to this in other divisions.

This calendar year validation has been outsourced to a company that specialises in RTT validation, as part of the review of the work undertaken by the company data issues were identified. The company has been tasked to resolve these issues; there

is close scrutiny with the work being monitored by the Deputy Divisional Director for Anaesthetics and Surgical Services Division.

Capacity & Demand

The capacity and demand modelling is completed on an annual basis. It is clear to see from this analysis that there are significant capacity shortfalls across a number of key specialties. All surgical specialties have a gap between the demand for Elective inpatient and Day case Surgery and the core capacity available.

There are significant challenges in Breast Surgery, Colorectal Surgery, ENT, Gastroenterology, Ophthalmology, Upper GI, T&O, Oral Surgery and Urology.

There are further capacity challenges at sub specialty level in a number of areas. For example T&O; there is a significant shortfall in Trauma capacity. In the same way that urgent cancer referrals lead to longer waits for routine patients, the shortfall in Trauma capacity regularly results in Elective theatre lists being converted to Trauma, to meet the emergency demand.

There is also a shortfall in capacity as a result of consultant and junior doctor vacancies which we are not always able to fill e.g. Dermatology Urology and ENT.

In addition to the shortfalls in capacity against demand there is also an upward trend in demand. There is also an increase in the number of urgent and suspected cancer referrals being received. Clinically, these patients are prioritised over routine referrals. As specialties are unable to create enough additional capacity for all patients, RTT patients wait longer as they are lower clinical priority.

Recommendations

Analysis of the current trajectory and performance has been undertaken to understand the required clock stops needed to; maintain the current PTL size and to reduce the current PTL to 22,472.

Diagram 3

Data	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
1. Additional Stops to Maintain PTL Size at March 2019 Position - 22472	836	836	836	836	836	836	**5015**
2. Additional Stops to Maintain PTL Size at Current Position	782	714	680	748	680	748	**4352**
3. Total to Maintain PTL (excludes backlog clearance to achieve 92%)	**1618**	**1550**	**1516**	**1584**	**1516**	**1584**	**9367**

Diagram 3 above includes details of the additional volume of activity or validation (clock stops) required:

1. Deliver the waiting list size of 22,472 as per March 31st 2019 – 5015 additional clock stops required on top of existing activity

2. Sustain waiting list size at current number of 27,000 – 4352 additional clock stops required on top of existing activity
3. Deliver 92% standard – 9367 additional clock stops required

Realistically delivering the waiting list size of 22,472 or the 92% standard will be extremely challenging, it will require a substantial amount of additional resource/expenditure/capacity and as we enter the winter period non elective pressure will restrict the volume of activity. As part of the winter stock take submission to GM, the Trust has included a year end RTT waiting list size forecast of 25,000, delivering on this will remain a challenge however with the actions outlined in appendix 3, it is possible to achieve this.

Appendix 2 includes a trajectory of the waiting list size at the end of March 2020; the trajectory includes undertaking additional activity as per appendix 4 and also undertaking high volume validation with use of internal and external validators. This additional intervention will bridge the gap to deliver the 25,000 waiting list size.

An action plan has been developed outlined in Appendix 3. To address the issues a multi-pronged approach will be required to tackle issues across a number of areas. The board are asked to support the follow three key actions:

- Implementation of changes to structures and processes to address data quality and validation issues long term. This will be a significant change from having validators checking the data, to a team who are able to undertake training and education to prevent data inaccuracies moving forward.
- Support the development of proposals to increase the validation efforts short term to clear backlog of data quality issues within the existing PTL.
- Support the backlog clearance plan proposed to undertake additional activity to clear backlogs within outpatients (Appendix 4).

Appendix 1

RTT and ASI Analysis

Current RTT PTL

Table 1

Specialty	00-06	06-12	12-18	18-24	24-30	30-36	36-42	42-48	48-52	52+	Under 18 Weeks	Over 18 Weeks	Total	% Under 18 Weeks
IP100 - General Surgery	1294	890	673	309	149	80	41	12	3	1	2857	595	3452	82.8%
IP101 - Urology	380	302	259	109	53	41	28	6	1		941	238	1179	79.8%
IP110 - Trauma & Orthopaedics	1302	881	890	440	132	64	26	14	3	1	3073	680	3753	81.9%
IP120 - Ent	1059	576	327	161	134	54	12	7	4		1962	372	2334	84.1%
IP130 - Ophthalmology	1614	1033	724	487	254	116	48	10	3		3371	918	4289	78.6%
IP140 - Oral Surgery	478	341	269	155	96	65	12	6			1088	334	1422	76.5%
IP160 - Plastic Surgery	145	71	58	50	23	16	11	4	2		274	106	380	72.1%
IP170 - Cardiothoracic Surgery	10	4	3	2							17	2	19	89.5%
IP300 - General Medicine	225	135	101	32	12	3	1			1	461	49	510	90.4%
IP301 - Gastroenterology	612	445	317	87	40	5	2				1374	134	1508	91.1%
IP320 - Cardiology	600	340	227	91	54	16	9	1			1167	171	1338	87.2%
IP320 - Cardiology Service	1										1	0	1	100.0%
IP330 - Dermatology	679	434	245	126	23	7	1	1			1358	158	1516	89.6%
IP340 - Respiratory Medicine	343	216	172	21	6	2	1				731	30	761	96.1%
IP400 - Neurology	53	20	8	6							81	6	87	93.1%
IP410 - Rheumatology	208	161	60	27	14	3		1			429	45	474	90.5%
IP430 - Geriatric Medicine	79	38	20		1						137	1	138	99.3%
IP502 - Gynaecology	722	348	318	134	50	59	16	6	2		1388	267	1655	83.9%
IPX01 - Other Specialties	1182	692	423	180	91	50	33	2	2	2	2297	360	2657	86.5%
Total	**10986**	**6927**	**5094**	**2417**	**1132**	**581**	**241**	**70**	**20**	**5**	**23007**	**4466**	**27473**	**83.7%**

PTL Amended with ASI Start Dates

Table 2

Specialty	00-06	06-12	12-18	18-24	24-30	30-36	36-42	42-48	48-52	52+	Under 18 Weeks	Over 18 Weeks	Total	% Under 18 Weeks
IP100 - General Surgery	1273	901	663	329	149	80	41	12	3	1	2837	615	3452	82.2%
IP101 - Urology	380	301	256	113	53	41	28	6	1		937	242	1179	79.5%
IP110 - Trauma & Orthopaedics	1284	897	892	439	133	64	26	14	3	1	3073	680	3753	81.9%
IP120 - Ent	733	559	471	304	176	68	12	7	4		1763	571	2334	75.5%
IP130 - Ophthalmology	1614	1033	724	487	254	116	48	10	3		3371	918	4289	78.6%
IP140 - Oral Surgery	441	373	274	155	96	65	12	6			1088	334	1422	76.5%
IP160 - Plastic Surgery	145	71	58	50	23	16	11	4	2		274	106	380	72.1%
IP170 - Cardiothoracic Surgery	10	4	3	2							17	2	19	89.5%
IP300 - General Medicine	225	135	101	32	12	3	1			1	461	49	510	90.4%
IP301 - Gastroenterology	535	442	336	147	41	5	2				1313	195	1508	87.1%
IP320 - Cardiology	582	341	237	95	53	20	9	1			1160	178	1338	86.7%
IP320 - Cardiology Service	1										1	0	1	100.0%
IP330 - Dermatology	611	460	287	126	23	7	1	1			1358	158	1516	89.6%
IP340 - Respiratory Medicine	343	211	162	35	7	2	1				716	45	761	94.1%
IP400 - Neurology	53	20	8	6							81	6	87	93.1%
IP410 - Rheumatology	197	157	67	35	14	3		1			421	53	474	88.8%
IP430 - Geriatric Medicine	78	39	20		1						137	1	138	99.3%
IP502 - Gynaecology	722	348	318	134	50	59	16	6	2		1388	267	1655	83.9%
IPX01 - Other Specialties	1182	690	425	180	91	50	33	2	2	2	2297	360	2657	86.5%
Total	**10409**	**6982**	**5302**	**2669**	**1176**	**599**	**241**	**70**	**20**	**5**	**22693**	**4780**	**27473**	**82.6%**

