Bolton NHS Foundation Trust – Board Meeting 3 October 2019

Location: Boardroom **Time: 0900 –**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00		Patient Story	CEO	Presentation	To note
09.30	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 25 July 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					
09.40	8.	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
09.50	9.	Audit Committee Chair Report	Audit Chair	Report	Audit Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
10.00	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
10.10	11.	Urgent Care Delivery Board Chair Report –	CEO	Report	To receive a report on the Urgent Care Delivery Board
10.20	12.	Nutrition update	DoN	Report	To note (QA Committee action)
10.30	13.	Performance Report	Chief Executive	Report	To receive

Coffee

11.15	14.	Maternity Services update		Presentation	To receive six monthly assurance update
Strategy					
11.35	15.	Workforce and OD Strategy one year update	Workforce Director	Report	To note
Governance					
11:50	16.	Complaints Report	Director of Nursing	Report	To note
12:00	17.	Revalidation	Medical Director	Report	To approve
12:10	18.	Standing Orders	Trust Secretary	Report	To approve
12:20	19.	Planning for the new format Board Performance Report	COO	Report	To approve
Reports from Sub-Committees (for information)					
	19.	Any other business			
Questions from Members of the Public					
	20.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
	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	25 July 2019	
Venue	Boardroom RBH	
Present:-		
Mrs D Hall	Chair	DW
Dr J Bene	Chief Executive	JB
Mrs T Armstrong-Child	Director of Nursing/Deputy Chief Executive	TAC
Mr A Thornton	Non-Executive Director	AT
Dr F Andrews	Medical Director	FA
Dr M Brown	Non-Executive Director	MB
Mr A Ennis	Chief Operating Officer	
Mrs S Martin	Director of Strategic Transformation	SM
Mr J Mawrey	Director of Workforce	JM
Mr M North	Non-Executive Director	MN
Mr A Stuttard	Non-Executive Director	AS
In attendance: -		
Mrs E Steel	Trust Secretary	ES
Ms R Ganz	Associate NED	RG
Mr A Chilton	Deputy Director of Finance	AC
Apologies	Mrs J Njoroge, Ms B Ismail, Mrs A Walker	

The Chair welcomed attendees and observers

Patient Story

Mrs N attended the Board meeting to share the story of her experiences as an inpatient on the ITU unit and later on E4. Mrs N was admitted to ITU post operatively in November 2018 and spent five days on the unit before being transferred to E4 and finally after approximately eight weeks in total being discharged home. After her discharge from hospital Mrs N continued to receive treatment from community teams.

Mrs N recalled the impact on her and her family, the trauma of the unexpected admission, the psychological impact of losing five days whilst unconscious and the benefit of aftercare support from the outreach team, the support group and the clinical psychologist. However, although this support was very much valued Mrs N expressed regret that a patient diary had not been completed for her as it had been for her late father during his spell on ITU. Referring to her late father's ITU diary, Mrs N advised that she and her mother would have liked the

opportunity to keep this after his death but had been advised that this would not be possible.

Responding to questions, Mrs N advised that care had been outstanding throughout her stay and although her diet was restricted for clinical reasons appropriate supplements had been provided and she could not fault the food.

Resolved: Board members thanked MRs N for sharing her story. The Director of Nursing agreed an action to follow up on the use of ITU diaries.

FT/19/44 TAC to follow up on points raised regarding ITU patient diaries

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 27 June 2019

The minutes of the meetings held on 27 June 2019 were approved as a true and accurate reflection of the meeting subject to a minor change to page 3 to correct a typographical error (change 2018 to 2019)

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.

Board members asked for further information on the actions taken by the Trust to improve ambulance turnaround times; the COO advised that this was achieved through changes to pathways, and changes to the assessment process followed by environmental changes to create a new ambulance bay. The Trust continues to receive more ambulance patients than any other single site in GM and achieves the best ambulance turnaround time in GM.

Board Assurance Framework – Board members noted the updated Board Assurance Framework and the updated actions to reflect the new Learning from Deaths process as outlined in a paper on today's agenda.

Resolved: the board noted the CEO update.

8. **Quality Assurance Committee Chair Report**

Dr Brown presented a summary of the meeting held on 17 July 2019. Board members noted the key items with discussion focused on the experience of mental health patients in the A&E department. The QA Committee had received a report including an analysis of A&E attendances showing that the overall number of patients with a mental health issue and the percentage of patients with a mental health issue had increased over the previous two years; these patients were also on average experiencing longer waits within the department. The QA Committee had discussed this issue and while recognising that this is a national issue it should be escalated to the full Board to ensure all Board members are aware of the impact on patient experience.

Board members discussed local and national actions being taken including actions by the mental health trust to provide more support before patients reach a crisis. It was agreed that a report should be provided to the Board in September2019.

In response to a question linked to the report from the Strategic Transformation Board, the Chair of the Finance and Investment Committee confirmed that system savings were included in reports to the F&I Committee.

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

FT/19/45	Update on care of patients with mental health issues

10. **Finance and Investment Committee Chair Report**

Mr Stuttard, the NED Chair of the Finance and Investment presented his report from the meeting held on 23 July 2019.

The main focus of the meeting had been on the current financial position, as outlined in the written report the Trust is currently reporting an overall shortfall of £2.4m against the plan (£4.3m deficit with PSF taken into account). The main reasons for the shortfall are income under plan, expenditure on pay worse than plan and ICIP off track. Committee members discussed each of the three areas identified – further detail to be provided within the Board update on the financial position.

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 Committee also considered the Capital Programme and noted that in line with national requirements the programme would be reduced by £3.0m through a rephasing of expenditure.

Committee members debated the current BAF risk score and agreed to maintain this at 16, it was recognised that the risk might be increased at the end of Q2 if the position has not improved.

Board members discussed the management of system savings, the main area of underachievement with the full target of £6.0m considered to be at risk. The Chair of the Finance and Investment Committee advised that there is on-going

dialogue with commissioners and GM regarding the financial position.

The Chair of the F&I Committee and Executive members of the Committee confirmed that regular updates are provided on the management of the ICIP programme; divisions have confirmed that they are focused on ICIP plans although it is recognised that additional PMO resource would help achieve delivery of schemes.

Board members agreed that the financial position was a significant concern and further debate would be required to provide assurance on the delivery of ICIPS and the income recovery plan.

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

FT/19/46	Update on income recovery plan

10. Workforce Assurance Committee Chair report

The Chief Executive presented her Chair's reports from the Workforce Assurance Committee meeting held on 19 July 2019. The Committee's main focus was on the WRES and WDES as included on the Board agenda. A presentation on equality and inclusion was delivered by the Trust EDI leads to facilitate debate on the actions needed to address inequalities and promote a strong equitable culture.

The Committee also discussed divisional workforce plans and challenged divisions to ensure plans would achieve the transformational changes needed given the challenges faced by the Trust.

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

11. Urgent Care Delivery Board

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

- The North East Commissioning Support (NECS) shared their approach to the management of capacity and demand.
- Discussion on mental health capacity in A&E, this issue as referred to in the QA Committee Chair report remains a key concern – GMMH advised that work is ongoing to improve response rate to patients in A&E but bed availability remains an issue. In response to a question, the CEO confirmed that patients waiting for a mental health bed are included within the four hour target
- A presentation from the GM clinical assessment service provided some assurance that alternative pathways to avoid A&E have the potential to deliver improvements.

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

12. Mortality Report

The Medical Director presented an update on recent mortality metrics and the ongoing actions to reduce mortality.

RAMI, HSMR and SHMI are all currently higher than expected with deaths from pneumonia a common factor across the three metrics. The Mortality Reduction Group and the Learning from Deaths group actively monitor the statistical measures and use the data to focus on potential areas of concern.

Trained reviewers have reviewed 30 pneumonia cases and have concluded that none of the deaths from pneumonia were more likely to have occurred due to problems with care; this provided assurance and validated an earlier audit of 80 cases with similar findings.

Board members thanked the Medical Director for his detailed report and reflected on the metrics and findings from the review. Board members agreed that they were assured that the correct actions were being taken and agreed with the proposal to continue with the internal review process and to follow this up with a third party review

Resolved: Board members noted the Mortality update.

12.1 Learning from Deaths Quarterly Report

The Medical Director presented the learning from deaths quarterly report and confirmed that the report had been produced in accordance with the guidance to provide data on the total number of deaths and the number of deaths subject to review as assurance that learning points are identified and acted on to continually improve the care we provide to our patients.

Learning points are discussed within the Learning from Death Committee and are then shared within divisional governance meetings for dissemination to all clinical teams.

Board members asked for assurance that the review process was independent; the Medical Director confirmed that the trust has a multidisciplinary team of reviewers who are assigned to cases where they had no involvement in the care. There was a positive response to requests for volunteers to support the process which is supported by the PMO. The process which includes deaths within 30 days of discharge but not all primary care deaths includes robust challenge and debate within the *Learning from Deaths Committee.*

Resolved: Board members thanked the Medical Director for his report and the systematic approach. It was noted that while 85% of reviews show care as adequate or above, there is still work to do with 15% of cases reviewed could have been improved in some way.

13. Cancer Performance

The Chief Operating Officer presented an update on cancer performance and advised Board members that although the Trust has reported consistently good performance against the 62 day cancer target, performance has shown a downward trajectory, the target will not be achieved for June 2019 and there is a

risk of failing the target for Q1.

The paper presented outlined a number of factors impacting on current performance including changes to pathways, earlier diagnosis and increasing demand.

Board members discussed the importance of early diagnosis and treatment and the positive impact of PR schemes. The CEO advised that breast services are included within the GM work on improving specialist care with a decision on the three hub sites expected within the next few months.

Board members asked for assurance that the overall figure was not masking any long waits, the COO advised that no harm has been identified as a result of delays, the cancer tracking team micromanage all patients on the PTL to ensure that pathways are closely monitored.

Resolved: The Board noted the update and confirmed support for the action plan.

14. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

The Director of Workforce presented the WRES and WDES as previously discussed within the Workforce Assurance Committee (WAC)

While some improvement has been made since the last report, it is recognised that further work is still required. Improvements include 40% of increased headcount from a BAME background with an increase in the percentage of BAME staff employed from 11.6% – 12.4%. Engagement scores are strong and there has been a reduction in the likelihood of BAME staff entering the disciplinary process.

Board members discussed the actions taken and agreed that this issue remained a key priority. The Director of Workforce advised that the BME network have adopted a robust process to hold the Trust to account and members were active in sourcing recruitment champions. Board members noted the discrepancy between disability status in ESR data and Staff survey data and asked if there might be a similar issue impacting on ethnicity recording or the reporting or harassment by staff.

Resolved: Board members noted the report, the opportunity to participate in Unconscious bias training in September was welcomed

FT/19/47	JM to check if any data recording issue in relation to staff reporting ethnicity
FT/19/48	JM to identify any trends in demographic of staff reporting harassment

15. Nurse Staffing update

The Director of Nursing presented the Nurse Staffing Report and acknowledged the work of her team in putting together the mandated report including UNIFY fill data and the actions being taken in each division to address unique issues and challenges and ensure that staffing levels are safe and sustainable.

Nurse staffing remains a national challenge however with just over 50 vacancies the Trust compare well to others.

Work is ongoing to understand the Model Hospital Metrics which suggest the Trust is an outlier for the number and cost of nursing staff – it is thought but not confirmed that this may be an interpretation of data.

Board members discussed the report and in particular the correlation between staffing levels and patient safety/experience. The Director of Nursing reminded Board members that in 2013 the Board approved the establishment of staffing levels in accordance with guidance and invested an additional £1.5m to fund this. The aim should be for 100% staffing, the matrons oversee staffing levels on a daily basis to meet activity and acuity but this remains a risk.

Resolved: Board members noted the safe staffing report.

16. 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

The Trust remain over trajectory for c. difficile with 12 cases reported to date against a trajectory of six there is however no evidence of cross contamination

Operational

Performance against the RTT target has deteriorated, this has been discussed with GM and NHSE with actions in place to address and micromanagement of patients with 52 week breaches all of whom have been offered multiple appointments.

Performance against the four hour ED performance remains below the 95% target but has continued to improve and compares favourably to others.

Workforce

The key factors leading to long term sickness absence are back problems and stress, in response to a question about how this reflects the health of the local population, the Director of Workforce confirmed that this question had also been asked in Workforce Assurance Committee and the team were reporting back.

Performance against the agency use target is good.

Use of Resources/Model Hospital – In future this data will be reported through the Finance and Investment Committee, it is recognised that there is work to do on the data.

Ward to Board dashboard - noted with recognition of the continued improvement.

Resolved: the Board noted the integrated performance report

17. Finance Committee Annual Report

The Chair of the F&I Committee presented the Committee's Annual Report, Committee members were thanked for their work in support of the Committee and the leadership of the previous Chair of the F&I Committee was recognised.

In response to a question about the development of business cases for the overall Trust redevelopment the CEO advised that the £100m quoted was a previously estimated amount for a full new build. The Estates Strategy session scheduled for 30th July would provide an update on the future vision for the Trust Estate.

Resolved: the Board noted the Annual Report from the Finance and Investment Committee.

18. Finance Committee Terms of Reference

Resolved: The Board approved the terms of reference for the Finance and Investment Committee.

19 CNST submission approval

The Head of Midwifery and General Manager for Obstetrics attended to seek approval of the CNST submission. It was confirmed that prior to presenting to Board, the submission had been reviewed twice within the Quality Assurance Committee and Clinical Governance Committee and had been subject to scrutiny by the Director of Nursing and the Director of Clinical Governance.

Board members discussed the process for challenge and assurance and agreed that for the next submission review as part of the internal audit plan.

The Director of Nursing confirmed that the team had considered recent information from HENW concerning feedback from trainee doctors and had included narrative to refer to these concerns.

Resolved: Board members approved the submission and welcomed the proposed approach for 2019/20.

20. Any other business

Board members noted that data entry/accuracy was a recurring theme across a number of areas and while accepting that EPR should help, agreed it would be beneficial to revisit the data review previously undertaken by Deloitte LLP and discussing further within the Audit Committee

FT/19/49	Data effectiveness debate and review – September Audit Committee

21. Questions from members of the public

No questions submitted

Date and Time of Next Meeting

29 August 2019

August 2019 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/19/44	25/07/2019	patient story	TAC to follow up on points raised about patient diary for ICU	TAC	Sep-19	verbal update
FT/19/45	25/07/2019	QA Committee	update on care of patients with mental health issues	AE	Sep-19	close and link with FT/19/36 for QA update in October
FT/19/56	29/08/2019	Finance recovery plan	circulate NHSI and JB letter	ES	Sep-19	complete (email 30/08/19)
FT/19/55	29/08/2019	Finance recovery plan	Board to Board with Bolton cabinet	ES	Sep-19	complete - date agreed
FT/19/57	29/08/2019	branding	SM and AW to discuss/agree funding for signage	AW/SM	Sep-19	complete - quotes being obtained
FT/19/41	27/06/2019	Declarations	internal audit to include review of QIA in ICIP review	AW	Oct-19	complete included in internal audit plan
FT/19/54	29/07/2019	Estates Strategy	Invite Bolton Council partners to present their plans to a future Strategic Estates Board	ES	Oct-19	agenda item September 30 SEB
FT/19/47	25/07/2019	WRES/WDES	JM to check if any data recording issue in relation to staff declaring ethnicity	JM	Sep-19	reasonable level of confidence with regard to ethnicity recording on ESR, further work being undertaken to improve disability reporting/recording
FT/19/48	25/07/2019	WRES/WDES	JM to identify any trends in demographic of staff reporting harassment	JM	Sep-19	the 2018 NHS national staff survey identified that 63% of disabled respondents had reported harassment compared to 44.5% non-disabled. Go Engage survey highlighted that staff with disabilities feel less safe reporting a concern under the FTSU process (66% compared to 54%). Monitoring results to determine whether this is a continuing trend. We will also continue to promote the FTSU approach and explore this area further with the new Disabled Workers Forum when it is established.
FT/19/12	28/02/2019	Gender pay gap	include update on actions within Workforce and OD strategy to Board in September	JM	Sep-19	Workforce and OD strategy agenda item
FT/19/29	25/04/2019	ICIP opportunities	future debate about business development opportunities	SM	Sep-19	within Finance recovery update
FT/19/34	30/05/2019	heatmap	review progress by reviewing with an earlier version	TAC	Sep-19	agenda item
FT/19/39	27/06/2019	performance report	next maternity update to include home births, still births and any impact following changes to booking process	TAC	Sep-19	agenda item
FT/19/58	29/08/2019	Making Data Count	Report to October board - timescales and priorities for development of SPC charts in performance report	AE	Oct-19	agenda item
FT/19/53	25/07/2019	BCMS	Full business case to September Board	TAC	Oct-19	deferred to October Board
FT/19/36	27/06/2019	Urgent Care Board	System wide discussion/report on mental health including proactive approach	AE	Oct-19	
FT/19/49	25/07/2019	AoB - Data	Data effectiveness debate and review - Exec discussion and update to September Audit Committee	ES	Oct-19	verbal update followed by written report
FT/19/40	27/06/2019	performance report	Further information for Board members on Model Hospital	AW	Oct-19	development session confirmed
FT/19/55	29/07/2019	Strategy	Update on Estates Vision to October part two Board meeting		Oct-19	

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 - sustainability	update on work of the sustainability group	AE	Dec-19	

Key

complete	agenda item	due	overdue	not due

Agenda Item No:	**7**
Meeting:	Board of Directors
Date:	3 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

July 2019

Hannah Silcock, Physiotherapist, Elective Care Division – for work within her team to improve staff morale

August 2019

Rachel Brennan, Speech and Language Therapist, Integrated Community Services – commitment and dedication to her service

Team of the Month

July 2019

Neonatal Outreach team – for their work in supporting new families

August 2019

IT team for enabling work to introduce a new system in iFM Bolton (alongside current EPR work)

2. News and Developments

2.1 NHSI/NHSE

Baroness Dido Harding, the Chair of NHSI/E visited the Trust on September 12th to open the new Urology unit and meet with the Chair, CEO and members of staff.