Diff

Table 3

Specialty	00-06	06-12	12-18	18-24	24-30	30-36	36-42	42-48	48-52	52+	Under 18 Weeks	Over 18 Weeks	Total	% Under 18 Weeks
IP100 - General Surgery	-21	11	-10	20	0	0	0	0	0	0	-20	20	0	-0.6%
IP101 - Urology	0	-1	-3	4	0	0	0	0	0	0	-4	4	0	-0.3%
IP110 - Trauma & Orthopaedics	-18	16	2	-1	1	0	0	0	0	0	0	0	0	0.0%
IP120 - Ent	-326	-17	144	143	42	14	0	0	0	0	-199	199	0	-8.5%
IP130 - Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
IP140 - Oral Surgery	-37	32	5	0	0	0	0	0	0	0	0	0	0	0.0%
IP160 - Plastic Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
IP170 - Cardiothoracic Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
IP300 - General Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
IP301 - Gastroenterology	-77	-3	19	60	1	0	0	0	0	0	-61	61	0	-4.0%
IP320 - Cardiology	-18	1	10	4	-1	4	0	0	0	0	-7	7	0	-0.5%
IP320 - Cardiology Service	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
IP330 - Dermatology	-68	26	42	0	0	0	0	0	0	0	0	0	0	0.0%
IP340 - Respiratory Medicine	0	-5	-10	14	1	0	0	0	0	0	-15	15	0	-2.0%
IP400 - Neurology	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
IP410 - Rheumatology	-11	-4	7	8	0	0	0	0	0	0	-8	8	0	-1.7%
IP430 - Geriatric Medicine	-1	1	0	0	0	0	0	0	0	0	0	0	0	0.0%
IP502 - Gynaecology	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
IPX01 - Other Specialties	0	-2	2	0	0	0	0	0	0	0	0	0	0	0.0%
Total	**-577**	**55**	**208**	**252**	**44**	**18**	**0**	**0**	**0**	**0**	**-314**	**314**	**0**	**-1.1%**

RTT Trajectory for 2019/20

Appendix 2

Current Trajectory

Data	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PTL Size	23298	24259	24416	24394	25184	26705	27487	28201	28881	29629	30309	31057

Recovery Plan Activity

Data	*Apr-19*	*May-19*	*Jun-19*	*Jul-19*	*Aug-19*	*Sep-19*	*Oct-19*	*Nov-19*	*Dec-19*	*Jan-20*	*Feb-20*	*Mar-20*	*Total*
Stops								*270*	*223*	*252*			***745***

Validation (based on March 2019 Removals/Validation)

Data	*Apr-19*	*May-19*	*Jun-19*	*Jul-19*	*Aug-19*	*Sep-19*	*Oct-19*	*Nov-19*	*Dec-19*	*Jan-20*	*Feb-20*	*Mar-20*	*Total*
Potential Removals from Validation								*721*	*721*	*721*	*721*	*721*	***3605***

Recovery Trajectory - based on the current Trajectory of increasing PTL Size

Data	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PTL Size	23298	24259	24416	24394	25184	26705	27487	27210	26946	26721	26680	26707

Return Internal Validation/Data Quality Errors to levels of 18/19

Data	*Apr-19*	*May-19*	*Jun-19*	*Jul-19*	*Aug-19*	*Sep-19*	*Oct-19*	*Nov-19*	*Dec-19*	*Jan-20*	*Feb-20*	*Mar-20*	*Total*
Removals or Errors not created								*464*	*464*	*464*	*464*	*464*	***2320***

Recovery Trajectory - Including All

Data	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PTL Size	23298	24259	24416	24394	25184	26705	27487	26746	26018	25329	24824	24387

Appendix 3

The following action plan has been put together to address the current position:

Action Number	Theme	Action	Owner	Target Date	Status
RTT1	Data Quality	Centralise RTT Validation resource to provide a resilient validation team and provide a targeted approach to validation, root cause analysis and subsequent training	Teresa Jowett - Deputy Head of Business Intelligence	15/12/2019	On track
RTT2	Data Quality	Deliver RTT Training Strategy including sessions from NHSI and e-learning developed	Maddie Szekely - Deputy DDO ASSD	31/12/2019	On track
RTT3	Data Quality	Progress recovery plan with existing outsourcing agency for RTT	Maddie Szekely - Deputy DDO ASSD	31/12/2019	On track
RTT4	Data Quality	Re-establish RTT steering group with refreshed terms of reference and remit to develop SOPs and protocols to prevent RTT data quality errors	Maddie Szekely - Deputy DDO ASSD	31/12/2019	On track
RTT5	Data Quality	Develop a rolling action plan of SOPs and protocols to address to prevent RTT data quality errors	Maddie Szekely - Deputy DDO ASSD	31/03/2020	On track
RTT6	Data Quality	Maintain and develop reports to highlight data quality errors to specialities to provide areas to target	Teresa Jowett - Deputy Head of Business Intelligence	31/12/2019	On track
RTT7	Data Quality	Review process for cashing up of clinics to ensure timely outcoming of patient appointments and optimum time to see the patient	Maddie Szekely - Deputy DDO ASSD	31/12/2019	On track
RTT8	Data Quality	Produce and options appraisal to explore options to source additional validation resource to clear backlog of validation	Maddie Szekely - Deputy DDO ASSD	31/12/2019	On track

RTT9	Clinical Leadership	Review options for establishing a Clinical Lead for RTT to ensure Medical Leadership of Performance and engage with Medical Workforce	Jez Wood - Divisional Clinical Director ASSD	31/12/2019	On track
RTT10	Clinical Leadership	Review options for clinical engagement programme with the consultant workforce to build understanding of 18 weeks			
RTT11	52 Week Breach Monitoring	Continue to micro manage all patients on the PTL over 40 weeks	Maddie Szekely - Deputy DDO ASSD	31/12/2019	On track
RTT12	52 Week Breach Monitoring	Maintain protected theatre sessions for long waiters	Maddie Szekely - Deputy DDO ASSD	31/12/2019	On track
RTT13	52 Week Breach Monitoring	Continue to undertake 52 week breach Root cause analysis and ensure feedback and learning in implemented via RTT steering group.	Maddie Szekely - Deputy DDO ASSD	31/03/2019	On track
RTT14	52 Week Breach Monitoring	Review options to source graft material elsewhere or undertake alternative procedure	Sonia Nosheen - OBM Ophthalmology & Head and Neck	31/03/2019	On track
RTT15	Creating Capacity	Link with the outpatient and theatre improvement programmes to optimise existing capacity, using slot utilisation reports, DNA reduction approaches etc.	Jen Riley - Deputy Director Transformation	31/03/2019	On track
RTT16	Creating Capacity	Review proposed backlog clearance proposal from specialities with commissioners to assess viability of delivering additional activity	Lianne Robinson - DDO ASSD	31/12/2019	On track
RTT17	Process Improvement	Review clinical correspondence turnaround times within specialities to ensure clinics are outcome and next steps progressed for patients on the pathway	DDOs	31/12/2019	On track
RTT18	Process Improvement	Deep dive review to be undertake for each speciality with divisional teams and BI to identify good practise to be shared, areas that require improvement to reduce PTL size and what is needed to bring forward first appointment to enable delivery against 18 92% performance.	DDOs	31/12/2019	On track

		Production of action plan for each specialty to be agreed			
RTT19	Process Improvement	Resolve issues with G2 dictation which lead to delays to clinical correspondence	Philippa Winter - CIO	31/12/2019	On track

Appendix 4

PTL RECOVERY PLAN	Oct-19	Nov-19	Dec-19	Jan-20	Total	Comments/Risks/Concerns	Waiting List Size	Long Waiters	Avoidance
Orthopaedics/Rheumatology									
Theatre Sessions	3	3	0	0	6	Continue NWSS to focus on new breach patients and patients nearing breach date (16-20 weeks). This will also help us to offset any issues with trauma demand by allowing us to rebook patients cancelled to NWSS.	Yes	Yes	No
Number of patients per Theatre session	4	4	4	4	16				
Total Theatre Activity/Additional Cases	12	12	0	0	24				
OP Sessions	3	3	2	2	10	2 Rheumatology WLI's per month - normally clock stops on FA. F&A clinics for OIS in Oct/Nov to reduce wait - clock stop % quite high for this service	Yes	Yes	No
Number of patients per OP session	6	6	6	6	24				
Total OP/Additional ATTs	18	18	12	12	60				
Pathway Redesign - Reduction/Closures	0	0	0	0	0				
Other (please explain in comments)	0	0	0	0	0				
Total reduction/closures	0	0	0	0	0				
T&O Total - Patient ATT's/Cases	30	30	12	12	84				
Monthly OP Session Costs	£ 2,910.00	£ 2,910.00	£ 1,940.00	£ 1,940.00	£ 9,700.00				
Monthly Theatre Session Costs	£ 13,500.00	£ 13,500.00	£ -	£ -	£ 27,000.00				
Average cost per patient/case	£ 547.00	£ 547.00	£ 161.67	£ 161.67	£ 436.90				
Total Activity Cost by Specialty	£ 16,410.00	£ 16,410.00	£ 1,940.00	£ 1,940.00	£ 36,700.00				
General Surgery									
Theatre Sessions	0	6	6	6	18	Backfill 4 x in-week sessions per month@ WLI rate - this will treat 8 longwaiters based on an average casemix of 2 patients per list. Lists should already be staffed so it would just be the surgeon that would be extra. 1 x All Day LA Minor Ops list per month - this will treat 12 patients, not necessarily the longest waiters but would help with the PTL size. Running the lists would be dependant on volunteers which is a risk if there isn't the appetite to do the sessions.	Yes	Yes	No
Number of patients per Theatre session	0	3	3	3	9				
Total Theatre Activity/Additional Cases	0	18	18	18	54				
OP Sessions	0	0	0	0	0	Whilst outpatient waits are high, there isn't a high clock stop rate at 1st appt therefore running additional clinics wouldn't make a huge difference to the PTL size.	No	No	No
Number of patients per OP session	0	0	0	0	0				
Total OP/Additional ATTs	0	0	0	0	0				
Pathway Redesign - Reduction/Closures					0		Yes	No	Yes
Other (please explain in comments)					0				
Total reduction/closures	0	0	0	0	0				
GS Total - Patient ATT's/Cases	0	18	18	18	54				
Monthly OP Session Costs	£ -	£ -	£ -	£ -	£ -				
Monthly Theatre Session Costs	£ -	£ 16,062.00	£ 16,062.00	£ 16,062.00	£ 48,186.00				
Average cost per patient/case	#DIV/0!	£ 892.33	£ 892.33	£ 892.33	£ 892.33				
Total Activity Cost by Specialty	£ -	£ 16,062.00	£ 16,062.00	£ 16,062.00	£ 48,186.00				
Breast Surgery									
Theatre Sessions	3	3	3	3	12	Lack of theatre capacity is impacting on patients waiting longer for cancer surgery. Also a high number of patients waiting reconstruction surgery, patients are being cancelled to accommodate cancer surgery.	Yes	Yes	No
Number of patients per Theatre session	5	5	5	5	20				
Total Theatre Activity/Additional Cases	15	15	15	15	60				
OP Sessions	3	4	4	4	15	Referrals numbers have incresed significantly, delivering cancer 2WW standards remains challenging. Breast Symptomatic 2WW cancer performance has not been achieved for many months. However availability of Radiologist is required. Also, HMRC/ Pension issues are impacting on Consultants delivering WLIS'. ANP & Associate Specialist continue to deliver WLI's	Yes	Yes	No
Number of patients per OP session	10	10	10	10	40				
Total OP/Additional ATTs	30	40	40	40	150				
Pathway Redesign - Reduction/Closures					0	N/A	N/A	N/A	N/A
Other (please explain in comments)					0				
Total reduction/closures	0	0	0	0	0				
Breast Total - Patient ATT's/Cases	45	55	55	55	210				
Monthly OP Session Costs	£ 2,511.00	£ 3,348.00	£ 3,348.00	£ 3,348.00	£ 12,555.00				
Monthly Theatre Session Costs	£ 8,031.00	£ 8,031.00	£ 8,031.00	£ 8,031.00	£ 32,124.00				
Average cost per patient/case	£ 234.27	£ 206.89	£ 206.89	£ 206.89	£ 212.76				
Total Activity Cost by Specialty	£ 10,542.00	£ 11,379.00	£ 11,379.00	£ 11,379.00	£ 44,679.00				
Urology									
Theatre Sessions	3	3	3	3	12	Reduce current Theatre waiting list size. Support cancer 2WW.	Yes	Yes	No
Number of patients per Theatre session	6	6	6	6	24				
Total Theatre Activity/Additional Cases	18	18	18	18	72				
OP Sessions	3	3	3	3	12	Support RTT and DM01.	Yes	Yes	No
Number of patients per OP session	10	10	10	10	40				
Total OP/Additional ATTs	30	30	30	30	120				
Pathway Redesign - Reduction/Closures					0	N/A	N/A	N/A	N/A
Other (please explain in comments)					0				
Total reduction/closures	0	0	0	0	0				
Urol Total - Patient ATT's/Cases	48	48	48	48	192				
Monthly OP Session Costs	£ 2,511.00	£ 2,511.00	£ 2,511.00	£ 2,511.00	£ 10,044.00				
Monthly Theatre Session Costs	£ 8,031.00	£ 8,031.00	£ 8,031.00	£ 8,031.00	£ 32,124.00				
Average cost per patient/case	£ 219.63	£ 219.63	£ 219.63	£ 219.63	£ 219.63				
Total Activity Cost by Specialty	£ 10,542.00	£ 10,542.00	£ 10,542.00	£ 10,542.00	£ 42,168.00				
ENT									
Theatre Sessions	3	3	3	3	12	To reduce the current inpateint waiting list size as we are currently booking into the new year. Recently had a lot of cancelled inpatient activity due to staffing shortages in theatres	Yes	Yes	
Number of patients per Theatre session	4	4	4	4	16				
Total Theatre Activity/Additional Cases	12	12	12	12	48				
OP Sessions	4	4	4	4	16	ENT - Would require Locum Consultant (on bank not via agency) for 4 months to cover new/follow up clinics only (5 new, 10 follow up per session). Nursing, audiological and secretarial support would be required as extra.	Yes	Yes	Yes
Number of patients per OP session	10	10	10	10	40				
Total OP/Additional ATTs	40	40	40	40	160				
Pathway Redesign - Reduction/Closures					0	Having extra support via a vaildator who goes through PTL list would help reduce the size, we currently have someone part time on it (B3 rate)			
Other (please explain in comments)					0				
Total reduction/closures	0	0	0	0	0				
ENT Total - Patient ATT's/Cases	52	52	52	52	208				
Monthly OP Session Costs	£ 3,428.00	£ 3,428.00	£ 3,428.00	£ 3,428.00	£ 13,712.00				
Monthly Theatre Session Costs	£ 8,031.00	£ 8,031.00	£ 8,031.00	£ 8,031.00	£ 32,124.00				
Average cost per patient/case	£ 220.37	£ 220.37	£ 220.37	£ 220.37	£ 220.37				
Total Activity Cost by Specialty	£ 11,459.00	£ 11,459.00	£ 11,459.00	£ 11,459.00	£ 45,836.00				