Further to discussion at the August Board meeting, the finance recovery plan was approved and submitted to the regulator in line with their request.

2.2 Freedom to speak up month

October is Speak Up Month, - organisations throughout England will be making a special effort to raise awareness of speaking up and their willingness to listen to staff. Staff can sometimes find it difficult to speak up about issues. They may not know who to speak up to and may feel that anything they do raise will not be taken seriously and nothing will be done as a result.

It is important to break down barriers and remove obstacles that prevent or dissuade staff from speaking up. By speaking up, staff can help organisations affect change and embed learning.

Here at Bolton Freedom to Speak Up Guardian Tracey Garde and the Freedom to Speak Up Champions Network will be out and about talking to staff about the need to speak up about anything that may have a negative impact on patients or staff. A video has also been produced to support the awareness of speaking up.

Dr Henrietta Hughes National Guardian will be joining us in Bolton on Tuesday 15 October 2019 4pm-5pm in the Lecture Theatre to talk about the importance of speaking up in the NHS.

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 two serious incidents, both relating to patient care and one retained swab incident (never event)

3.2 **Red Complaints** – Two red complaints have been received, both relate to delays in diagnosis and treatment

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

3.4 **Health and Safety Executive** – The HSE conducted their follow up visit on September 25th, initial feedback the full report will be received by the Health and Safety Committee and reported to Board members through the QA Committee

3.5 Whistleblowing

No concerns to escalate to board

3.6 Information Loss

The Trust has written to the parents of 475 school children to advise that a spread sheet with names, addresses and dates of birth has been misplaced – although it is unlikely that this information has entered the public domain. The loss has been reported to the Information Commissioner's office.

3.7 Media Coverage

Key media coverage in September

Positive

Dementia – two page spread in the Bolton News including work we're doing to make the hospital more dementia friendly, there was also national coverage in the Nursing Times and Daily Express of hospitals (including the Royal Bolton Hospital) using reminiscence rooms, cafes etc.

Opening of Urology Unit – Bolton News and also NHS Executive website

Maternity Conference – Bolton News

Trish Armstrong-Child appointed CEO of Southport and Ormskirk NHS Trust – Bolton News, HSJ and others

Negative

Never events – Bolton News

Increase in waiting lists – Manchester Evening News

Use of Agency Staff – Bolton News

Key social media coverage in September

The Trust's top tweet this month was regarding the work of the Homeless and Vulnerable Adults Team and the work they do with St John Ambulance to provide a mobile treatment unit for homeless people in people. Over 6,000 people saw it on their Twitter feed and we had 328 engagements with the post in the form of likes, re-tweets and replies.

The visit to the Trust by Baroness Dido Harding to the Urology Unit received the next highest engagement, with activity on both the Trust account and the Baroness' account. Tweets from the Maternity Conference were well received, along with promotion of the Trust's strategy, and internal staff awards.

On the Trust's Facebook pages the post which received the highest engagement was a job advert for the Integrated Community Paediatric Service with nearly 6000 views and 776 clicks.

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 is reviewed in detail within the Audit Committee and the Risk Management Committee with a summary provided to the Board on a monthly basis through the CEO report.

Ambition	Lead	I	L		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	
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 Staffing for escalation areas Sickness rates esp within AACD	Recruitment workplan in place overseen through Workforce Assurance Committee Targeted actions to reduce sickness absence	IPM Workforce committee
To use our resources wisely **Financial sustainability**	AW	4	4	16	Delivery of ICIPs In year cost pressures Agency cost pressures (links to workforce) Income/contracting risk Commissioning decisions Transformation funding Cash flow iFM financial performance System wide savings PSF risk	PMO and ICIP escalation meetings IPM framework Integrated Care partnership development Actions to address agency pressures FT cross cutting cost improvement programme and PMO support Develop links with specialist commissioners Development of joint budgets within local system Development of PLICs and improved service line reporting and management iFM development including strategy and business plan System wide savings governance System Savings board	F&I committee Board Workforce assurance committee Contract and Performance Committee IPM Transformation Board ICIP escalation meetings
To make our hospital and our buildings fit for the future					Lack of capital funding Revenue affordability Local road Infrastructure Development of business cases	Links to partner organisations through the Bolton Strategic Estates Group Development of strategic financial plans to include revenue consequences of capital Identification on alternatives to capital funding Development of links to council	Strategic Estates Board
To join up services to improve the health of the people of Bolton					*The Executive team are currently considering the risks to the achievement of these ambitions within the new Strategy.*		
To develop partnerships across Greater Manchester to improve services	JB/SM	4	4	16	Healthier together/Improving Specialist Care	Ongoing discussions with WWL Involvement in theme three work Development of local care partnership	Board F&I

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:	24th September 2019	Date of next meeting:	22nd October 2019
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Andy Ennis, Bilkis Ismail, Annette Walker, Catherine Hulme, Lesley Wallace	Quorate (Yes/No):	Yes
		Key Members not present:	Donna Hall, Jackie Bene, Martin North, Sharon Martin, Andy Chilton

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
Month 5 Finance Report		Director of Finance	The financial position to the end of August 2019 (Month 5), excluding PSF, is a deficit of £7.7m, against a deficit plan of £3.4m, an overall shortfall of £4.3m. Taking PSF into account the deficit is £5.3m which is £3.8m off plan. The main reasons for the shortfall are: • Income shortfall of £1.7m • Expenditure overspend of £2.5m • ICIP off track by £1.5m When compared to the position at Month 4 the overall deficit has worsened by £0.6m. This does represent an improvement in the run rate from the previous month. The report set out a series of forecasts with the main focus being on a best case scenario of a deficit of £8.6m (excluding PSF) giving a variance to the control total plan of £11.3m and a mid case scenario giving a deficit of £13.2m (excluding PSF) with a variance to the control total plan of £16.2m. The best case deficit of £8.6m is the figure that has been incorporated into the Financial Recovery Plan. The Committee considered the various elements of the financial position. With regard to income work is ongoing with the Divisions in terms of reviewing and updating issues relating to coding. The Committee were advised that although activity was up in areas such as A&E the acuity of the case mix was lower. A deep dive is to be undertaken week commencing the 30th September to review the income work to date and	For noting.

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			the outcome will be reported to the Board. The income position is also overseen by a Contract and Performance Review Committee chaired by the Director of Strategic Transformation. With regard to expenditure, pay in August was on plan and variable pay was showing a reduction compared to the previous month. Agency spend was also down when compared to the Trust's internal plan. In terms of the ICIP the main concern remains around the delivery of system savings. The forecast on the Trust's internal savings with the Divisions is that the target of c£9.0m will be delivered. The cash position and Better Payments Practice Code (BPPC) are performing well at the end of Month 5. The Committee has also been focusing on aged debt and aged creditors. The aged debt position, particularly long term debt over 121 days, has worsened slightly and now stands at c£1.84m. However detailed discussions are ongoing with the organisations who owe the highest proportion of this debt and this figure should now start to reduce. The Committee were advised that since the report was produced £275k had been received. A similar process was underway with regard to aged credit where the Trust owes c£2.6m over 121 days. Of note is that there is a strong correlation between the organisations who owe money to the Trust and the organisations who the Trust owes money to. The Use of Resources rating for August is a 3 compared to a plan of 2.	
ICIP Progress Report			The Committee received an update on the delivery of the ICIP. There is a comprehensive range of actions in place to ensure delivery of the Trust's internal ICIP. It was noted that a number of schemes are non-recurrent in nature which would add pressure for next year. It was agreed that an analysis would be provided at the next meeting to quantify the risk. In addition with regard to the system savings a Bolton System Savings Board (BSSB) chaired by the CCG Chief Officer has been set up.	For noting.

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Committee/Group Chair's Report

Bolton System Financial Recovery Plan			The Committee received the joint submission from the Trust and the CCG to NHSI setting out the Financial Recovery Plan. The plan sets out a best case scenario of a deficit of £8.6m compared to a surplus control total of £3.2m resulting in an overall variance to plan of £11.8m. However there is a range of pressures and issues with regard to achieving this outcome. As part of the Recovery Plan, governance arrangements are being put in place both within the Trust and the CCG and jointly between the two organisations. This includes: • CCG and FT weekly executive vacancy panels • Weekly Financial Recovery Oversight Group between CCG and FT • FT divisional accountability and finance escalation meetings • Bolton System Savings Board • Operational support from the CCG and FT PMO It is anticipated that a follow up meeting will take place in early October with NHSI and in addition a meeting has been arranged with GM to discuss the position. It was agreed that the CCG CFO would be invited to the next meeting. The full submission will go to the Board.	For noting.
GM Health and Social Care Partnership Locality Finance Report as at July 2019 – Month 4	**N/A**		The Committee received an update for noting on the overall position across Greater Manchester. The main focus was on those organisations that were off track against plan of which Bolton was the main one although it was only one of two organisations that had originally agreed a surplus control total.	For noting.
Valuation Techniques			The Committee received a report on the valuation of fixed assets with a proposal not to implement the latest RICS guidance. This was agreed by the Committee but the Committee asked that it be referred to the Audit Committee as it had an impact on the accounting treatment which would affect the Annual Accounts.	For decision.

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Committee/Group Chair's Report

iFM Finance Paper			The Committee received an update on the financial position of iFM as at Month 5. Overall iFM had a surplus of £117k at the end of August against a surplus plan of £227k – an adverse variance of £111k. Against a surplus plan of £545k iFM were forecasting a probable outturn of a surplus of £699k which would represent an overachievement of £154k. This position was included in the overall Financial Recovery Plan for the Trust.	For noting.
BCMS Draft Heads of Terms Agreements			The Committee considered the BCMS draft Heads of Terms for the development of the new college. These have been drafted by the Trust's legal representative. The Committee made a couple of comments on the terms relating to underleases and funding structure and tax advice. The draft Heads of Terms would also be considered by the External and Internal Auditors. The Board will in due course need to approve the leases drafted based on the Heads of Terms as part of the Full Business Case approval process.	For comment.
Chair Report from the Digital Transformation Board			The Chief Operating Officer provided an update with regard to the go live of EPR on the 2nd October. This was currently on track with a risk identified to ensure that medical staff were fully trained on the system.	For noting.

Risks escalated

The Committee determined that the previous financial risk of 16 (4x4) should be uplifted to 20 (likelihood 5 x consequence 4). This took into account the financial position submitted in the Financial Recovery Plan and reflected the likelihood that the control total will not be met hence the increase in the score from a 4 to a 5.

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	19 Sept 2019	Date of next meeting:	21 Nov 2019
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	J Njoroge, B Ismail, R Ganz, A Walker, L Wallace, E Steel, Internal Audit, , C Ryan	Quorate (Yes/No):	Yes
		Key Members not present:	M Brown, M North, External Audit

Key Agenda Items:	RAG	Key Points	Action/decision
Internal Audit Reports			
Internal Audit Progress and Follow up Report		Discussed outstanding actions Committee assured that for most recommendations action has been taken to address findings.	Follow up briefings requested on IT and iFM actions that have remained open
Agency Use follow up report (draft)		High risk follow up report – found that although some action had been taken to address previous findings, further evidence needed that improvements have been fully embedded. Although improvements had been made since the previous report, Committee members were concerned that there were three high risk actions still outstanding	Follow up report requested from Director of Workforce.
Serious Incidents and Complaints		Medium risk report – overall clear processes in place for identifying and investigating serious incidents with good practice identified in relation to timeliness of complaints responses and communication between the clinical risk team and divisions however in some cases a more timely response to actions could have been achieved	Report noted
Risk Management Committee Review		Low risk report provided assurance that there is a clear and formalised Risk Management committee structure in place with appropriate reporting and escalation.	Report noted
Income Allocation processes report		Low risk report provided assurance that there is a clear month end timetable in place to meet internal and national reporting deadlines with consistent reconciliations in place for devices and high cost drugs.	Report noted

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Committee/Group Chair's Report

Ward visits – cleaning report (draft)		High risk report received in draft prior to full management response. The audit found that further work is needed on the oversight of cleaning processes	Response requested from iFM Bolton, concerns to be escalated to the QA committee
Security review (draft)		High risk report received in draft prior to full management response. the report identified areas for improvement - a new group security committee has been established	Management response requested for next meeting
IT Projects review		Medium risk report on the project methodology applied to the GP IT project identified a number of areas of good practice with regard to planning, governance. Actions were agreed in regard to contingency planning and resource constraints	Report noted
Local Counter Fraud Specialist Report			
Counter Fraud report		Detailed report on the work of the Local Counter Fraud Specialist	Report noted
Governance			
Waivers			Report noted
Losses			Report noted
Register of Interests			Report noted
Use of the Trust Seal			Report noted
Comments			
Risks Escalated – Cleaning report escalated to QA committee			

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Board of Directors
Date of Meeting:	September, 2019	Date of next meeting:	October, 2019
Chair:	T Armstrong-Child	Parent Committee:	Trust Board
Members present/attendees:	J Mawrey, C Sheard, L Gammack , A Chilton and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	J Bene, F Andrews, E Steel

Key Agenda Items:	RAG	Key Points	Action/decision
Workforce Inclusion		• The Committee received the quarterly Inclusion report. The report included the progress being made on the numerous inclusion work streams. • It was requested that the next report include quantitative data as well as qualitative so that progress can be tracked quarterly to ensure delivery against annual KPI's agreed at Trust Board e.g. WRES/WDES • As the largest employer in Bolton it was pleasing that the Trust has heavily supported Bolton Pride on 21st September.	**Actions agreed:-** • Quantitative data to be included in the next quarterly report so that the Committee can track progress being made against KPI's agreed at 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 note that improvements have been made on effective roster management. • Workforce & OD metrics generally positive with the exception of sickness management. Whilst the Committee took some comfort in Bolton having the second lowest sickness rate in GM (Acute trusts), it remains a concern. Enabling actions were considered further under the Health & Wellbeing Strategy item (later in report)	**Actions agreed:-** • None as the Committee confirmed the report was helpful in considering the key workforce challenges.