Ophthalmology									
Theatre Sessions	3	3	3	3	12	Currently 250 cataract patients undated. Would run extra Saturday lists only, would be WLI for SAS. ?Consultants may request time off in lieu due to pension issue. Non complex cataract surgery would be done under sub tenon or topical. Anaesthetic support not required. Would require inhouse theatre support on overtime.	Yes	Yes	No
Number of patients per Theatre session	6	6	6	6	24				
Total Theatre Activity/Additional Cases	18	18	18	18	72				
OP Sessions	4	4	4	4	16	Already running WLI clinic to reduce follow up backlog across retinal, glaucoma, diabetics and general funding against vacancies, despite this, still facing pressures and challenges with waiting lists.	Yes	Yes	No
Number of patients per OP session	10	10	10	10	40				
Total OP/Additional ATTs	40	40	40	40	160				
Pathway Redesign - Reduction/Closures	0	0	0	0	0		No	No	No
Other (please explain in comments)	0	0	0	0	0				
Total reduction/closures	0	0	0	0	0				
Oph Total - Patient ATT's/Cases	58	58	58	58	232				
Monthly OP Session Costs	£ 4,168.00	£ 4,168.00	£ 4,168.00	£ 4,168.00	£ 16,672.00				
Monthly Theatre Session Costs	£ 5,241.00	£ 5,241.00	£ 5,241.00	£ 5,241.00	£ 20,964.00				
Average cost per patient/case	£ 162.22	£ 162.22	£ 162.22	£ 162.22	£ 162.22				
Total Activity Cost by Specialty	£ 9,409.00	£ 9,409.00	£ 9,409.00	£ 9,409.00	£ 37,636.00				
Gynaecology									
Theatre Sessions	3	3	3	3	12	If additional capacity is found within DCU this would close pathways (all day Sat session proposed with 10 pts listed) 1 Additional session per month to includes a trial of delivery Inpatients scopes differently (hysteroscopies under sedation) -4pts per list - would pilot in DCU in the first instance with a longer term view of transferring to outpatient setting - would avoid going to theatre.	Yes	Yes	Yes
Number of patients per Theatre session	11	11	11	11	44				
Total Theatre Activity/Additional Cases	33	14	14	14	75				
OP Sessions	2	2	2	2	8	This includes 1 additional PPB clinic per month (8) which would treat patient and close pathway and reduce waiting times. Also includes 1 sesssion per month for OP hysteroscopies (6) which would ensure routine patients are not move/deferred or have the clinic converted for urgent scopes	Yes	Yes	No
Number of patients per OP session	14	14	2	14	44				
Total OP/Additional ATTs	28	16	4	16	64				
Pathway Redesign - Reduction/Closures					0	1 Session per week for a consultant to review patients awaiting results to dictate discharge letters - cost should also incorporate B2 time to retrieve notes and additional bank for B3 to type letters. Could avoid attended to OP clinic for some patients.	Yes	Yes	Yes
Other (please explain in comments)	1	1	1	1	4				
Total reduction/closures	10	14	4	4	32				
Gynae Total - Patient ATT's/Cases	71	44	22	34	171				
Monthly OP Session Costs	£ 1,420.00	£ 1,420.00	£ 1,420.00	£ 1,420.00	£ 5,680.00				
Monthly Theatre Session Costs	£ 7,044.00	£ 7,044.00	£ 7,044.00	£ 7,044.00	£ 28,176.00				
Average cost per patient/case	£ 119.21	£ 192.36	£ 384.73	£ 248.94	£ 197.99				
Total Activity Cost by Specialty	£ 8,464.00	£ 8,464.00	£ 8,464.00	£ 8,464.00	£ 33,856.00				
Oral Surgery									
Theatre Sessions	3	3	3	3	12	To help with the current waits and backlog for inpatient waitingl lists. Had a high number of cancellations due to theater staffing which has increased waits furter			
Number of patients per Theatre session	4	4	4	4	16				
Total Theatre Activity/Additional Cases	12	12	12	12	48				
OP Sessions	4	4	4	4	16	Income genereation - Minor Ops clinics. Current wait to 1st appt is 16 weeks.Would also include sedation patients. Specialty Dr would undertake on WLI, nursing support needed.	Yes	No	Yes
Number of patients per OP session	10	10	10	10	40				
Total OP/Additional ATTs	40	40	40	40	160				
Pathway Redesign - Reduction/Closures					0	1 Session per week for a consultant to review patients awaiting results to dictate discharge letters - cost should also incorporate B2 time to retrieve notes and additional bank for B3 to type letters. Could avoid attended to OP			
Other (please explain in comments)					0				
Total reduction/closures	0	0	0	0	0				
Oral Surgery Total OP/Additional ATTs	52	52	52	52	208				
Monthly OP Session Costs	£ 3,428.00	£ 3,428.00	£ 3,428.00	£ 3,428.00	£ 13,712.00				
Monthly Theatre Session Costs	£ -	£ -	£ -	£ -	£ -				
Average cost per patient/case	£ 65.92	£ 65.92	£ 65.92	£ 65.92	£ 65.92				
Total Activity Cost by Specialty	£ 3,428.00	£ 3,428.00	£ 3,428.00	£ 3,428.00	£ 13,712.00				
Endocrinology									
Theatre Sessions					0	N/A			
Number of patients per Theatre session	0	0	0	0	0				
Total Theatre Activity/Additional Cases	0	0	0	0	0				
OP Sessions	2	2	0	2	6	New capacity from new consultant - will support New and Follow Up capacity	Yes	Yes	No
Number of patients per OP session	12	12	0	12	36				
Total OP/Additional ATTs	24	24	0	24	72				
Pathway Redesign - Reduction/Closures					0	Advice and guidance now ongoing to deflect referrals. Plan underway with help of admin resource across diab & endo to reduce validation list significantly from current position.Already cleared any over 40 weeks - aiming to get below 25 weeks before Xmas & then continue to reduce	No	No	Yes
Other (please explain in comments)					0				
Total reduction/closures	0	0	0	0	0				
Endocrine Total - Patient ATT's/Cases	24	24	0	24	72				
Monthly OP Session Costs	£ 1,674.00	£ 1,674.00	£ -	£ 1,674.00	£ 5,022.00				
Monthly Theatre Session Costs	£ -	£ -	£ -	£ -	£ -				
Average cost per patient/case	£ 69.75	£ 69.75	#DIV/0!	£ 69.75	£ 69.75				
Total Activity Cost by Specialty	£ 1,674.00	£ 1,674.00	£ -	£ 1,674.00	£ 5,022.00				

Finance	Oct-19	Nov-19	Dec-19	Jan-20	Total
Theatre Related Activity Cost	£ 22,050.00	£ 22,887.00	£ 20,243.00	£ 21,917.00	£ 87,097.00
Outpatient Related Activity Cost	£ 49,878.00	£ 65,940.00	£ 52,440.00	£ 52,440.00	£ 220,698.00
Total Cost per Month	£ 71,928.00	£ 88,827.00	£ 72,683.00	£ 74,357.00	£ 307,795.00

Agenda Item No:	**18**
Meeting:	Board of Directors
Date:	31 October 2019

NHS Bolton NHS Foundation Trust

Title:	iFM Articles of Association
Purpose	For the Board of Bolton NHS FT as Controlling Shareholder of iFM Bolton to consider and approve a change to the Articles of iFM Bolton
Executive Summary:	As a listed company, the Trust's wholly owned subsidiary iFM Bolton is governed by Articles of Association. Following changes to the structure of the Board the previous requirement for quoracy is no longer practical – it is therefore proposed that the quorum required for a Board meeting of iFM Bolton is reduced from two to one. The Articles are included for information – the change is proposed to para 14 of the attached articles
Previously considered by:	

Next steps/future actions (please ✓):				
	Discuss		Receive	
	Approve	✓	Note	
	For Information		Confidential y/n	no

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

Prepared by:	Esther Steel	**Presented by:**	Esther Steel

iFM Bolton

Clean Safe and Sustainable

A wholly owned subsidiary of Bolton NHS Foundation Trust NHS

THE COMPANIES ACT 2006

PRIVATE COMPANY LIMITED BY SHARES

ARTICLES OF ASSOCIATION OF INTEGRATED FACILITIES MANAGEMENT BOLTON

INDEX TO THE ARTICLES

PART 1

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PART 2

DIRECTORS

DIRECTORS' POWERS AND RESPONSIBILITIES

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PART 5

ADMINISTRATIVE ARRANGEMENTS

DIRECTORS' INDEMNITY AND INSURANCE

PRELIMINARY

1. **DEFAULT ARTICLES NOT TO APPLY**

Neither the regulations in the Companies (Model Articles) Regulations 2008 nor any other articles or regulations prescribing the form of articles applicable to the company under any former enactment relating to companies shall apply to the company.