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Committee/Group Chair's Report

Staff Health & Wellbeing Strategy		• The Committee commended the report to implement the Staff Health and Wellbeing Strategy 2019-2022 and associated action plan. The strategy aims to:
		  • Create a safe and healthy working environment
		  • Improve physical and mental wellbeing
		  • Empower and support employees to take responsibility for their own health and wellbeing and make healthier lifestyle choices
		  • Support people with manageable health problems or disabilities to maintain access to or regain work
		• The intention is to launch the Staff Health and Wellbeing Strategy on 10th October 2019 to mark World Mental Health Day.
			Actions agreed:-
			• The Committee fully supported the action plan and requested quarterly updates.
			• Whilst the Strategy noted a number of KPI's, it was confirmed that the high level KPI remains the delivery of lower sickness absence rates.
			• Given the importance of this subject matter then it was suggested that consideration should be given to a full Board paper being presented

Go engage and Readiness for NHS Staff Survey		• The Trust's Q2 survey results continue to perform strongly compared to other Trusts that use Go Engage. The Trust achieved an overall engagement score of 7.60 which has slightly reduced from Q1 which was 7.70. This latest engagement score remains higher than what the Trust achieved in the 2018 NHS national staff survey (7.40). • The NHS national staff survey will open on 23rd September 2019 and run until 29th November 2019. 1250 staff across the Trust will be invited to take part in the survey. • The Trust will receive its' full management report week commencing 27th January 2020. Our results will be embargoed until the end of February 2020.	**Actions agreed:-** • Verbal update be provided at the next meeting on the response rate for the NHS Staff Survey at both Trust & Divisional level

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Committee/Group Chair's Report

Freedom to Speak Up Report		• The Trust received a very helpful report from the FTSU Guardian. It was noted that 17 cases had been raised via the FTSU rate for Quarter 1. Of note the majority of these cases were already in HR process. • Monthly meetings remain in place with the FTSU Guardian, Chief executive and Director of Workforce to ensure actions are taken in a timely manner. • The National FTSU Guardian will be visiting the Trust in October	**Actions agreed:-** • Report noted
Guardian of Safeworking (GOSW) report		• The Committee were disappointed to receive another poor report from the GOSW. • The report noted that three departments had not submitted returns and where escalations had been raised there was little evidence that the matters had been resolved. • As sufficient resources were being provided by the Trust, it was agreed the need to bring back an update on the remedial actions that will be taken.	**Actions agreed:-** • Medical Director bring back to the next Committee an update on the remedial actions that will be taken.
Obstetrics & Gynaecology Trainees Action Plan		• The Committee received little assurance 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) and Trust Board in November.	**Actions agreed:-** • Divisional Medical Director to urgently review the action plan. Update to be provided to the Executive team in two weeks, along with follow up to the October Committee (in advance of submission to HEE and Trust Board).
Terms of Reference		• Amendments made to membership and sub-committee reporting arrangements	
Equality & Diversity Group		• The Chairs report was noted	**Actions agreed:-** Paper noted
Staff Engagement Group		• The Chairs report was noted	**Actions agreed:-** Paper noted

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Committee/Group Chair's Report

Staff Health & Wellbeing Group		• The Chairs report was noted	**Actions agreed:-** • Paper noted
Education Governance Group		• The Chairs report was noted	**Actions agreed:-** • Paper noted
Risks escalated None – matters being managed within Committee (GOSW report and Obstetrics & Gynaecology) **Recommendations** Staff Health & Wellbeing Strategy - Given the importance of this subject matter then it was suggested that consideration should be given to a full Board paper being presented.			

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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:	10th September 2019	Date of next meeting:	8th October 2019
Chair:	Su Long	Parent Committee:	Board of Directors
Members Present:	All System representatives present	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Terms of reference annual review	Green	SL	Revised terms of reference were agreed	• Noted
A&E patient survey results	Amber	Nicola Onley	Patient survey had been undertaken in A&E over 2 weeks (including evenings and weekends) 227 responses recorded 49% attended for injury 40% considered A&E to be the most appropriate place	• Findings noted • Continue with public engagement agenda
Demand and Capacity Review	Amber	NECS	First draft of the report was provided by NECS A number of points were raised and inaccuracies highlighted.	• Report noted • Feedback to be provided to NECS to resolve some of the questions raised
Comments Review of dashboard undertaken.				
Risks escalated **None**				

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Agenda Item No:	**12**
Meeting:	Board of Directors
Date:	September 2019

NHS Bolton NHS Foundation Trust

Title:	Nasogastric tube (NGT) misplacement
Purpose	The purpose of this paper is to provide the an update on the Trust position on training for medical and nursing staff in relation to Nasogastric tube placement in line with NPSA Alert NHS/PSA/RE/2016/006
Executive Summary:	This briefing paper provides the background to the NHS England and NHS Improvement letter of 21st April 2017 in relation to Nasogastric tube misplacement:(NHS/PSA/RE/2016/006) which was signed off at Trust Board Through our monitoring and governance structures it has highlighted that challenges have been identified in ensuring the mitigations that were put in place at the time to ensure compliance, are sustainable. The on-going actions to address this are included in this report
Previously considered by:	The matter has been discussed extensively at Clinical Governance & Quality Committee since December 2018 and Quality Assurance Committee (re action QA/19/25)
Recommendation Please state if approval required or if for information	To update the Board of Directors

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:	Various contributors (see end of document)	**Presented by:**	Trish Armstrong-Child, Director of Nursing and Deputy CEO & Dr Francis Andrews Medical Director

Situation

In April 2017 NHSI wrote to health care providers (Appendix 1) to articulate, following a HM Coroner's Inquest, their expectation that Trust Boards would take an active interest in overseeing compliance with the 2016 issued alert (Appendix 2)

Background

In July 2016, NHS Improvement issued a Patient Safety Alert (PSA) in relation to Nasogastric tube misplacement: continuing risk of death and severe harm (Appendix 2). The actions identified in the alert were applicable to all organisations where nasogastric or orogastric tubes are used for patients receiving NHS-funded care. Actions identified were:

1. Identify a named executive director* who will take responsibility for the delivery of the actions required in this alert.
2. Undertake a centrally coordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.

The deadline for completion of the above actions was 21st April 2017.

On 21st April 2017 (also the deadline for the alert), NHS England and NHS Improvement issued a joint 'Prevention of Future Deaths' letter further highlighting the dangers associated with nasogastric tube feeding following a Coroner's report in the death of two patients (not at Bolton NHS FT Trust).

The Trust signed off compliance with the alert (Appendix 2) within stipulated timescales, however a review of safeguards designed to reduce the likelihood of the occurrence of Never Events (including NG tube misplacement followed by feeding) identified some weaknesses.

An updated action plan was presented to Clinical Governance & Quality Committee - December 2018 which covered actions related to Nursing and Medical training including the following:

- Medical staff (FY/CMT doctors) have received dedicated teaching sessions (4 in total) on x-ray interpretation of position of NG tube and this will be repeated annually.
- Development of an e-learning module for x-ray interpretation of tube placement which can be completed as part of all FY/CMT induction is in progress.
- Competency training of nursing staff on insertion and maintenance of NG tubes includes plans to competency assess any new staff prior to allowing them to proceed with insertion and maintenance of NG tubes.
- Existing nursing staff – there will be a self-assessment against guideline and criteria of competency that all staff involved will undertake. If they are unable to proceed to self-assessment, then they will be offered training and competency assessment.

Assessment

Whilst considerable efforts and actions have been undertaken to ensure full compliance with the alert actions can be evidenced, it is clear that some aspects of the work remain on-going – this particularly applies to the training of all relevant medical staff.

Recommendations

1. For the Clinical Governance & Quality Committee to receive a detailed report outlining the completion of audits that demonstrates full compliance with the expectations of the correspondence from NHSI (Appendix 1) and original alert (Appendix 2) via the Nutrition Steering Group – Deadline 31st March 2020

2. For the Clinical Risk Manager/Director of Quality Governance to be invited to join the Nutrition Steering Group for challenge and scrutiny purposes and convey the expectations outlined in action 1. – Deadline 30th September

3. For the Clinical Governance & Quality Committee to provide assurance to the Quality Assurance Committee that Action 1 has been completed - Deadline April 2020 Quality Assurance Committee

Contributors:

- Nashaba Ellahi – Assistant Director of Nursing
- Sue Ellis – Nutrition Specialist Nurse
- Emily Harrison – Clinical Risk Manager
- Richard Sachs – Director of Quality Governance
- Dr Sal Singh – Consultant

NHS England & NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

21st April 2017

Dear Chief Executive, Medical and Nursing Directors,

Prevention of future deaths: Nasogastric Tubes Patient Safety Alert

A recent Coroner's report on the death of two patients has highlighted the dangers of nasogastric (feeding) tubes. In both cases the tubes were inserted into the lung - not the stomach as intended - and safety checks to confirm tube placement were misread. Approximately 800,000 nasogastric tubes are used in the NHS each year. Fatalities are rare, but there have been 100 incidents and 32 deaths in England over the last 5 years.

A national NHS Improvement Patient Safety Alert (NHS/PSA/RE/2016/006) [1] is due for completion 21st April 2017. It asks senior members of Trust Boards, typically the medical and nurse directors or CEO, to take a personal interest in nasogastric tube safety. Key to this is ensuring systematic training for medical and nursing staff of all grades who are required to confirm nasogastric tube placement. It is also vital to ensure all staff, particularly at induction, are aware that they should not be undertaking confirmation of nasogastric placement until they have completed such training. Over and above a plan, safety processes and Trust culture should support every doctor and nurse to confidently manage nasogastric tube safety, even in the early hours on a busy acute ward, mental health unit, or community service.

Analysis of incidents shows two major concerns:

1. **Misinterpreted X-Rays**: more than half of all fatal cases reviewed related to misinterpretation of X-rays, or in some cases failure to review the most up-to-date x-ray and predominately involved doctors (of all grades). Causes typically included lack of training in the 'four criteria[2]' technique

[1] NHS Improvement Patient Safety Alert *'Nasogastric tube misplacement: continuing risk of death and severe harm'* https://improvement.nhs.uk/news-alerts/nasogastric-tube-misplacement-continuing-risk-of-death-severe-harm/ issued via the Central Alerting System July 2016

[2] NHS Improvement *'Resource Set: Initial placement checks for nasogastric and orogastric tubes'* https://improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes/ published July 2016.

2. **Misinterpreted pH testing**: misinterpreted pH tests, predominately carried out by nurses (of all grades) accounted for about a third of cases. Causes typically included a lack of training or gaps in the content of training.

Trusts can find more information and staff support in the resource set[2] with the Alert provided by NHS Improvement, but in summary:

- Embed competency based **training** for all doctors and nurses of all grades who are required to check nasogastric tube
- Ensure all staff who have not received this training understand they should not be undertaking these checks
- Improve **X-ray interpretation** by using the '**four criteria'**
- Better bedside documentation formats to embed safe checking processes
- Clarifying communication to **radiographers** and from **radiologists**
- Improved **pH test interpretation** using CE pH strips marked for human gastric aspiration
- Avoiding **outdated methods** for safety checks, NEVER use the Whoosh or Bubble test
- **Buying safe equipment;** such as fully radio-opaque NG tubes with clear external length markings.

We hope you will support us to ensure every Trust complies with the Alert action to ensure the NHS does all it can to prevent future patient deaths due to misplaced nasogastric tubes. Together we can make the NHS the safest healthcare system in the world.

Yours sincerely,

Professor Sir Bruce Keogh
National Medical Director
NHS England

Professor Jane Cummings
Chief Nursing Officer England
NHS England

Dr Kathy McLean
Executive Medical Director
NHS Improvement

Ruth May
Executive Director of Nursing
& Deputy Chief Nursing Officer
NHS Improvement

NHS Improvement

Patient Safety Alert

Nasogastric tube misplacement: continuing risk of death and severe harm

22 July 2016

Alert reference number: NHS/PSA/RE/2016/006

Alert stage: Two - Resources

Use of misplaced nasogastric and orogastric tubes[1] was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005[2] and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.[3-5] Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers.'[6]

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period,[7] these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Examination of these incident reports by NHS Improvement clinical reviewers shows that misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement checking methods, and communication failures resulting in tubes not being checked. The reports included 32 incidents where the patient subsequently died, although given many patients were critically ill before the tube was introduced, it is not always clear whether the death was directly related to the misplaced tube.

Review of local investigations into these incidents suggests problems with organisational processes for implementing previous alerts. This Patient Safety Alert is therefore directed **at trust boards** (or their equivalent in other providers of NHS funded care) and the processes that support clinical governance. It is NOT directed at frontline staff. Some of the implementation issues identified were:

- problems with systems to ensure staff who were checking tube placement had received competency-based training
- problems with ensuring bedside documentation formats include all safety-critical checks
- problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips.

The resource set that accompanies this alert provides a range of support for trust boards (or their equivalents) to assess whether previous nasogastric tube guidance has been implemented and embedded within their organisations improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes. It includes briefings to help non-executives and governors to understand the issues, summaries of safety-critical requirements of past alerts, self-assessment/assurance checklists, and learning from reported incidents.

Actions

Who: All organisations where nasogastric or orogastric tubes are used for patients receiving NHS-funded care

When: To commence as soon as possible and to be completed by 21 April 2017

1. Identify a named executive director* who will take responsibility for the delivery of the actions required in this alert.
2. Using the resources supplied with this alert, undertake a centrally co-ordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.**

* For organisations that are not trusts/foundation trusts and do not have executive directors, a role with equivalent senior responsibility should be identified.

**For organisations without a board, an equivalent publically available alternative to a board paper should be identified eg a report on a public-facing website.

See page 2 for references

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Resources

Patient safety incident reporting

For detail of dates and search strategy within the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) see page x of the supporting *initial placement checks for nasogastric and orogastric tubes resource set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

References

1. Hanna G, Phillips, L, Priest O & Zhifang N (201) Improving the safety of nasogastric feeding tube insertion A report for the NHS Patient Safety Research Portfolio July 2010 www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS048ImprovingthesafetyofnasogastricfeedingtubeinsertionREVISEDHannaetal.pdf
2. National Patient Safety Agency - Reducing the harm caused by misplaced nasogastric feeding tubes 2005 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59794&p=4
3. National Patient Safety Agency Patient Safety Alert: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants 2011 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=129640
4. National Patient Safety Agency Rapid Response Report: Harm from flushing of nasogastric tubes before confirmation of placement 2012 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=133441
5. NHS England Patient Safety Alert: Stage 1 - Placement devices for nasogastric tube placement DO NOT replace initial placement checks 2013 www.england.nhs.uk/wp-content/uploads/2013/12/psa-ng-tube.pdf
6. NHS England Never Events Policy and Framework 2015 www.england.nhs.uk/patientsafety/never-events/
7. Page 9 of the supporting *initial placement checks for nasogastric and orogastric tubes resouirce set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

Stakeholder engagement

- Medical Specialities Patient Safety Expert Group
- Children and Young People's Patient Safety Expert Group
- Surgical Services Patient Safety Expert Group
- Patient Safety Steering Group

For details of the membership of the NHS Improvement patient safety expert groups and steering group see www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/

Integrated Summary Dashboard - August 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		
Use of Resources & 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

Bolton NHS Foundation Trust

Quality and Safety

Harm Free Care

Pressure Ulcers
The number of patients developing pressure ulcers in the hospital and the community has remained under trajectory in August, with 3 Category 2 pressure ulcers developing in the hospital, and in the community 5 Category 2 pressure ulcers and 3 Category 3 pressure ulcers being identified. The number of pressure ulcers developing following a lapse in care has also remained under trajectory, with only 2; 1 in the hospital and 1 in the community for the month of August.