PART 1

INTERPRETATION AND LIMITATION OF LIABILITY

Defined terms

2.1 In the articles, unless the context requires otherwise:

Act	The Companies Act 2006
Articles	means the company's articles of association;
bankruptcy	includes individual insolvency proceedings in a jurisdiction other than England and Wales or Northern Ireland which have an effect similar to that of bankruptcy;
chairman	has the meaning given in article 12;
chairman of the meeting	has the meaning given in article 39;
Companies Acts	means the Companies Acts (as defined in section 2 of the Companies Act 2006), in so far as they apply to the company;
Controlling Shareholder	The some member of the Company
director	means a director of the company, and includes any person occupying the position of director, by whatever name called;
document	includes, unless otherwise specified, any document sent or supplied in electronic form;
instrument	means a document in hard copy form;
participate	in relation to a directors' meeting, has the meaning given in article 10;
proxy notice	has the meaning given in article 45;
subsidiary	has the meaning given in section 1159 of the Companies Act 2006;
writing	means the representation or reproduction of words, symbols or other information in a visible form by any method or combination of methods, whether sent or supplied in electronic form or otherwise.

Unless the context otherwise requires, other words or expressions contained in these articles bear the same meaning as in the Companies Act 2006 as in force on the date when these articles become binding on the company.

2.2 In these articles:

(a) any gender includes any other gender

(b) the singular includes the plural and vice versa

(c) references to persons includes bodies corporate partnerships and trusts (in each case whether or not having separate legal personality.

(d) the headings in these Articles are for convenience only and shall not affect the interpretation of the Articles.

Liability of members

3. The liability of the members is limited to the amount, if any, unpaid on the shares held by them.

PART 2

DIRECTORS

DIRECTORS' POWERS AND RESPONSIBILITIES

4. **Directors' general authority**

Subject to the articles, the directors are responsible for the management of the company's business, for which purpose they may exercise all the powers of the company.

4.1 Unless and until otherwise determined by the shareholder, there shall be no maximum number of directors and the minimum number of directors shall be one.

5. **Controlling Shareholder powers**

5.1 For so long as the controlling shareholder is the holder of not less than 51 per cent of the Ordinary Shares, the following provisions shall apply and the extent of any inconsistency shall have overriding effect as against all other provisions of these articles.

a. the controlling shareholder may at any time and from time to time, by notice in writing to the company appoint any person to be a Director to fill a vacancy or to be an additional Director.

b. the controlling shareholder may at any time and from time to time, by notice in writing to the company terminate any Directors appointment.

c. any or all powers of the Directors shall be restricted in such respects, to such extent and for such duration as the Controlling Shareholder may by written notice to the company prescribe.

Any such appointment, removal, consent or notice shall be effected by an instrument in writing, signed on behalf of the Controlling shareholder and shall take effect upon receipt at the registered office of the company.

5.2 The Company shall provide the Controlling Shareholder promptly with such other information concerning the Company and its business as the Controlling Shareholder may reasonably require from time to time.

6. Shareholders' reserve power

6.1 The shareholders may, by special resolution, direct the directors to take, or refrain from taking, specified action. No such special resolution invalidates anything which the directors have done before the passing of the resolution.

6.2 No changes can be made to the Standing Financial Instructions without the written consent of the Controlling Shareholder.

7. Directors may delegate

7.1 Subject to the articles, the directors may delegate any of the powers which are conferred on them under the articles—

(a) to such person or committee;

(b) by such means (including by power of attorney);

(c) to such an extent;

(d) in relation to such matters or territories; and

(e) on such terms and conditions;

as they think fit.

7.2 If the directors so specify, any such delegation may authorise further delegation of the directors' powers by any person to whom they are delegated.

7.3 The directors may revoke any delegation in whole or part, or alter its terms and conditions.

8. Committees

8.1 Committees to which the directors delegate any of their powers must follow procedures which are based as far as they are applicable on those provisions of the articles which govern the taking of decisions by directors.

8.2 The directors may make rules of procedure for all or any committees, which prevail over rules derived from the articles if they are not consistent with them.

DECISION-MAKING BY DIRECTORS

9. Directors to take decisions collectively

9.1 The general rule about decision-making by directors is that any decision of the directors must be either a majority decision at a meeting or a decision taken in accordance with article 8.

9.2 If the company only has one director, and no provision of the articles requires it to have more than one director, the general rule does not apply, and the director may, subject to article 20 (for so long as the director remains the sole director) take decisions without regard to any of the provisions of the articles relating to directors' decision-making.

10. Directors' Written Resolutions

10.1 Any Director may propose a written resolution by giving written notice to the other Directors.

10.2 A Directors' written resolution is adopted when all the eligible directors have signed one or more copies of it or otherwise indicated their agreement to it in writing.

11. **Unanimous decisions**

11.1 A decision of the directors is taken in accordance with this article when all eligible directors indicate to each other by any means that they share a common view on a matter.

11.2 References in this article to eligible directors are to directors who would have been entitled to vote on the matter had it been proposed as a resolution at a directors' meeting.

11.3 A decision may not be taken in accordance with this article if the eligible directors would not have formed a quorum at such a meeting.

12. Calling a directors' meeting

12.1 Any director may call a directors' meeting by giving notice of the meeting to the other directors or by authorising the company secretary (if any) to give such notice.

12.2 Notice of any directors' meeting must indicate:

(a) its proposed date and time;

(b) where it is to take place; and

(c) Proposed agenda items

(d) if it is anticipated that directors participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting.

12.3 Notice of a directors' meeting must be given to each director and to the shareholder, but need not be in writing.

12.4 Notice of a directors' meeting need not be given to directors who waive their entitlement to notice of that meeting, by giving notice to that effect to the company not more than 7 days after the date on which the meeting is held. Where such notice is given after the meeting has been held, that does not affect the validity of the meeting, or of any business conducted at it.

13. Participation in directors' meetings

13.1 Subject to the articles, directors participate in a directors' meeting, or part of a directors' meeting, when—

(a) the meeting has been called and takes place in accordance with the articles, and

(b) they can each communicate to the others any information or opinions they have on any particular item of the business of the meeting.

13.2 In determining whether directors are participating in a directors' meeting, it is irrelevant where any director is or how they communicate with each other.

13.3 If all the directors participating in a meeting are not in the same place, they may decide that the meeting is to be treated as taking place wherever any of them is.

14. Quorum for directors' meetings

14.1 At a directors' meeting, unless a quorum is participating, no proposal is to be voted on, except a proposal to call another meeting.

14.2 The quorum for directors' meetings may be fixed from time to time by a decision of the directors, but it must never be less than two, and unless otherwise fixed it is **two**. The **two** must include at least one Executive and one Non-Executive Director.

14.3 If the total number of directors for the time being is less than the quorum required, the directors must not take any decision other than a decision to call a general meeting so as to enable the shareholders to appoint further directors.

15. Chairing of directors' meetings

15.1 The Controlling Shareholder may appoint a Non-Executive Director to chair meetings of the Company Board.

15.2 The person so appointed for the time being is known as the Chairman.

15.3 The Controlling Shareholder may terminate the Chairman's appointment at any time.

15.4 The Chairman shall hold such office for a term of three years from the date of appointment. Upon expiry of the term, the Chairman's appointment will be automatically terminated and the Controlling Shareholder will be required to appoint another Chairman in accordance with 15.1.

If considered appropriate, the controlling Shareholder shall be entitled to reappoint the previous Chairman.

15.5 If the Chairman is not participating in a directors' meeting within ten minutes of the time at which it was to start, the participating directors must appoint one of themselves to chair it.

16. Casting vote

16.1 If the numbers of votes for and against a proposal are equal, the chairman or other director chairing the meeting has the casting vote.

17. Records of decisions to be kept

17.1 The directors must ensure that the company keeps a record, in writing, for at least 10 years from the date of the decision recorded, of every unanimous or majority decision taken by the directors.

18. Directors' discretion to make further rules

18.1 Subject to the articles and the prior written approval of the controlling shareholder, the directors may make any rule which they think fit about how they take decisions, and about how such rules are to be recorded or communicated to directors.