Falls
Inpatient falls in August have increased above local target but remains below national benchmark. Falls cquin quarter 2, compliance improved to 43%.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
6 - Compliance with preventative measure for VTE	>= 95%	97.4%	Aug-19			>= 95%	97.3%	Jul-19		>= 95%	97.1%		95.5 - 97.8%	
9 - Never Events	= 0	0	Aug-19			= 0	0	Jul-19		= 0	0		0 - 1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	6.19	Aug-19			<= 5.30	4.91	Jul-19		<= 5.30	5.40		3.60 - 6.19	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	2	Aug-19			<= 1.6	2	Jul-19		<= 8.0	7		0 - 5	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	3.0	Aug-19			<= 6.0	1.0	Jul-19		<= 30.0	26.0		1.0 - 8.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Aug-19			<= 0.5	0.0	Jul-19		<= 2.5	0.0		0.0 - 2.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Aug-19			= 0.0	0.0	Jul-19		= 0.0	0.0		0.0 - 0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	5.0	Aug-19			<= 7.0	5.0	Jul-19		<= 35.0	37.0		2.0 - 12.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	3.0	Aug-19			<= 4.0	0.0	Jul-19		<= 20.0	14.0		0.0 - 8.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Aug-19			<= 1.0	0.0	Jul-19		<= 5.0	1.0		0.0 - 2.0	

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

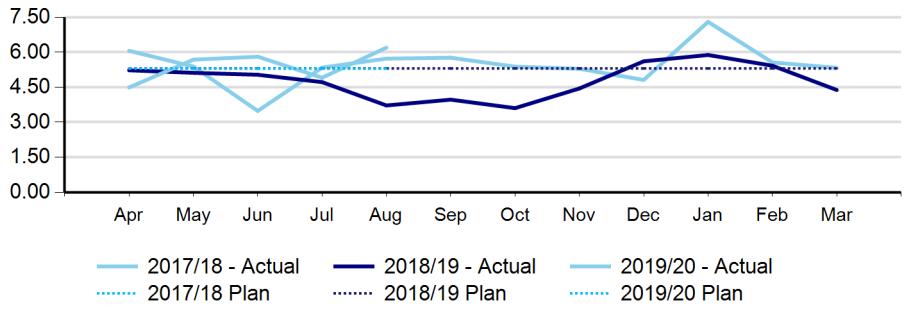
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
21 - Total Pressure Damage due to lapses in care	<= 6	2	Aug-19			<= 6	0	Jul-19		<= 28	15		0 - 8	
28 - Emergency patients screened for Sepsis (quarterly)	>= 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%	80.0%	Aug-19			>= 80%	75.2%	Jul-19		>= 80%	78.6%		75.2 - 80.9%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	72.2%	Aug-19			>= 72.5%	70.9%	Jul-19		>= 72.5%	59.8%		50.1 - 79.3%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	100.0%	Aug-19			= 100%	100.0%	Jul-19		= 100%	90.8%		33.3 - 100.0%	
88 - KPI Audits linked to Bolton System of Accreditation (BOSCA)	>= 85%	92.2%	Aug-19			>= 85%	91.7%	Jul-19		>= 85%	92.5%		91.7 - 94.0%	
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	100.0%	Aug-19			= 100%	100.0%	Jul-19		= 100%	114.3%		0.0 - 100.0%	

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

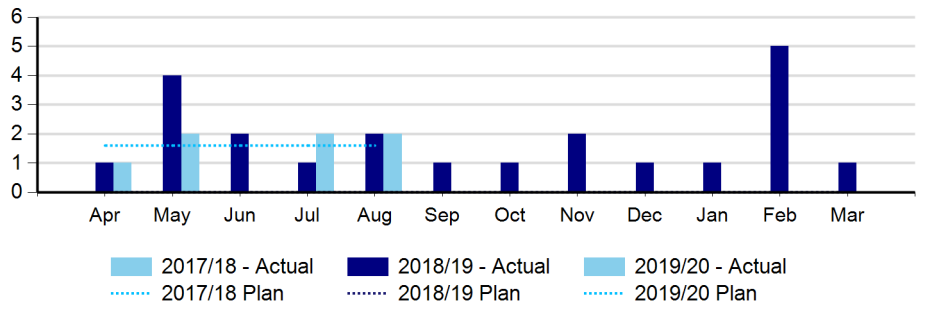
Exceptions

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



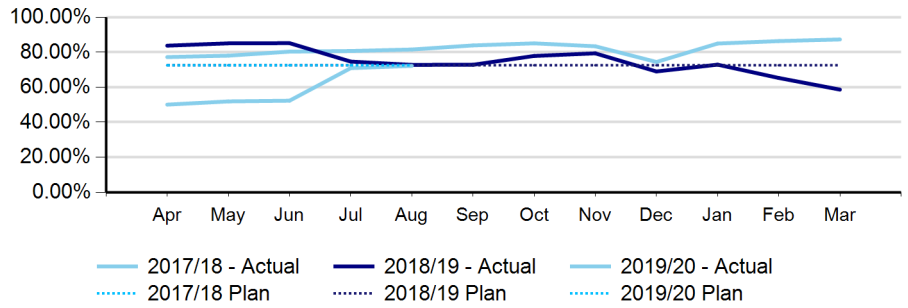
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6.06	5.38	3.48	5.34	5.72	5.76	5.38	5.29	4.81	7.30	5.56	5.33
18/19	5.22	5.11	5.03	4.72	3.72	3.97	3.60	4.45	5.61	5.88	5.42	4.38
19/20	4.49	5.68	5.80	4.91	6.19							

14 - Inpatient falls resulting in Harm (Moderate +)



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

31 - Clinical Correspondence - Outpatients %<5 working days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	77.2%	78.0%	80.3%	80.7%	81.5%	83.8%	85.0%	83.4%	74.4%	84.9%	86.3%	87.2%
18/19	83.7%	85.0%	85.1%	74.6%	72.7%	72.8%	77.8%	79.3%	69.0%	72.9%	65.3%	58.6%
19/20	50.1%	51.9%	52.3%	70.9%	72.2%							

NHS Bolton NHS Foundation Trust

Infection Prevention and Control

There has been a sustained increase in the number of C. Difficile cases. In line with our processes a 'Period of Increased Incidents' (PII) meeting has convened to review these cases. This is chaired by the DIPC and there is currently focus and scrutiny around all our clinical environments and cleaning standards. A full action plan is in place and formal updates provided to the Executive Directors meeting. A full deep cleaning programme has been implemented

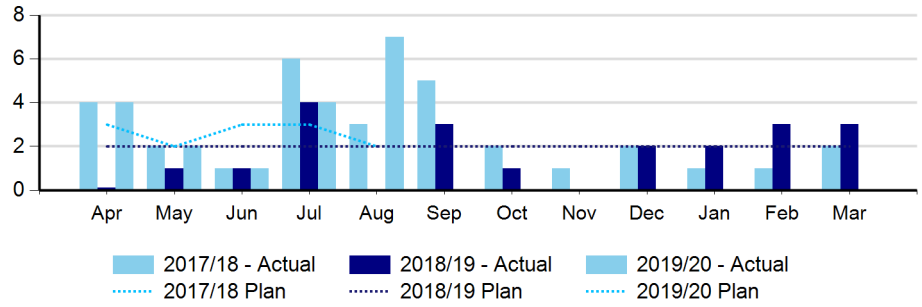
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
215 - Total Hospital Onset C.diff infections	<= 2	7	Aug-19			<= 3	4	Jul-19		<= 13	18		0 - 7	
346 - Total Community Onset Hospital Associated C.diff infections	<= 1	5	Aug-19			<= 1	3	Jul-19		<= 5	19		1 - 7	
347 - Total C.diff infections contributing to objective	<= 3	12	Aug-19			<= 3	7	Jul-19		<= 13	31		2 - 12	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Aug-19			= 0	1	Jul-19		= 0	1		0 - 1	
218 - Total Trust apportioned E. coli BSI	<= 4	4	Aug-19			<= 4	1	Jul-19		<= 20	15		0 - 7	
219 - Blood Culture Contaminants (rate)	<= 3%	4.5%	Aug-19			<= 3%	4.5%	Jul-19		<= 3%	4.0%		2.8 - 6.8%	
199 - Compliance with antibiotic prescribing standards	>= 95%	85.2%	Q3 2018/19			>= 95%	86.0%	Q1 2018/19		>= 95%			85.2 - 85.2%	
304 - Total Trust apportioned MSSA BSIs	<= 1.3	0.0	Aug-19			<= 1.3	1.0	Jul-19		<= 6.5	2.0		0.0 - 4.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	= 0	1	Aug-19			<= 1	3	Jul-19		<= 4	5		0 - 3	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	= 0	0	Aug-19			= 0	1	Jul-19		<= 1	1		0 - 1	

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

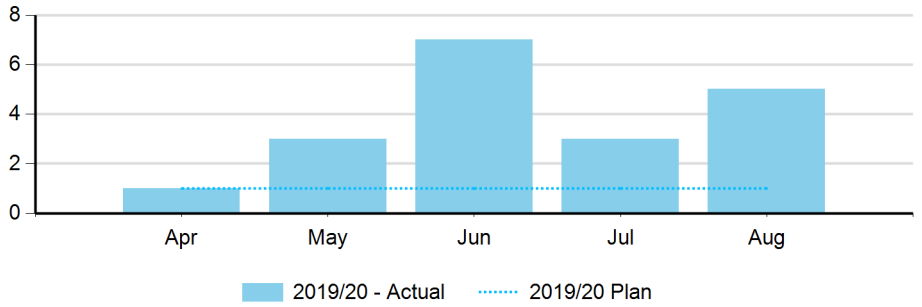
Exceptions

215 - Total Hospital Onset C.diff infections



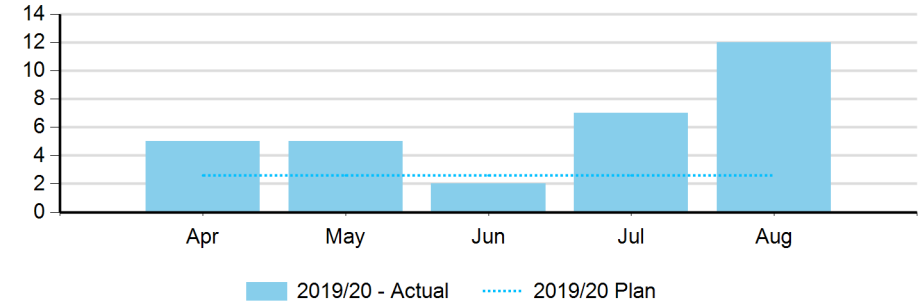
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4	2	1	6	3	5	2	1	2	1	1	2
18/19	0	1	1	4	0	3	1	0	2	2	3	3
19/20	4	2	1	4	7							

346 - Total Community Onset Hospital Associated C.diff infections



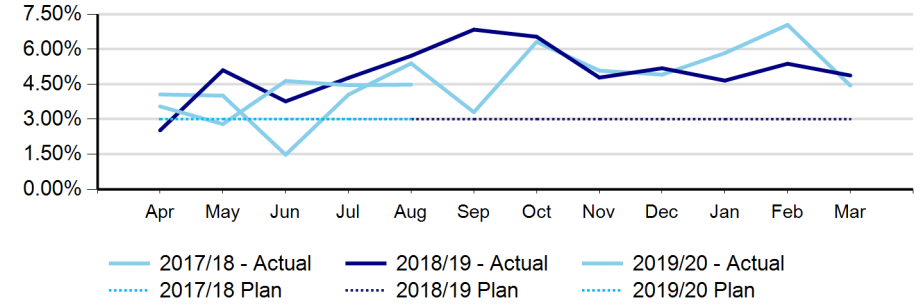
	Apr	May	Jun	Jul	Aug
19/20	1	3	7	3	5

347 - Total C.diff infections contributing to objective



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

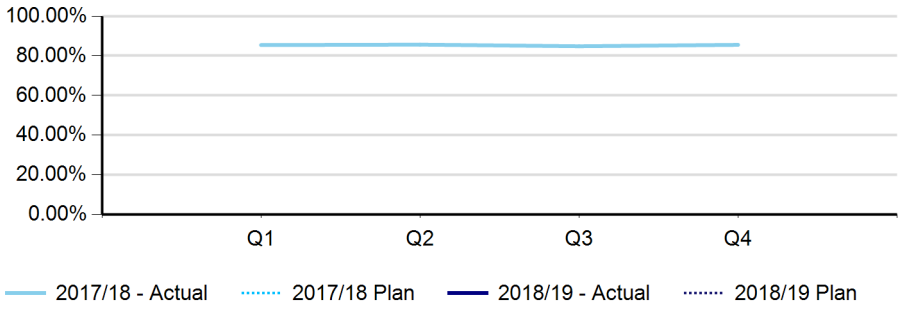
219 - Blood Culture Contaminants (rate)



	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%							

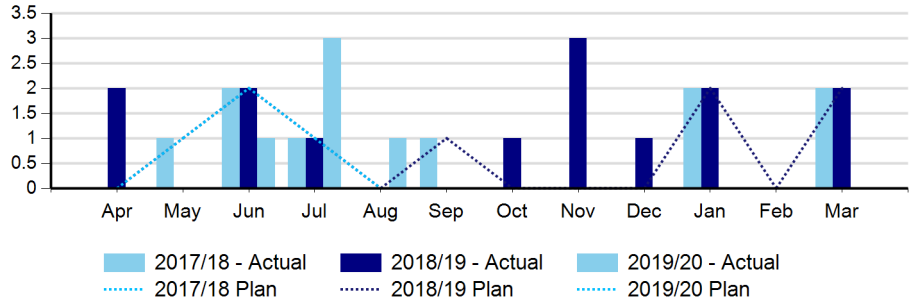
Bolton NHS Foundation Trust

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%	

305 - Total Trust apportioned Klebsiella spp. BSIs



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

Bolton NHS Foundation Trust

Mortality

The SHMI data reported here is for January – December 2018, NHS Digital have published SHMI from April 2018 to March 2019 as 116.00, this is a reduction, however, it is still significantly higher than the national average. It is hoped a further reduction will occur in the next period.

The mortality board continue to monitor certain disease groups, also highlighting disease groups that are alerting and report disease groups that are close to alerting in the future.

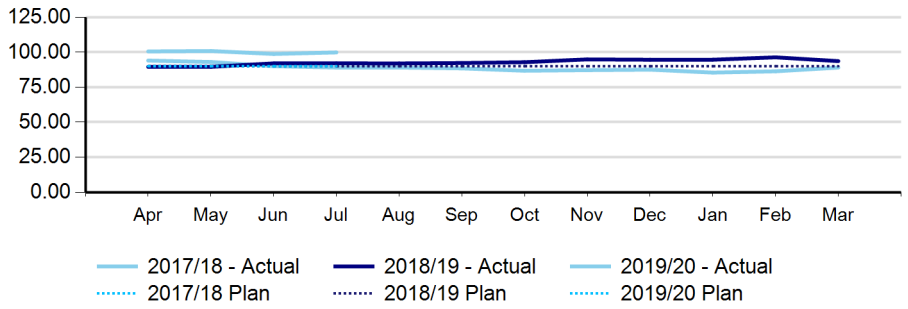
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Aug-19			>= 85%	100.0%	Jul-19		>= 85%	95.7%		85.1 - 100.0%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	99.8	Jul-19			<= 90	98.7	Jun-19		<= 90	99.8		92.0 - 100.8	
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.00	119.00	Q3 2018/19			<= 100.00	113.85	Q2 2018/19		<= 100.00			119.00 - 119.00	
12 - Crude Mortality %	<= 2.9%	2.0%	Aug-19			<= 2.9%	1.7%	Jul-19		<= 2.9%	1.9%		1.7 - 2.7%	

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

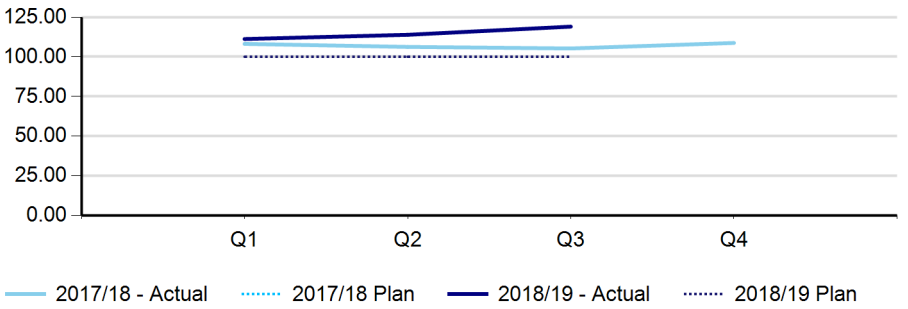
Exceptions

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	99.8								

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	

NHS Bolton NHS Foundation Trust

Patient Experience

Overall the performance for August remains strong for the Trust's patient experience metrics.