19. Change of Name

The Company may only change its name by the passing of a special resolution of its controlling shareholder.

20. Conflicts of Interest

20.1 If a proposed decision of the directors is concerned with an actual or proposed transaction or arrangement with the company in which a director is interested, that director is not to be counted as participating in the decision-making process for quorum or voting purposes.

20.2 The exceptions to this are as follows:

(a) the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest;

(b) the company by ordinary resolution disapplies the provision of the articles which would otherwise prevent a director from being counted as participating in the decision-making process

(c) the director's conflict of interest arises from a permitted cause.

20.3 For the purposes of this article, the following are permitted causes:

(a) a guarantee given, or to be given, by or to a director in respect of an obligation incurred by or on behalf of the company or any of its subsidiaries;

(b) subscription, or an agreement to subscribe, for shares or other securities of the company or any of its subsidiaries, or to underwrite, sub-underwrite, or guarantee subscription for any such shares or securities; and

(c) arrangements pursuant to which benefits are made available to employees and directors or former employees and directors of the company or any of its subsidiaries which do not provide special benefits for directors or former directors.

20.4 For the purposes of this article, references to proposed decisions and decision-making processes include any directors' meeting or part of a directors' meeting.

20.5 Subject to paragraph 20.6, if a question arises at a meeting of directors or of a committee of directors as to the right of a director to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting, be

referred to the chairman whose ruling in relation to any director other than the chairman is to be final and conclusive.

20.6 If any question as to the right to participate in the meeting (or part of the meeting) should arise in respect of the chairman, the question is to be decided by a decision of the directors at that meeting, for which purpose the chairman is not to be counted as participating in the meeting (or that part of the meeting) for voting or quorum purposes.

APPOINTMENT OF DIRECTORS

21. Methods of appointing directors

21.1 Any person who is willing to act as a director, and is permitted by law to do so, may be appointed to be a director:

(a) by ordinary resolution, or

(b) by a notice given in accordance with 5.1.

(c) the appointment and termination of Directors is the exclusive right of the Controlling shareholder

22. Termination of director's appointment

22.1 A person ceases to be a director as soon as—

(a) that person ceases to be a director by virtue of any provision of the Companies Act 2006 or is prohibited from being a director by law;

(b) a bankruptcy order is made against that person;

(c) a composition is made with that person's creditors generally in satisfaction of that person's debts;

(d) a registered medical practitioner who is treating that person gives a written opinion to the company stating that that person has become physically or mentally incapable of acting as a director and may remain so for more than three months;

(e) notification is received by the company from the director that the director is resigning from office, and such resignation has taken effect in accordance with its terms.

(f) that person is absent from meetings of directors for six months without permission and the controlling Shareholder has resolved that the person should cease to be a Director.

(g) notice of the director's removal is given in accordance with Article 5.1

(h) in the case of a Non-Executive Director employed by the controlling shareholder, such director ceases to be employed by the Controlling Shareholder

22.2 If a director holds an appointment to an executive office which automatically terminates on termination of his office as a Director, his removal from office pursuant to this Article 27 shall be deemed an act of the Company and shall have effect without prejudice to any claim for damages for breach of any contract of service between him and the Company.

23. Directors' remuneration

23.1 Directors may undertake any services for the company that the directors decide.

23.2 Directors are entitled to such remuneration as the Company may determine by ordinary resolution:

(a) for their services to the company as directors, and

(b) for any other service which they undertake for the company.

23.3 Subject to the articles, a director's remuneration may—

(a) take any form, and

(b) include any arrangements in connection with the payment of a pension, allowance or gratuity, or any death, sickness or disability benefits, to or in respect of that director.

23.4 Unless the Company by ordinary resolution decides otherwise, directors' remuneration accrues from day to day.

23.5 Unless the Controlling Shareholder decides otherwise, directors are not accountable to the company for any remuneration which they receive as directors or other officers or employees of the company's subsidiaries or of any other body corporate in which the company is interested.

24. Directors' expenses

24.1 The company may pay any reasonable expenses which the directors and the company secretary properly incur in connection with their attendance at:

(a) meetings of directors or committees of directors,

(b) general meetings, or

(c) or otherwise in connection with the exercise of their powers and the discharge of their responsibilities in relation to the company.

PART 3

SHARES AND DISTRIBUTIONS

SHARES

25. All shares to be fully paid up

25.1 No share is to be issued for less than the aggregate of its nominal value and any premium to be paid to the company in consideration for its issue.

25.2 This does not apply to shares taken on the formation of the company by the subscribers to the Company's memorandum.

26. Powers to issue different classes of share

The directors shall not exercise any power of the Company to allot shares or other securities in, or to grant rights to subscribe for, or convert into, shares or other securities of the Company without the prior written consent of the Controlling Shareholder. Without limitation, the powers of the directors under section 550 of the CA 2006, are limited accordingly.

27. Company not bound by less than absolute interests

Except as required by law, no person is to be recognised by the company as holding any share upon any trust, and except as otherwise required by law or the articles, the company is not in any way to be bound by or recognise any interest in a share other than the holder's absolute ownership of it and all the rights attaching to it.

28. Share certificates

28.1 The company must issue each shareholder, free of charge, with one or more certificates in respect of the shares which that shareholder holds.

28.2 Every certificate must specify—

(a) in respect of how many shares, of what class, it is issued;

(b) the nominal value of those shares;

(c) that the shares are fully paid; and

(d) any distinguishing numbers assigned to them.

28.3 No certificate may be issued in respect of shares of more than one class.

28.4 If more than one person holds a share, only one certificate may be issued in respect of it.

28.5 Certificates must be executed in accordance with the Companies Acts.

29. Replacement share certificates

29.1 If a certificate issued in respect of a shareholder's shares is damaged or defaced, or said to be lost, stolen or destroyed, that shareholder is entitled to be issued with a replacement certificate in respect of the same shares.

29.2 A shareholder exercising the right to be issued with such a replacement certificate:

(a) may at the same time exercise the right to be issued with a single certificate or separate certificates;

(b) must return the certificate which is to be replaced to the company if it is damaged or defaced; and

(c) must comply with such conditions as to evidence and indemnity as the directors decide.

30. Purchase of Own Shares

30.1 Subject to the Act, but without prejudice to any other provision in these Articles, the Company may purchase its own shares with cash up to any amount in a financial year, not exceeding the lower of:

(a) £15,000 and

(b) the value of 5% of the Company's share capital

31. Share transfers

31.1 Shares may be transferred by means of an instrument of transfer in any usual form or any other form approved by the directors, which is executed by or on behalf of the transferor.

31.2 No fee may be charged for registering any instrument of transfer or other document relating to or affecting the title to any share.

31.3 The company may retain any instrument of transfer which is registered.

31.4 The transferor remains the holder of a share until the transferee's name is entered in the register of members as holder of it.

31.5 The directors may, by majority decision, refuse to register the transfer of a share, and if they do so, the instrument of transfer must be returned to the transferee with the notice of refusal unless they suspect that the proposed transfer may be fraudulent.

32. Transmission of shares

32.1 If title to a share passes to a transmittee, the company may only recognise the transmittee as having any title to that share.

32.2 A transmittee who produces such evidence of entitlement to shares as the directors may properly require:

(a) may, subject to the articles, choose either to become the holder of those shares or to have them transferred to another person, and

(b) subject to the articles, and pending any transfer of the shares to another person, has the same rights as the holder had.

32.3 A transmittee does not have the right to attend or vote at a general meeting, or agree to a proposed written resolution, in respect of shares to which it is entitled, by reason of the holder's death or bankruptcy or otherwise, unless they become the holders of those shares.

33. Exercise of transmittees' rights

33. Transmittees who wish to become the holders of shares to which they have become entitled must notify the company in writing of that wish.

33.2 If the transmittee wishes to have a share transferred to another person, the transmittee must execute an instrument of transfer in respect of it.

33.3 Any transfer made or executed under this article is to be treated as if it were made or executed by the person from whom the transmittee has derived rights in respect of the share, and as if the event which gave rise to the transmission had not occurred.