	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%	23.4%	Aug-19		↑	>= 20%	19.4%	Jul-19		>= 20%	18.5%		15.1 - 23.4%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	92.3%	Aug-19		↑	>= 90%	90.8%	Jul-19		>= 90%	91.4%		88.9 - 92.3%	
80 - Inpatient Friends and Family Response Rate	>= 30%	28.6%	Aug-19		↓	>= 30%	31.7%	Jul-19		>= 30%	29.6%		25.7 - 32.7%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	96.6%	Aug-19		↑	>= 90%	96.1%	Jul-19		>= 90%	96.8%		95.8 - 97.9%	
81 - Maternity Friends and Family Response Rate	>= 15%	36.6%	Aug-19		↑	>= 15%	30.5%	Jul-19		>= 15%	32.0%		25.0 - 43.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	96.0%	Aug-19		↓	>= 90%	96.5%	Jul-19		>= 90%	95.9%		92.4 - 97.3%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	23.5%	Aug-19		↑	>= 15%	20.7%	Jul-19		>= 15%	22.6%		7.3 - 43.4%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	96.7%	Aug-19		↓	>= 90%	100.0%	Jul-19		>= 90%	98.6%		95.9 - 100.0%	
83 - Birth - Friends and Family Response Rate	>= 15%	28.1%	Aug-19		↓	>= 15%	39.3%	Jul-19		>= 15%	34.5%		26.1 - 50.2%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	91.5%	Aug-19		↓	>= 90%	95.8%	Jul-19		>= 90%	93.2%		88.7 - 97.6%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	58.0%	Aug-19		↑	>= 15%	25.1%	Jul-19		>= 15%	34.7%		17.7 - 58.0%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	96.7%	Aug-19		↑	>= 90%	91.1%	Jul-19		>= 90%	93.9%		88.1 - 96.7%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	44.6%	Aug-19		↑	>= 15%	37.0%	Jul-19		>= 15%	39.2%		28.8 - 75.1%	

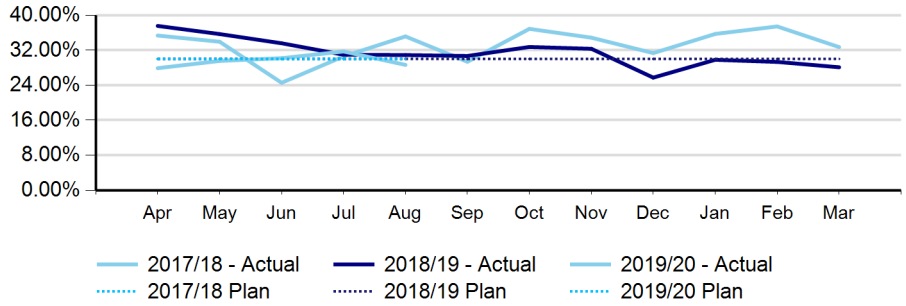
Integrated Summary Dashboard - August 2019

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
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	98.3%	Aug-19			>= 90%	98.2%	Jul-19		>= 90%	98.4%		93.2 - 99.5%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Aug-19			= 100%	100.0%	Jul-19		= 100%	100.0%		100.0 - 100.0%	
90 - Complaints responded to within the period	>= 95%	95.7%	Aug-19			>= 95%	97.1%	Jul-19		>= 95%	97.5%		88.5 - 100.0%	

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%							

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

Maternity

There were 2 stillbirths in August. Both cases have been presented at the Maternity Risk meeting. Stillbirth data shows no statistical concern.

Booking by 12+6; unfortunately we just missed the 90% target in August and achieved 89.13%.

Improved performance of all C/Section births at 26.24% (YTD average is 29.23%).

3rd and 4th degree tears improved in month to 2.25%.

Breast feeding and smoking at time of delivery continues to perform well within target.

Percentage of all births on Beehive MLU still continues to improve on month. Currently at 8.58% but still off the target of 13%.

Pre-term birth is for information only as this is a national QI improvement piece of work. We are being supported by GM LMS along with the other maternity providers.

	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	4.13	Aug-19			<= 3.50	0.00	Jul-19		<= 3.50	4.15		0.00 - 7.94	
23 - Maternity -3rd/4th degree tears	<= 2.5%	2.3%	Aug-19			<= 2.5%	2.8%	Jul-19		<= 2.5%	2.4%		1.3 - 3.3%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.8%	Aug-19			>= 95.0%	99.1%	Jul-19		>= 95.0%	98.9%		97.8 - 99.8%	
203 - Booked 12+6	>= 90.0%	89.4%	Aug-19			>= 90.0%	90.7%	Jul-19		>= 90.0%	88.6%		82.9 - 90.7%	
204 - Inductions of labour	<= 35%	40.4%	Aug-19			<= 35%	41.8%	Jul-19		<= 35%	42.1%		37.6 - 45.0%	
208 - Total C section	<= 29.0%	25.7%	Aug-19			<= 29.0%	29.3%	Jul-19		<= 29.0%	27.2%		24.6 - 31.4%	
210 - Initiation breast feeding	>= 65%	65.76%	Aug-19			>= 65%	72.28%	Jul-19		>= 65%	68.55%		63.30 - 72.60%	
213 - Maternity complaints	<= 5	1	Jul-19			<= 5	3	Jun-19		<= 20	9		0 - 8	
319 - Maternal deaths (direct)	= 0	0	Aug-19			= 0	0	Jul-19		= 0	0		0 - 1	

Integrated Summary Dashboard - August 2019

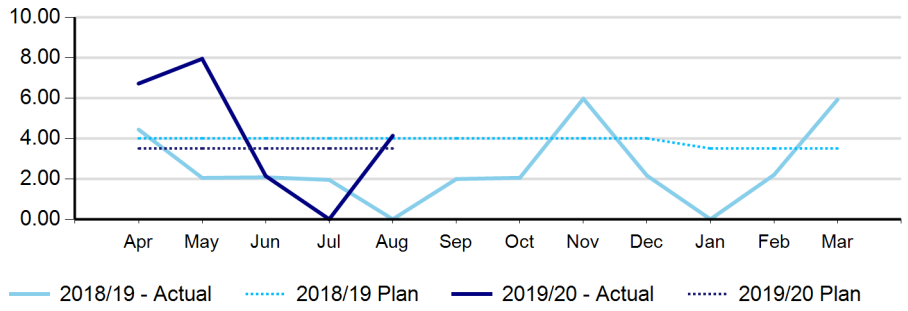
Bolton NHS Foundation Trust

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.9%	Aug-19			<= 6%	8.8%	Jul-19		<= 6%	9.5%		7.6 - 11.4%	

Bolton NHS Foundation Trust

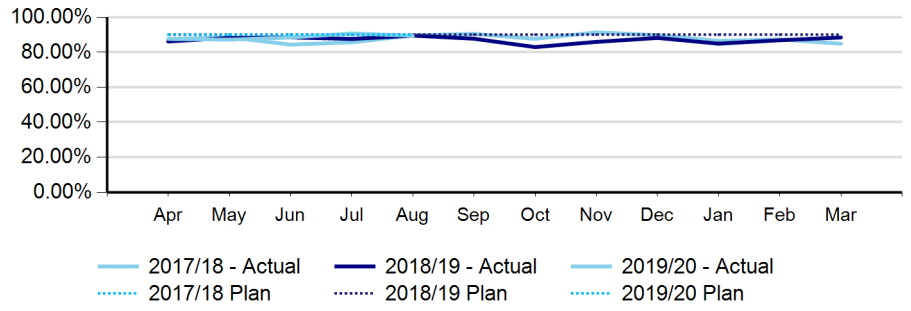
Exceptions

322 - Maternity - Stillbirths per 1000 births



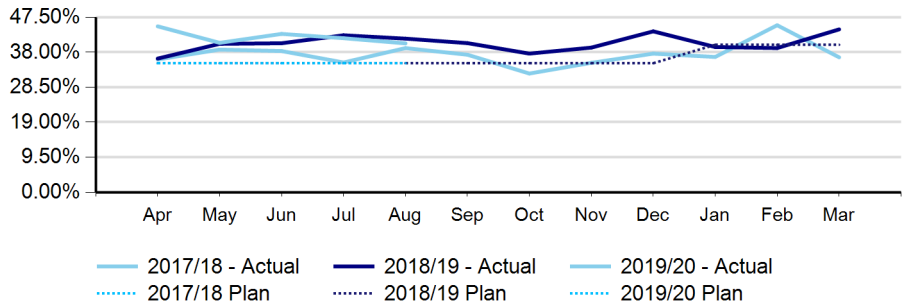
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	4.43	2.04	2.07	1.95	0.00	1.99	2.05	5.96	2.16	0.00	2.19	5.92
19/20	6.71	7.94	2.14	0.00	4.13							

203 - Booked 12+6



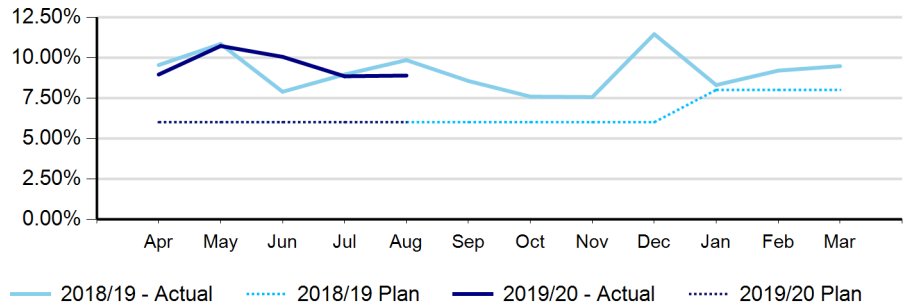
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	87.4%	88.5%	84.3%	85.6%	89.6%	90.4%	87.6%	91.3%	89.7%	86.4%	87.3%	84.8%
18/19	86.1%	88.1%	88.4%	87.5%	89.4%	87.7%	82.9%	85.9%	88.1%	84.8%	86.8%	88.4%
19/20	87.5%	87.1%	88.4%	90.7%	89.4%							

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%							

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%	8.9%							

NHS Bolton NHS Foundation Trust

Operational Performance

Access

A&E – A&E performance deteriorated slightly in August compared with the previous month and the same period last year. There is a direct correlation between A&E performance and the number patients staying in hospital for greater than 7 days and the Trust has taken action with other parts of the system to reduce the number of long stay patients.

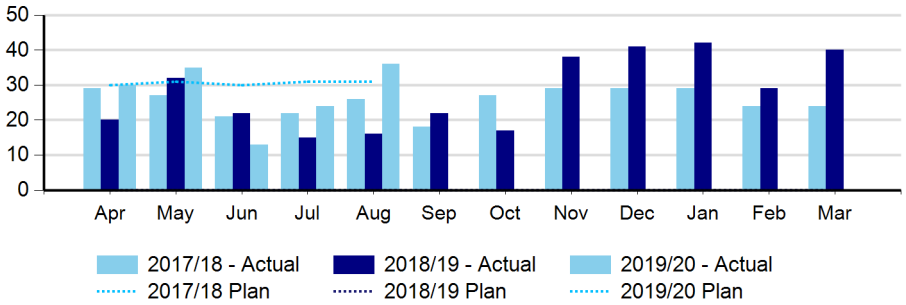
RTT – whilst the Trust continues to validate and review the waiting list on a daily basis, there is concern that the waiting list will continue to grow and the incomplete standard will not be achieved by year end.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 31	36	Aug-19			<= 31	24	Jul-19		<= 153	138		13 - 42	
8 - Same sex accommodation breaches	= 0	17	Aug-19			= 0	10	Jul-19		= 0	62		2 - 20	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	63.9%	Aug-19			>= 75%	72.7%	Jul-19		>= 75%	70.9%		56.8 - 90.6%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	84.4%	Aug-19			>= 92%	85.4%	Jul-19		>= 92%	85.5%		84.4 - 89.6%	
42 - RTT 52 week waits (incomplete pathways)	= 0	6	Aug-19			= 0	6	Jul-19		= 0	28		1 - 10	
314 - RTT 18 week waiting list	<= 22,812	25,184	Aug-19			<= 22,812	24,394	Jul-19		<= 22,812	25,184		22,554 - 25,184	
53 - A&E 4 hour target	>= 95%	85.2%	Aug-19			>= 95%	86.2%	Jul-19		>= 95%	85.5%		78.9 - 91.3%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	3.1%	Aug-19			= 0.0%	3.6%	Jul-19		= 0.0%	3.6%		3.1 - 9.7%	
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	0.81%	Aug-19			= 0.00%	1.25%	Jul-19		= 0.00%	1.20%		0.35 - 3.50%	
72 - Diagnostic Waits >6 weeks %	<= 1%	0.9%	Aug-19			<= 1%	0.9%	Jul-19		<= 1%	1.0%		0.4 - 3.2%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	83.3%	Aug-19			= 100%	33.3%	Jul-19		= 100%	69.7%		0.0 - 100.0%	

Bolton NHS Foundation Trust

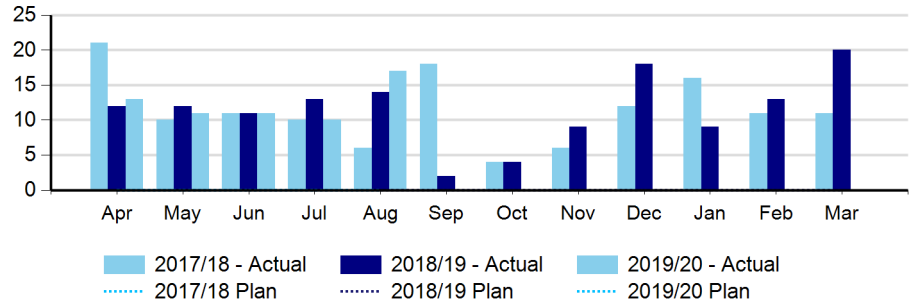
Exceptions

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



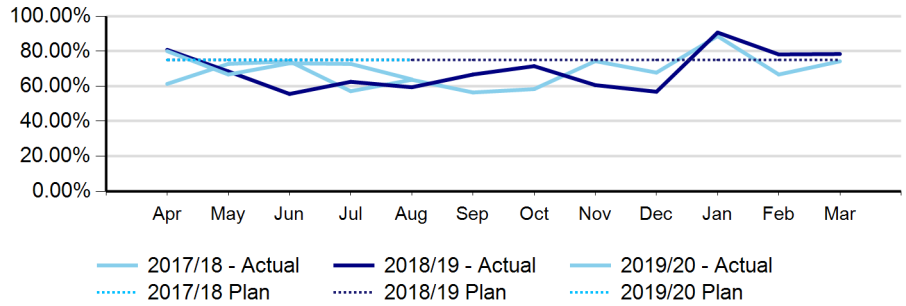
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	29	27	21	22	26	18	27	29	29	29	24	24
18/19	20	32	22	15	16	22	17	38	41	42	29	40
19/20	30	35	13	24	36							

8 - Same sex accommodation breaches



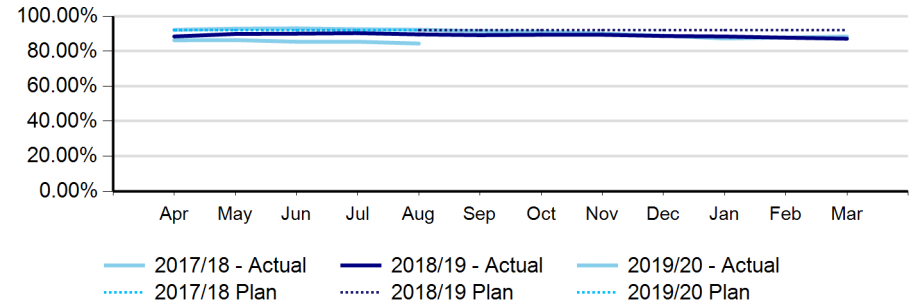
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	21	10	11	10	6	18	4	6	12	16	11	11
18/19	12	12	11	13	14	2	4	9	18	9	13	20
19/20	13	11	11	10	17							

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%							

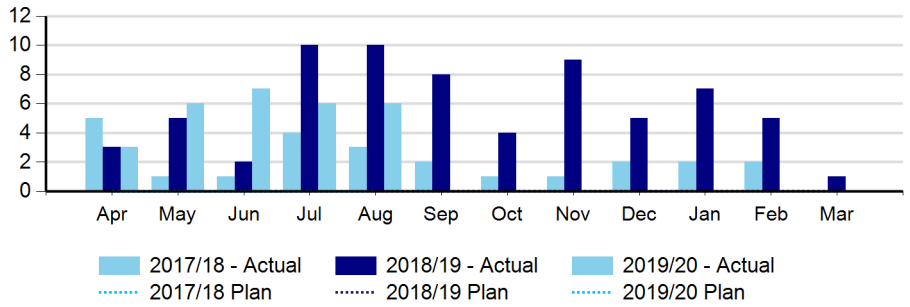
41 - RTT Incomplete pathways within 18 weeks %



	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%							

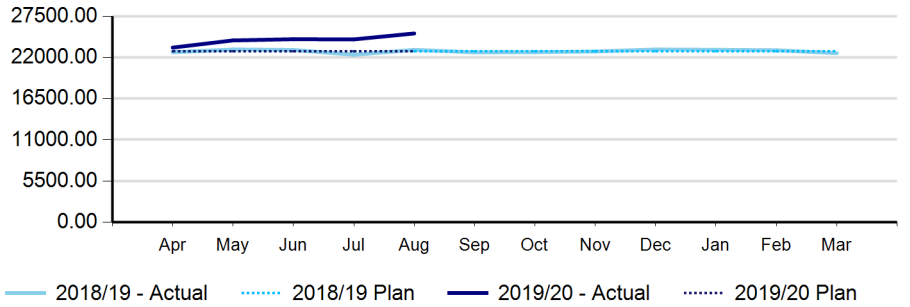
Bolton NHS Foundation Trust

42 - RTT 52 week waits (incomplete pathways)



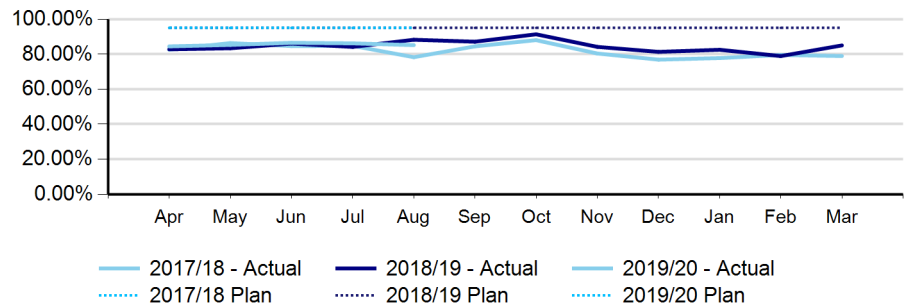
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	5	1	1	4	3	2	1	1	2	2	2	0
18/19	3	5	2	10	10	8	4	9	5	7	5	1
19/20	3	6	7	6	6							

314 - RTT 18 week waiting list



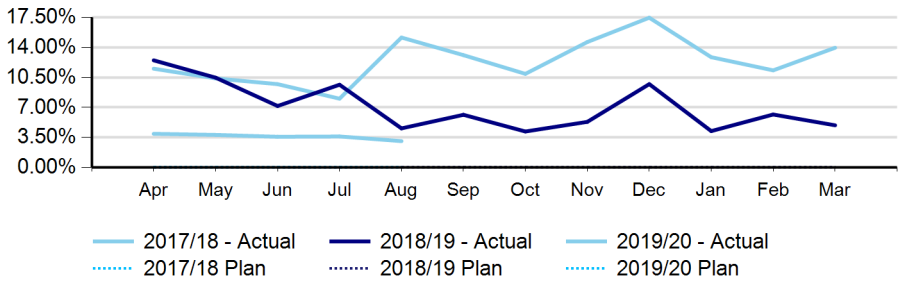
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	22,675	23,052	22,985	22,344	23,003	22,663	22,691	22,783	23,050	23,004	22,949	22,554
19/20	23,298	24,259	24,416	24,394	25,184							

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%							

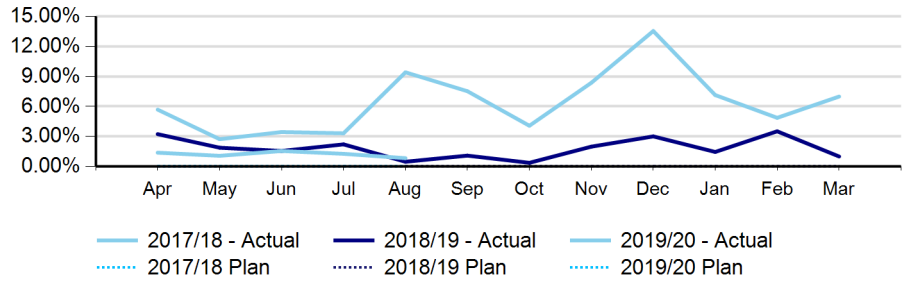
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



	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%							

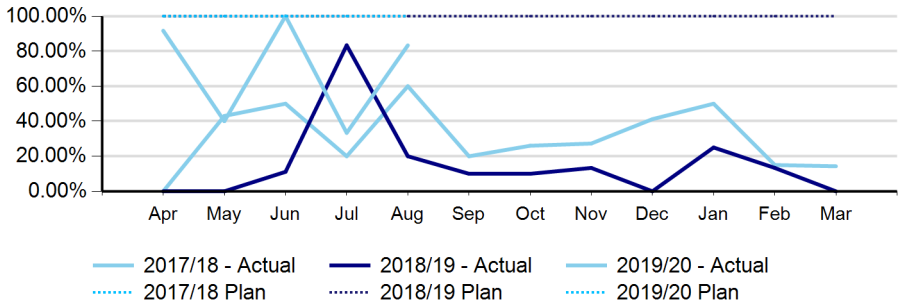
Bolton NHS Foundation Trust

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%							

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%							

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

Productivity

There is on going focussed work within the Divisions to reduce length of stay and improve 12pm & 4pm discharges. The Division are targeting specific wards where they know better use of SAFER would improve the timeliness of discharges.

There has been an increase in the non elective length of stay, this is linked to the long length of stay piece of work which is underway within the Trust .

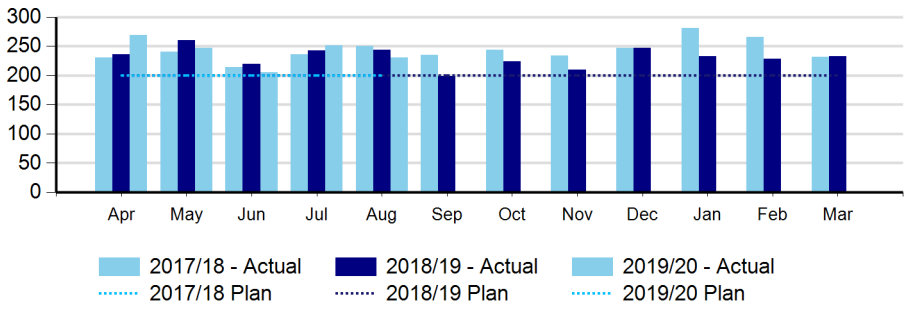
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
56 - Stranded patients	<= 200	230	Aug-19			<= 200	251	Jul-19		<= 200	230		199 - 269	
307 - Stranded Patients - LOS 21 days and over	<= 69	91	Aug-19			<= 69	91	Jul-19		<= 69	91		68 - 100	
57 - Discharges by Midday	>= 30%	28.2%	Aug-19			>= 30%	28.4%	Jul-19		>= 30%	29.1%		26.2 - 33.1%	
58 - Discharges by 4pm	>= 70%	68.7%	Aug-19			>= 70%	67.1%	Jul-19		>= 70%	67.5%		63.4 - 70.0%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	12.6%	Jul-19			<= 13.5%	11.0%	Jun-19		<= 13.5%	11.6%		10.8 - 12.9%	
60 - Daycase Rates	>= 80%	90.5%	Aug-19			>= 80%	88.7%	Jul-19		>= 80%	89.4%		87.1 - 90.6%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	2.1%	Aug-19			<= 1%	1.7%	Jul-19		<= 1%	1.8%		1.4 - 2.4%	
62 - Cancelled operations re-booked within 28 days	= 100%	93.2%	Aug-19			= 100%	95.2%	Jul-19		= 100%	87.6%		70.8 - 100.0%	
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	2.8%	Jul-19			<= 3.3%	1.9%	Jun-19		<= 3.3%	2.5%		1.1 - 2.8%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.39	Aug-19			<= 2.00	2.43	Jul-19		<= 2.00	2.47		2.06 - 2.90	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.97	Aug-19			<= 3.70	4.47	Jul-19		<= 3.70	4.73		4.09 - 4.97	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	95.2%	Jul-19			>= 80%	89.5%	Jun-19		>= 80%	92.3%		78.6 - 95.2%	

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

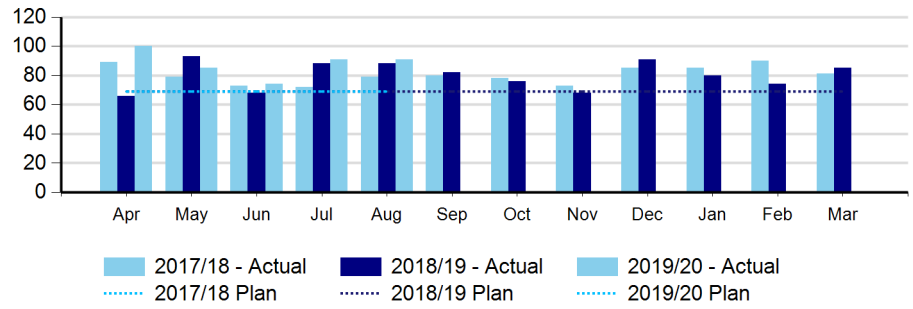
Exceptions

56 - Stranded patients



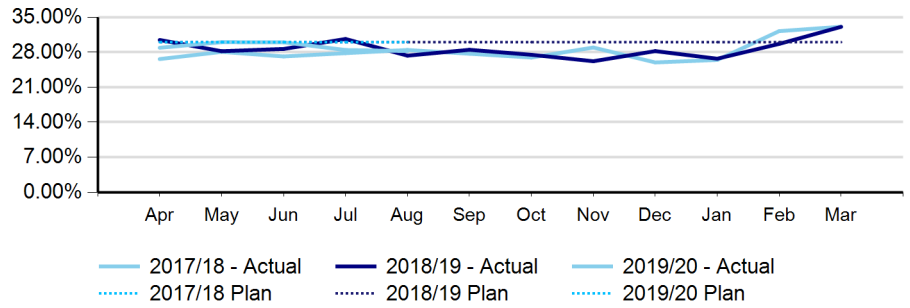
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	230	240	214	236	250	235	244	234	247	281	265	232
18/19	236	260	219	242	243	199	224	210	247	233	228	233
19/20	269	247	205	251	230							

307 - Stranded Patients - LOS 21 days and over



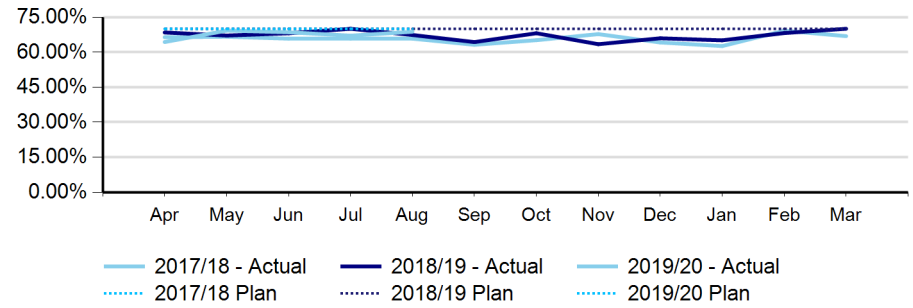
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	89	79	73	72	79	80	78	73	85	85	90	81
18/19	66	93	68	88	88	82	76	68	91	80	74	85
19/20	100	85	74	91	91							

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%							

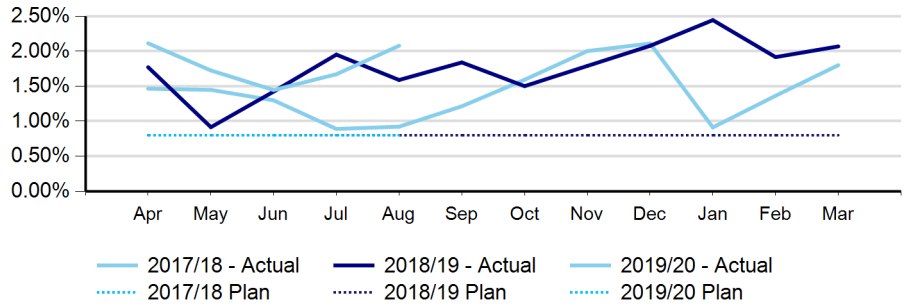
58 - Discharges by 4pm



	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%							

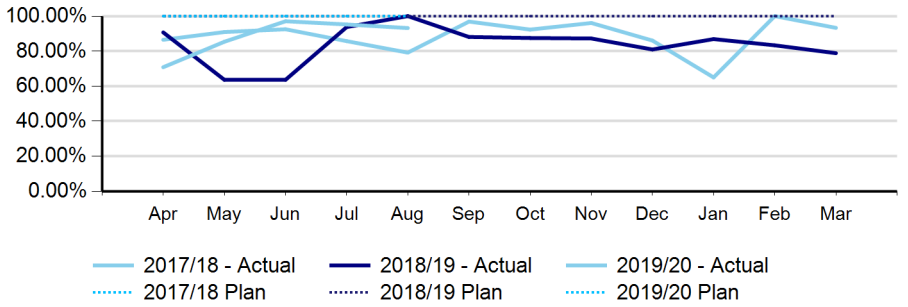
Bolton NHS Foundation Trust

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



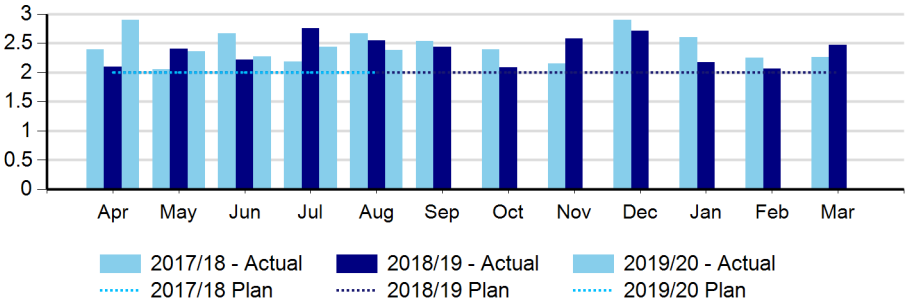
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1.5%	1.4%	1.3%	0.9%	0.9%	1.2%	1.6%	2.0%	2.1%	0.9%	1.4%	1.8%
18/19	1.8%	0.9%	1.4%	2.0%	1.6%	1.8%	1.5%	1.8%	2.1%	2.4%	1.9%	2.1%
19/20	2.1%	1.7%	1.4%	1.7%	2.1%							

62 - Cancelled operations re-booked within 28 days



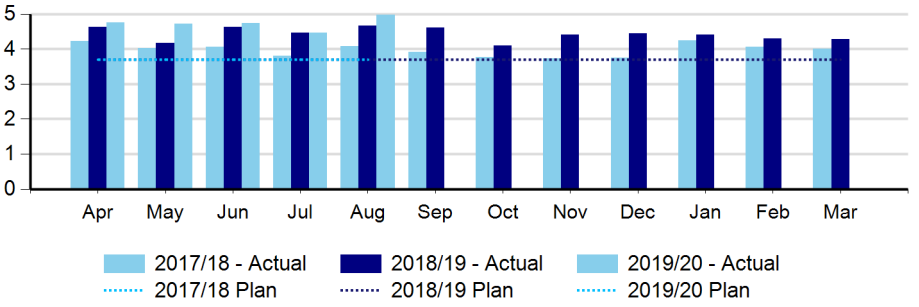
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86.5%	90.9%	92.5%	85.7%	79.2%	96.9%	92.3%	96.1%	86.0%	65.0%	100.0%	93.3%
18/19	90.7%	63.6%	63.6%	93.8%	100.0%	88.1%	87.5%	87.2%	81.0%	86.9%	83.3%	78.8%
19/20	70.8%	85.4%	97.1%	95.2%	93.2%							

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	2.43	2.39							

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							

Bolton NHS Foundation Trust

Cancer

The Trust met the target for 62 day for July and August, and is still expected to pass the quarter (which is the national measure). In month pressure on the number of cancer referrals and diagnostic pressure across Greater Manchester remain a significant concern.