34. Transmittees bound by prior notices

If a notice is given to a shareholder in respect of shares and a transmittee is entitled to those shares, the transmittee is bound by the notice if it was given to the shareholder before the transmittee's name has been entered in the register of members.

DIVIDENDS AND OTHER DISTRIBUTIONS

Procedure for declaring dividends

35.1 The company may by ordinary resolution declare dividends, and the directors may decide to pay interim dividends.

35.2 A dividend must not be declared unless the directors have made a recommendation as to its amount. Such a dividend must not exceed the amount recommended by the directors.

35.3 No dividend may be declared or paid unless it is in accordance with shareholders' respective rights.

35.4 Unless the shareholders' resolution to declare or directors' decision to pay a dividend, or the terms on which shares are issued, specify otherwise, it must be paid by reference to each shareholder's holding of shares on the date of the resolution or decision to declare or pay it.

35.5 The directors may pay at intervals any dividend payable at a fixed rate if it appears to them that the profits available for distribution justify the payment.

35.7 If the directors act in good faith, they do not incur any liability to the holders of shares conferring preferred rights for any loss they may suffer by the lawful payment of an interim dividend on shares with deferred or non-preferred rights.

36. Payment of dividends and other distributions

36.1 Profits available for distribution within the meaning of the CA 2006 shall be apportioned amongst the holders of Ordinary Shares in proportion to the number of shares held.

36.2 Where a dividend or other sum which is a distribution is payable in respect of a share, it must be paid by one or more of the following means:

(a) transfer to a bank or building society account specified by the distribution recipient either in writing or as the directors may otherwise decide;

(b) sending a cheque made payable to the distribution recipient by post to the distribution recipient at the distribution recipient's registered address (if the distribution recipient is a holder of the share), or (in any other case) to an address specified by the distribution recipient either in writing or as the directors may otherwise decide;

(c) any other means of payment as the directors agree with the distribution recipient either in writing or by such other means as the directors decide.

36.3 In the Articles, "the distribution recipient" means, in respect of a share in respect of which a dividend or other sum is payable:

(a) the holder of the share; or

(b) if the share has two or more joint holders, whichever of them is named first in the register of members; or

(c) if the holder is no longer entitled to the share by reason of death or bankruptcy, or otherwise by operation of law, the transmittee.

(d) such other person or persons as the holder may direct.

37. No interest on distributions

37.1 The company may not pay interest on any dividend or other sum payable in respect of a share unless otherwise provided by:

(a) the terms on which the share was issued, or

(b) the provisions of another agreement between the holder of that share and the company.

38. Unclaimed distributions

38.1 All dividends or other sums which are:

(a) payable in respect of shares, and

(b) unclaimed after having been declared or become payable,

may be invested or otherwise made use of by the directors for the benefit of the company until claimed.

38.2 The payment of any such dividend or other sum into a separate account does not make the company a trustee in respect of it.

38.3 If, twelve years have passed from the date on which a dividend or other sum became due for payment, and the distribution recipient has not claimed it, the distribution recipient is no longer entitled to that dividend or other sum and it ceases to remain owing by the company.

39. Non-cash distributions

39.1 Subject to the terms of issue of the share in question, the company may, by ordinary resolution on the recommendation of the directors, decide to pay all or part of a dividend or other distribution payable in respect of a share by transferring non-cash assets of equivalent value (including, without limitation, shares or other securities in any company).

39.2 For the purposes of paying a non-cash distribution, the directors may make whatever arrangements they think fit, including, where any difficulty arises regarding the distribution:

(a) fixing the value of any assets;

(b) paying cash to any distribution recipient on the basis of that value in order to adjust the rights of recipients; and

(c) vesting any assets in trustees.

40. Waiver of distributions

40.1 Distribution recipients may waive their entitlement to a dividend or other distribution payable in respect of a share by giving the company notice in writing to that effect, but if:

(a) the share has more than one holder, or

(b) more than one person is entitled to the share, whether by reason of the death or bankruptcy of one or more joint holders, or otherwise,

the notice is not effective unless it is expressed to be given, and signed, by all the holders or persons otherwise entitled to the share.

CAPITALISATION OF PROFITS

41. Authority to capitalise and appropriation of capitalised sums

41.1 Subject to the articles, the directors may, if they are so authorised by an ordinary resolution:

(a) capitalise any profits of the company (whether or not they are available for distribution) which are not required for paying a preferential dividend, or any sum standing to the credit of the company's share premium account or capital redemption reserve; and

(b) appropriate any sum which they so decide to capitalise (a "capitalised sum") to the persons who would have been entitled to it if it were distributed by way of dividend (the "persons entitled") and in the same proportions.

41.2 Capitalised sums must be applied:

(a) on behalf of the persons entitled, and

(b) in the same proportions as a dividend would have been distributed to them.

41.3 Any capitalised sum may be applied in paying up new shares of a nominal amount equal to the capitalised sum which are then allotted credited as fully paid to the persons entitled or as they may direct.

41.4 A capitalised sum which was appropriated from profits available for distribution may be applied in paying up new debentures of the company which are then allotted credited as fully paid to the persons entitled or as they may direct.

41.5 Subject to the articles the directors may:

(a) apply capitalised sums in accordance with paragraphs 47.3 and 47.4 partly in one way and partly in another;

(b) make such arrangements as they think fit to deal with shares or debentures becoming distributable in fractions under this article (including the issuing of fractional certificates or the making of cash payments); and

(c) authorise any person to enter into an agreement with the company on behalf of all the persons entitled which is binding on them in respect of the allotment of shares and debentures to them under this article.

PART 4

DECISION-MAKING BY SHAREHOLDERS

ORGANISATION OF GENERAL MEETINGS

42. Attendance and speaking at general meetings

42.1 A person is able to exercise the right to speak at a general meeting when that person is in a position to communicate to all those attending the meeting, during the meeting, any information or opinions which that person has on the business of the meeting.

42.2 A person is able to exercise the right to vote at a general meeting when—

(a) that person is able to vote, during the meeting, on resolutions put to the vote at the meeting, and

(b) that person's vote can be taken into account in determining whether or not such resolutions are passed at the same time as the votes of all the other persons attending the meeting.

42.3 The directors may make whatever arrangements they consider appropriate to enable those attending a general meeting to exercise their rights to speak or vote at it.

42.4 In determining attendance at a general meeting, it is immaterial whether any two or more members attending it are in the same place as each other.

42.5 Two or more persons who are not in the same place as each other attend a general meeting if their circumstances are such that if they have (or were to have) rights to speak and vote at that meeting, they are (or would be) able to exercise them.

43. Quorum for general meetings

43.1 No business other than the appointment of the chairman of the meeting is to be transacted at a general meeting if the persons attending it do not constitute a quorum.

43.2 The quorum shall be the Controlling Shareholder present in person, by proxy or by authorised representative.

44. Chairing general meetings

44.1 The chairman shall chair general meetings if present and willing to do so.

44.2 If the chairman is unwilling to chair the meeting or is not present within ten minutes of the time at which a meeting was due to start—

(a) the directors present, or

(b) (if no directors are present), the meeting,

must appoint a director or shareholder to chair the meeting, and the appointment of the chairman of the meeting must be the first business of the meeting.

44.3 The person chairing a meeting in accordance with this article is referred to as "the chairman of the meeting".

45. Attendance and speaking by directors and non-shareholders

45.1 Directors may attend and speak at general meetings, whether or not they are shareholders.

45.2 The chairman of the meeting may chose to permit other persons who are not—

(a) shareholders of the company, or

(b) otherwise entitled to exercise the rights of shareholders in relation to general meetings,

to attend and speak at a general meeting.

46. Adjournment

46.1 If the persons attending a general meeting within half an hour of the time at which the meeting was due to start do not constitute a quorum, or if during a meeting a quorum ceases to be present, the chairman of the meeting must adjourn it.

46.2 The chairman of the meeting may adjourn a general meeting at which a quorum is present if:

(a) the meeting consents to an adjournment, or

(b) it appears to the chairman of the meeting that an adjournment is necessary to protect the safety of any person attending the meeting or ensure that the business of the meeting is conducted in an orderly manner.