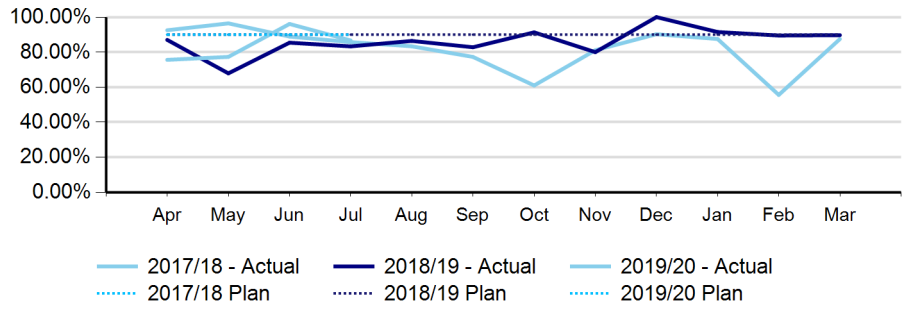
The continued rise in predicted referrals to Breast services exacerbates the pressure on the 14 day target, the Trust has responded by putting on more waiting lists and agreed recruitment of a medical and nursing staff at risk. Funding has not been agreed with CCG's as yet.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
46 - 62 day standard % (1 mth in arrears)	>= 85%	92.6%	Jul-19			>= 85%	80.0%	Jun-19		>= 85%	87.1%		80.0 - 92.6%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	86.7%	Jul-19			>= 90%	96.1%	Jun-19		>= 90%	84.7%		75.6 - 100.0%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	98.4%	Jul-19			>= 96%	98.9%	Jun-19		>= 96%	98.8%		98.1 - 100.0%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Jul-19			>= 94%	100.0%	Jun-19		>= 94%	100.0%		87.5 - 100.0%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	Jul-19			>= 98%	100.0%	Jun-19		>= 98%	100.0%		100.0 - 100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	96.2%	Jul-19			>= 93%	97.2%	Jun-19		>= 93%	97.1%		93.8 - 98.7%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	46.0%	Jul-19			>= 93%	49.1%	Jun-19		>= 93%	42.6%		27.1 - 94.8%	

Bolton
NHS Foundation Trust

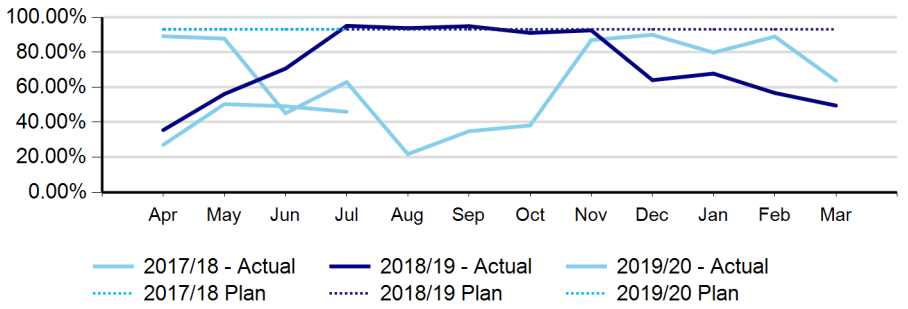
Exceptions

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.5%	96.4%	88.9%	85.7%	83.3%	77.3%	61.0%	81.1%	90.2%	87.5%	55.6%	87.5%
18/19	87.0%	67.9%	85.4%	83.3%	86.4%	82.8%	91.3%	80.0%	100.0%	91.5%	89.5%	89.7%
19/20	75.6%	77.3%	96.1%	86.7%								

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%								

Bolton NHS Foundation Trust

Community

The length of time people spend in the intermediate tier services in total has increased for the second month in a row but overall remains lower than 12 months ago and is below the threshold set for the service.

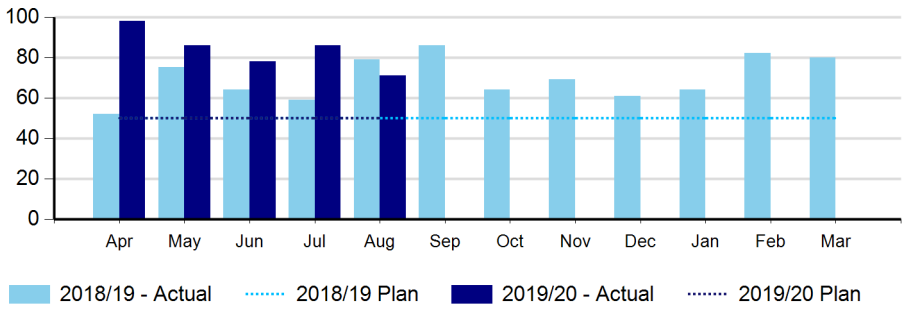
There has been significant deterioration in the number of people remaining in hospital once medically optimised and the days occupied by people once medically optimised. The Trust is an early adopter of the Discharge Patient Tracking List and Long Length of Stay review process and the Integrated Discharge Team changed their processes in July to help meet this new standard. In response to the deterioration in performance the team has reinstated the previous method of support and challenge to the medically optimised list with effect from 19th August.

	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	541	Aug-19			>= 400	553	Jul-19		>= 2,000	2,641		341 - 553	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.21	Aug-19			<= 6.00	4.93	Jul-19		<= 6.00	5.21		3.86 - 6.47	
230 - Medically Optimised Numbers	<= 50	71	Aug-19			<= 50	86	Jul-19		<= 250	419		61 - 98	
231 - Medically Optimised Days	<= 209	696	Aug-19			<= 209	651	Jul-19		<= 1,045	3,062		388 - 790	

Bolton
NHS Foundation Trust

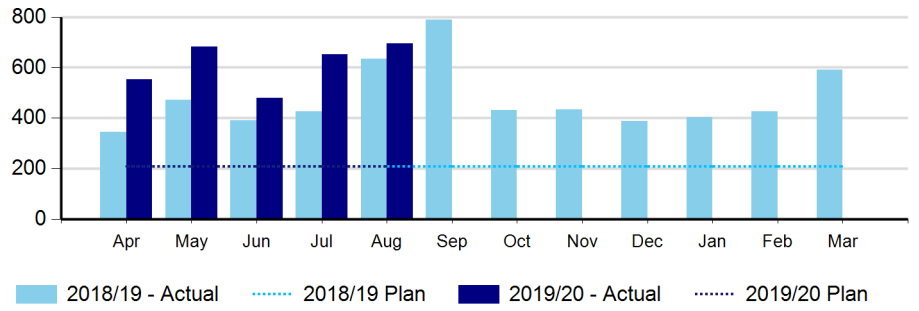
Exceptions

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							

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							

NHS Bolton NHS Foundation Trust

Workforce

Sickness, Vacancy and Turnover

The sickness rate 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. Recent benchmarking data shows Bolton as having the second lowest sickness absence rate amongst GM Acute Trust's, it is worthy of note though that GM has significantly higher levels of sickness than when compared to the recent of England. The Trust is working with Public health to better understand whether there is any correlation in higher sickness absence rates and population demographics. Sickness management remains an on-going item for discussion at the Workforce Assurance Committee, with specific consideration being given as to why the plethora of actions being taken are not having the impact that would have been anticipated. To this end the Committee received the Health & Wellbeing Strategy, which sets out the enabling actions that will be taken moving forward.

Performance on the recruitment & 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 & Workforce Teams is evident which is supporting this positive position.

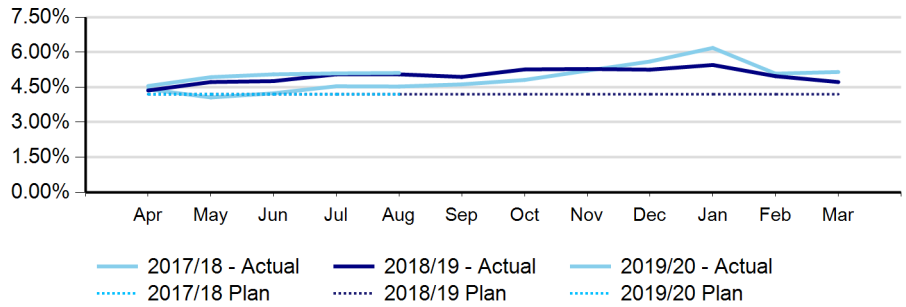
As noted in the previous Board Dashboard colleagues will see that the Dashboard includes the number of investigations over 8 weeks. A KPI has not been set at this time as this will be considered at the Workforce Assurance Committee in October.

	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%	5.11%	Aug-19			<= 4.20%	5.09%	Jul-19		<= 4.20%	4.95%		4.55 - 5.45%	
120 - Vacancy level - Trust	<= 6%	4.17%	Aug-19			<= 6%	4.57%	Jul-19		<= 6%	5.23%		2.61 - 6.78%	
121 - Turnover	<= 9.90%	9.88%	Aug-19			<= 9.90%	9.89%	Jul-19		<= 9.90%	9.92%		9.16 - 10.65%	
366 - Ongoing formal investigation cases over 8 weeks		2	Aug-19				5	Jul-19			7		2 - 5	

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%							

NHS Bolton NHS Foundation Trust

Organisational Development

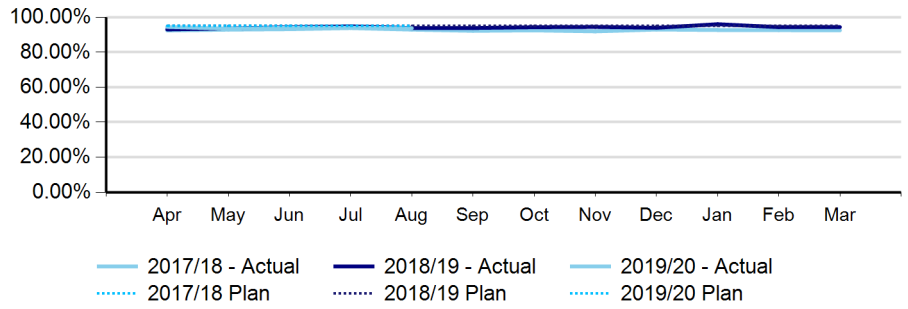
The Organisational Development indicators remain strong however, there has been an in month deterioration which is likely to be due to the peak holiday period when it's often difficult to release staff. The team are continuing to roll-out the team appraisal approach and are currently redesigning the appraisal process to improve the quality of discussions. In an effort to help increase mandatory training compliance additional sessions have been scheduled and capacity on sessions has been increased where possible. The team are currently reviewing the mandatory training delivery model to increase accessibility to training and ensure that the training remains fit for purpose.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
37 - Staff completing Statutory Training	>= 95%	93.7%	Aug-19			>= 95%	94.0%	Jul-19		>= 95%	93.9%		93.4 - 96.0%	
38 - Staff completing Mandatory Training	>= 85%	91.7%	Aug-19			>= 85%	91.8%	Jul-19		>= 85%	91.9%		85.9 - 93.1%	
39 - Staff completing Safeguarding Training	>= 95%	95.75%	Aug-19			>= 95%	96.19%	Jul-19		>= 95%	95.87%		94.73 - 96.19%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.5%	Aug-19			>= 85%	84.6%	Jul-19		>= 85%	84.4%		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

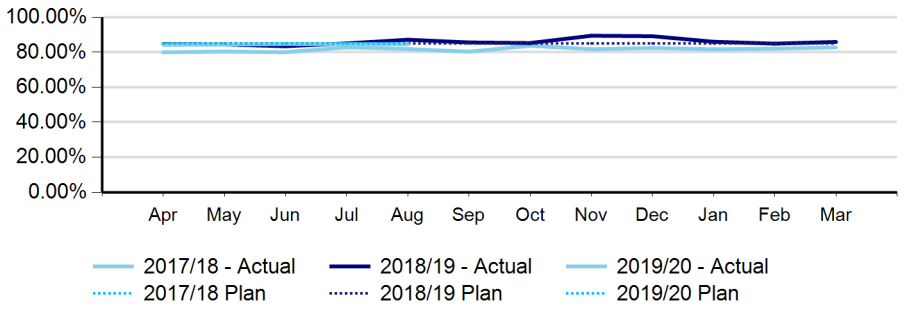
Exceptions

37 - Staff completing Statutory Training



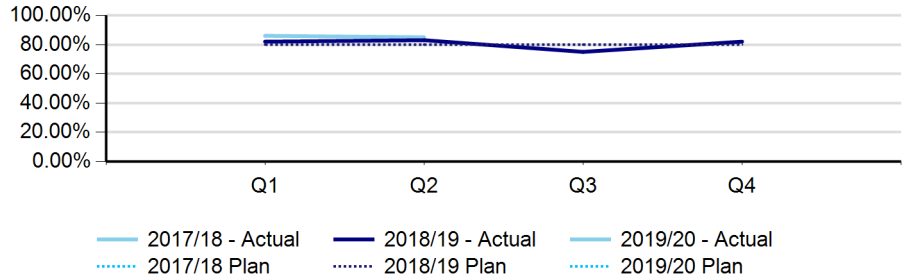
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.4%	92.8%	93.1%	93.8%	92.9%	92.2%	92.4%	91.9%	92.9%	92.6%	92.6%	92.5%
18/19	93.0%	93.6%	94.2%	94.7%	93.8%	93.8%	94.2%	94.4%	93.9%	96.0%	94.3%	94.3%
19/20	94.4%	93.4%	94.0%	94.0%	93.7%							

101 - Increased numbers of staff undertaking an appraisal



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	79.9%	80.3%	80.0%	82.7%	81.8%	80.3%	83.7%	81.7%	82.3%	81.7%	82.0%	82.7%
18/19	84.5%	84.3%	83.4%	85.0%	87.1%	85.5%	85.2%	89.4%	89.1%	85.9%	84.9%	85.8%
19/20	84.2%	84.3%	84.7%	84.6%	84.5%							

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%			

NHS Bolton NHS Foundation Trust

Agency

Colleagues will note the in-month Agency spend remains below the Trust's forecast. As would be expected the two areas of greatest spend being Nursing, Medical. The Trust continues to benchmark very favourable on Agency spend when compared to peer organisations for percentage 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)	<= 0.66	0.52	Aug-19			<= 0.69	0.56	Jul-19		<= 3.45	3.05		0.52 - 0.90	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.26	0.17	Aug-19			<= 0.29	0.19	Jul-19		<= 1.53	1.14		0.17 - 0.33	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.32	0.25	Aug-19			<= 0.32	0.23	Jul-19		<= 1.62	1.37		0.19 - 0.50	

Bolton NHS Foundation Trust

Finance

Finance

The August YTD performance against the control total is a deficit of £7.7m, £4.3m worse than the plan. The variance is mainly as a result on the under delivery of ICIP, income performance and control of costs.

PSF/MRET of £2.5m has been earned year to date compared to a plan of £2.0m. 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 £5.3m year to date compared to a plan deficit of £1.5m.

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 and a financial recovery plan has been submitted to NHSI/E. 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 £2.4m which is on plan.

In August there was a net cash outflow of £3.9m with a closing cash balance of £23.6m, which is £9.7m above plan.