46.3 The chairman of the meeting must adjourn a general meeting if directed to do so by the meeting.

46.4 When adjourning a general meeting, the chairman of the meeting must specify the time and place to which it is adjourned or state that it is to continue at a time and place to be fixed by the directors, and

46.5 If the continuation of an adjourned meeting is to take place more than 14 days after it was adjourned, the company must give at least 7 clear days' notice of it (that is, excluding the day of the adjourned meeting and the day on which the notice is given):

(a) to the same persons to whom notice of the company's general meetings is required to be given, and

(b) containing the same information which such notice is required to contain.

46.6 No business may be transacted at an adjourned general meeting which could not properly have been transacted at the meeting if the adjournment had not taken place.

VOTING AT GENERAL MEETINGS

47. Voting: general

47.1 A resolution put to the vote of a general meeting must be decided on a show of hands unless a poll is duly demanded in accordance with the articles.

54. Errors and disputes

48.1 No objection may be raised to the qualification of any person voting at a general meeting except at the meeting or adjourned meeting at which the vote objected to is tendered, and every vote not disallowed at the meeting is valid.

48.2 Any such objection must be referred to the chairman of the meeting, whose decision is final.

49. Poll votes

49.1 A poll on a resolution may be demanded:

(a) in advance of the general meeting where it is to be put to the vote, or

(b) at a general meeting, either before a show of hands on that resolution or immediately after the result of a show of hands on that resolution is declared.

49.2 A poll may be demanded by—

(a) the chairman of the meeting;

(b) the directors; or

(c) two or more persons having the right to vote on the resolution;

49.3 A demand for a poll may be withdrawn if—

(a) the poll has not yet been taken, and

(b) the chairman of the meeting consents to the withdrawal.

49.4 Polls must be taken immediately and in such manner as the chairman of the meeting directs.

50. Content of proxy notices

50.1 Proxies may only validly be appointed by a notice in writing (a "proxy notice") which:

(a) states the name and address of the shareholder appointing the proxy;

(b) identifies the person appointed to be that shareholder's proxy and the general meeting in relation to which that person is appointed;

(c) is signed by or on behalf of the shareholder appointing the proxy, or is authenticated in such manner as the directors may determine; and

(d) is delivered to the company in accordance with the Articles and any instructions contained in the notice of the general meeting.

50.2 The company may require proxy notices to be delivered in a particular form, and may specify different forms for different purposes.

50.3 Proxy notices may specify how the proxy appointed under them is to vote (or that the proxy is to abstain from voting) on one or more resolutions.

50.4 Unless a proxy notice indicates otherwise, it must be treated as:

(a) allowing the person appointed under it as a proxy discretion as to how to vote on any ancillary or procedural resolutions put to the meeting, and

(b) appointing that person as a proxy in relation to any adjournment of the general meeting to which it relates as well as the meeting itself.

51. Delivery of proxy notices

51.1 A person who is entitled to attend, speak or vote (either on a show of hands or on a poll) at a general meeting remains so entitled in respect of that meeting or any adjournment of it, even though a valid proxy notice has been delivered to the company by or on behalf of that person.

51.2 An appointment under a proxy notice may be revoked by delivering to the company a notice in writing given by or on behalf of the person by whom or on whose behalf the proxy notice was given.

51.3 A notice revoking a proxy appointment only takes effect if it is delivered before the start of the meeting or adjourned meeting to which it relates.

51.4 If a proxy notice is not executed by the person appointing the proxy, it must be accompanied by written evidence of the authority of the person who executed it to execute it on the appointor's behalf.

52. Amendments to resolutions

52.1 An ordinary resolution to be proposed at a general meeting may be amended by ordinary resolution if:

(a) notice of the proposed amendment is given to the company in writing by a person entitled to vote at the general meeting at which it is to be proposed not less than 48 hours before the meeting is to take place (or such later time as the chairman of the meeting may determine), and

(b) the proposed amendment does not, in the reasonable opinion of the chairman of the meeting, materially alter the scope of the resolution.

52.2 A special resolution to be proposed at a general meeting may be amended by ordinary resolution, if:

(a) the chairman of the meeting proposes the amendment at the general meeting at which the resolution is to be proposed, and

(b) the amendment does not go beyond what is necessary to correct a grammatical or other non-substantive error in the resolution.

52.3 If the chairman of the meeting, acting in good faith, wrongly decides that an amendment to a resolution is out of order, the chairman's error does not invalidate the vote on that resolution.

PART 5

ADMINISTRATIVE ARRANGEMENTS

53. Means of communication to be used

53.1 Subject to the articles, anything sent or supplied by or to the company under the articles may be sent or supplied in any way in which the Companies Act 2006 provides for documents or information which are authorised or required by any provision of that Act to be sent or supplied by or to the company.

53.2 Subject to the articles, any notice or document to be sent or supplied to a director in connection with the taking of decisions by directors may also be sent or supplied by the means by which that director has asked to be sent or supplied with such notices or documents for the time being.

53.3 A director may agree with the company that notices or documents sent to that director in a particular way are to be deemed to have been received within a specified time of their being sent, and for the specified time to be less than 48 hours.

54. Joint Holders

54.1 Except as otherwise specified in the articles, anything which needs to be agreed or specified by the joint holders of a share shall for all purposes be taken to be agreed or specified by all the joint holders.

54.2 Except as otherwise specified in the Articles, any notice, document or information which is authorised ore required to be sent to joint holders of a share may be sent or supplied to the joint holder whose name stands first in the register of members in respect of the share.

55. Company seals

55.1 Any common seal may only be used by the authority of the directors.

55.2 The directors may decide by what means and in what form any common seal is to be used.

55.3 Unless otherwise decided by the directors, if the company has a common seal and it is affixed to a document, the document must also be signed by at least one authorised person in the presence of a witness who attests the signature.

55.4 For the purposes of this article, an authorised person is:

(a) any director of the company;

(b) the company secretary (if any); or

(c) any person authorised by the directors for the purpose of signing documents to which the common seal is applied.

56. No right to inspect accounts and other records

Except as provided by law or authorised by the directors or an ordinary resolution of the company, no person is entitled to inspect any of the company's accounting or other records or documents merely by virtue of being a shareholder.

57. Provision for employees on cessation of business

The directors may decide to make provision for the benefit of persons employed or formerly employed by the company or any of its subsidiaries (other than a director or former director or shadow director) in connection with the cessation or transfer to any person of the whole or part of the undertaking of the company or that subsidiary.

58. Bank Mandates

The Directors may by majority decision or written resolution authorise such person or persons as they think fit to act as signatories to any bank account of the company and may amend or remove such authorisation from time to time by resolution.

DIRECTORS' INDEMNITY AND INSURANCE

59. Indemnity

59.1 Subject to 65.2, a relevant director of the company may be indemnified out of the company's assets against:

(a) any liability incurred by that director in connection with any negligence, default, breach of duty or breach of trust in relation to the company or an associated company,

(b) any liability incurred by that director in connection with the activities of the company or an associated company in its capacity as a trustee of an occupational pension scheme (as defined in section 235(6) of the Companies Act 2006),

(c) any other liability incurred by that director as an officer of the company or an associated company.

59.2 This article does not authorise any indemnity which would be prohibited or rendered void by any provision of the Companies Acts or by any other provision of law.

59.3 In this article—

(a) companies are associated if one is a subsidiary of the other or both are subsidiaries of the same body corporate, and

(b) a "relevant director" means any director or former director of the company or an associated company.

60. Insurance

60.1 The directors may decide to purchase and maintain insurance, at the expense of the company, for the benefit of any relevant director in respect of any relevant loss.

60.2 In this article:

(a) a “relevant director” means any director or former director of the company or an associated company,

(b) a “relevant loss” means any loss or liability which has been or may be incurred by a relevant director in connection with that director’s duties or powers in relation to the company, any associated company or any pension fund or employees’ share scheme of the company or associated company, and

(c) companies are associated if one is a subsidiary of the other or both are subsidiaries of the same body corporate.