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

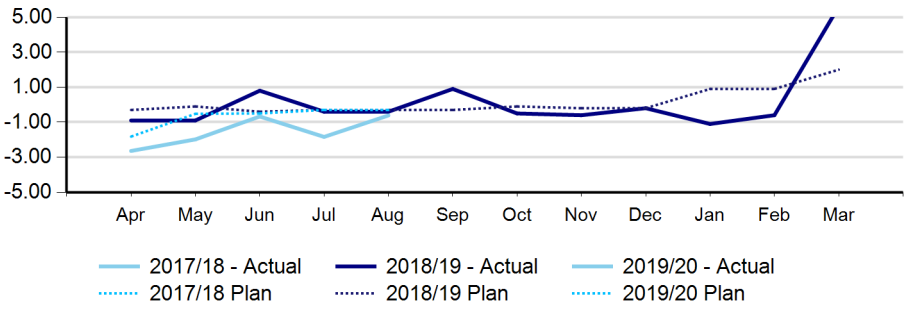
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
220 - Control Total (£ millions)	>= -0.3	-0.6	Aug-19		↑	>= -0.3	-1.8	Jul-19		>= -3.4	-7.7		-2.6 - 5.6	
221 - Provider Sustainability Fund (£ millions)	>= -0.01	-0.01	Aug-19		→	>= -0.01	-0.01	Jul-19		>= -0.03	-0.06		-0.01 - 1.30	
222 - Capital (£ millions)	>= 0.7	0.7	Aug-19		↓	>= 0.8	1.0	Jul-19		>= 2.9	2.3		0.2 - 4.2	
223 - Cash (£ millions)	>= 13.9	23.6	Aug-19		↓	>= 13.6	27.5	Jul-19		>= 13.9	23.6		6.0 - 27.5	
224 - Use of Resources	>= 2	3	Aug-19		→	>= 3	3	Jul-19		>= 2	3		2 - 3	

Integrated Summary Dashboard - August 2019

Bolton NHS Foundation Trust

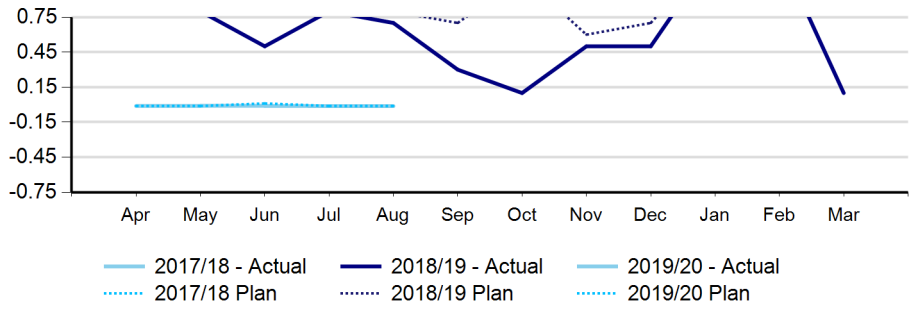
Exceptions

220 - Control Total (£ millions)



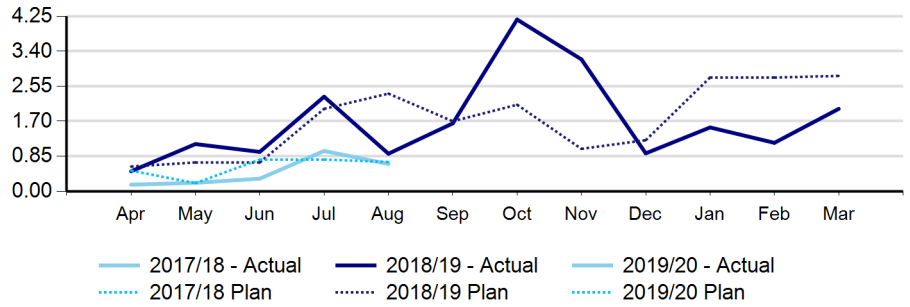
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18												2.3
18/19	-0.9	-0.9	0.8	-0.4	-0.4	0.9	-0.5	-0.6	-0.2	-1.1	-0.6	5.6
19/20	-2.6	-2.0	-0.7	-1.8	-0.6							

221 - Provider Sustainability Fund (£ millions)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18												0.60
18/19	0.80	0.80	0.50	0.80	0.70	0.30	0.10	0.50	0.50	1.30	1.30	0.10
19/20	-0.01	-0.01	-0.01	-0.01	-0.01							

222 - Capital (£ millions)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18												2.9
18/19	0.5	1.1	1.0	2.3	0.9	1.6	4.2	3.2	0.9	1.5	1.2	2.0
19/20	0.2	0.2	0.3	1.0	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: 20 September 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	Aug 2019	2 - Targeted support offer	
The finance score	Jul 2019	3	

Financial Sustainability	Data period	Trust value	Performance band description
Capital service capacity - value	Jul 2019	-0.99	In quartile 1 - Lowest 25% (blue)
• Capital service capacity - SOF Score	Jul 2019	4	
Liquidity (days) - value	Jul 2019	11.08	In quartile 4 - Highest 25% (blue)
• Liquidity (days) - SOF Score	Jul 2019	1	

Financial Efficiency	Data period	Trust value	Performance band description
Income and expenditure (I&E) margin - value	Jul 2019	-4.96%	In quartile 2 - Mid-Low 25% (blue)
• Income and expenditure (I&E) margin - SOF score	Jul 2019	4	

Financial Controls	Data period	Trust value	Performance band description
Distance from financial plan - value	Jul 2019	-3.52%	In quartile 1 - Lowest 25% (blue)
• Distance from financial plan - SOF score	Jul 2019	4	
Distance from agency spend cap - value	Jul 2019	31.00%	In quartile 3 - Mid-High 25% (blue)
• Distance from agency spend cap - score	Jul 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	Q1 2019/20	0.09	In quartile 2 - Mid-Low 25% (amber / green)	0.16	0.12
Pre-procedure non-elective bed days	Q1 2019/20	1.20	In quartile 4 - Highest 25% (red)	0.73	0.66
Did not attend (DNA) rate	Q1 2019/20	8.93%	In quartile 4 - Highest 25% (red)	8.00%	7.06%
Emergency Readmission 30 days	Q1 2019/20	8.02%	In quartile 3 - Mid-High 25% (amber / red)	8.12%	7.97%

People	Data period	Trust value	Performance band description	Peer median	National median
Staff retention rate	31/12/2018	86.9%	In quartile 3 - Mid-High 25% (amber / green)	86.8%	85.6%
Sickness absence rate	30/06/2019	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)	2017/18	£741.21k	In quartile 3 - Mid-High 25% (amber / red)	£619.28k	£676.48k
HR function cost per £100m turnover (comparison within sector)	2017/18	£827.23k	In quartile 2 - Mid-Low 25% (amber / green)	£966.04k	£898.02k

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	Jul 2019	-0.99	In quartile 1 - Lowest 25% (blue)
Liquidity (days) - value	Jul 2019	11.08	In quartile 4 - Highest 25% (blue)
Distance from agency spend cap - value	Jul 2019	31.00%	In quartile 3 - Mid-High 25% (blue)
Income and expenditure (I&E) margin - value	Jul 2019	-4.96%	In quartile 2 - Mid-Low 25% (blue)
Distance from financial plan - value	Jul 2019	-3.52%	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	19	0	25	26	26	26	10	14	23	22	26	26	12	24	10	8	25	25	25	22	24	24	16	25	9	11	4	31	7	17	6	26	15	5	4	44	38	775
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	G>=100%, A>80% <99.9%, R = <80%=R, >80% <94.9%=A >95%	100.0%	100.0%	65.0%	85.0%	100.0%		95.0%		100.0%	95.0%	95.0%	95.0%	100.0%	100.0%	80.0%	100.0%	95.0%	100.0%	100.0%	95.0%	100.0%	100.0%	90.0%	100.0%	100.0%	90.0%	90.0%	100.0%	100.0%	70.0%	100.0%	100.0%	100.0%	95.0%		100.0%		100.0%	100.0%	100.0%		100.0%	95.0%	97.2%
	IPC Rapid Improvement Tool %		96.0%	92.0%	86.0%	95.0%	71.0%		71.0%		83.0%	100.0%	96.0%	83.0%	96.0%	71.0%	79.0%	88.0%	83.0%	96.0%	91.0%	Non Return	100.0%	96.0%	100.0%	100.0%	96.0%	96.0%	88.0%	91.0%	100.0%	91.0%	100.0%	100.0%	95.0%	100.0%		Non Return		Non Return	92.0%	95.0%		96.0%	95.0%	92.9%
	Mattress Audit Compliance %	Yes=G, No Return=White	100.0%	100.0%			100%		Non Return		100%	100%	100%	100%	100%	100%	96%	100%	72%	Non Return	Non Return	100%	Non Return	100%	100%	100%	100%	100%	100%	100%					100%		Non Return		100%	100.0%	100%		100%	100%	98.9%
	C - Diff	0	0	0	0	0	0		0		0	0	0	3	0	0	0	1	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	5
	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
	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
	MRSA acquisitions	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harm Free Care	Safety Express Programme Harm Free Care (%)	95%	96.3%	95.2%			95.7%		90.5%		96.0%	96.2%	96.2%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%	Non Return	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%					100.0%		100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	98.1%
	All Inpatient Falls (Safeguard)	0	10	3	3	0	3		9		11	9	11	1	1	2	4	2	7	5	1	2	0	1	2	6	0	2	3	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100
	Harms related to falls (moderate and above)	1.6	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	VTE Assessment Compliance	95%		0.0%			0.0%		Non Return		100.0%	50.0%	91.9%	100.0%	100.0%	96.6%	95.4%	95.6%	100.0%	100.0%		100.0%	100.0%	100.0%	91.7%	100.0%	99.0%	98.9%	94.3%	100.00%	95.8%	98.9%	100.0%	100.0%	72.4%			98.7%	99.4%	99.6%	96.0%	88.1%	41.7%	100.0%		97.5%
	Monthly New pressure Ulcers (Grade 2)	0	0	0	0	0	1		1		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	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
	Monthly New pressure Ulcers (Grade 4)	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0
	PU due to lapses in care	0	0	0	0	0	0		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	92.28	0	0	93
Audit	Monthly KPI Audit %	R=<80%,A>80%<94.9%,G>=95%	97.1%	89.3%	94.2%	86.1%	85.6%		91.5%		88.6%	92.9%	96.1%	79.4%	98.5%	92.3%	97.3%	97.0%	98.7%	87.9%		97.7%	100.0%	100.0%	78.5%	96.0%	98.3%	90.5%	98.1%	97.9%	90.9%	93.9%	100.0%	100.0%	94.6%		98.7%		96.3%		98.1%	100.0%	100.0%	81.7%	100.0%	non return	
	Bolton System of Care Accreditation (BoSCA)	R=<70%,A=>70%<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%	88.0%	90.4%		90.4%	85.9%	
	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	silver	gold		gold	silver	
Patient Experience	Friends and Family Response Rate	**30%**	100.0%	65.3%	16.5%	43.6%	66.0%		25.9%		37.6%	22.6%	28.9%	18.2%	57.7%	35.9%	38.7%	27.7%	28.4%	47.5%		56.7%	54.5%	15.4%	37.8%	36.7%	36.8%	42.4%	51.6%	69.4%	42.9%	24.1%	24.9%	25.8%	16.0%	15.3%	0.0%	17.7%		23.5%	16.2%	45.2%		58.0%	72.5%	28.6%
	Friends and Family Recommended Rate	**97%**	92.3%	100.0%	89.9%	94.9%	100.0%		100.0%		97.1%	100.0%	100.0%	80.0%	100.0%	98.2%	93.1%	89.5%	100.0%	89.3%		100.0%	100.0%	100.0%	97.8%	100.0%	98.8%	98.6%	100.0%	100.0%	100.0%	86.6%	94.4%	98.0%	100.0%	97.0%	N/A	97.4%		96.7%	93.1%	92.9%		96.7%	100.0%	96.6%
	Number of complaints received	**0**	0	0	4	0	0		0		0	2	0	0	0	0	0	1	0	1	0	0	1	0	2	0	0	0	0	0	0	0	1	0	0	0		0		6	0	1	0	4	1	24
Governance	SIs in Month	**0**	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Incidents over 20 days, not yet signed off	**0**	3	0	37	10	6		0		8	0	3	1	0	0	0	0	1	3	1	3	0	0	2	0	0	0	2	0	0	0	0	0	0	1	0	30	11	9	1	2	6	30	2	172
	Harms related to Incidents (Moderate and above)	**0**	0	0	0	0	0		0		0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Staff Development	Appraisals	85%	98.3%	86.1%	90.9%		78.4%		82.6%		85.7%	93.0%	89.7%	86.5%	92.9%	89.5%	83.0%	87.8%	94.4%	78.0%	87.5%	85.4%	90.5%	93.7%	90.3%	83.3%	87.2%	81.8%	95.9%	91.7%	90.0%	90.9%	97.3%	80.4%	94.4%	84.1%		72.0%		70.3%				78.8%		84.5%
	Statutory Training	95%	98.27%	89.79%	96.57%		87.31%		86.46%		89.32%	94.31%	88.30%	90.33%	97.94%	97.37%	85.36%	89.69%	93.23%	89.44%	100.00%	88.85%	95.97%	99.06%	89.47%	87.89%	99.65%	88.79%	96.08%	90.24%	99.28%	96.65%	93.66%	88.85%	100.00%	97.0%		92.44%		90.5%				97.19%		93.7%
	Mandatory Training	85%	98.0%	89.7%	96.32%		84.1%		88.2%		89.0%	94.2%	86.8%	89.4%	92.1%	97.6%	79.5%	87.5%	95.5%	87.4%	96.0%	90.7%	96.6%	97.8%	84.4%	89.3%	97.4%	91.4%	95.8%	90.5%	98.8%	98.6%	92.9%	88.8%	100.0%	96.3%		84.8%		88.4%				93.3%		91.7%
Staffing & Workforce	% Qualified Staff (Day)			100.3%			96.9%		76.0%		80.2%	70.6%	84.5%	84.0%	100.1%				91.1%	93.2%		86.3%	80.2%	89.7%	82.2%	90.9%		95.5%	86.2%	83.3%	92.3%					57.3%		82..4%		93.8%	83.0%	67.1%		67.2%	99.8%	
	% Qualified Staff (Night)			100.0%			98.4%		97.3%		96.8%	99.1%	95.2%	97.1%	102.2%				92.0%	98.4%		100.0%	91.1%	86..9%	100.2%	97.8%		125.0%	98.3%	97.8%	94.3%					64.5%		96.9%		93.8%	76.3%	46.8%		59.6%	97.8%	
	% un-Qualified Staff (Day)			101.6%			81.3%		96.3%		93.0%	107.7%	82.1%	77.0%	102.9%				82.7%	99.6%		99.2%		78.0%	91.0%	91.1%		114.4%	109.0%	110.8%	115.3%					130.9%		103.1%		100.0%	81.6%	91.4%		72.0%		
	% un-Qualified Staff (Night)			99.3%			81.9%		102.4%		95.7%	102.9%	87.8%	76.6%	94.1%				79.8%	110.5%		101.1%			91.7%	106.5%		139.0%	98.3%	99.2%	120.5%					3.2%		97.1%		93.8%	82.9%	80.0%		101.6%		
	Budgeted Nurse: Bed Ratio (WTE)		1.64	0.57			1.50		1.93		-0.33	-0.30	4.42	-2.54	2.79	-1.67	-1.75	-3.65	2.33	-0.30		-1.09	3.48	0.87	1.34	-4.06	-2.65	-1.99	0.96	-2.24	1.15	-1.34	8.84	-0.14	0.74	-3.94		4.40							5.50	14.47
	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							105.69	1406.47
	Actual WTE In-Post (From Ledger)		41.74	32.26	141.09		36.53		40.41		34.04	41.53	38.27	38.23	24.14	21.64	49.57	43.33	33.68	39.27		36.24	35.10	54.15	31.18	32.27	38.52	30.20	41.53	44.73	15.92	29.59	51.55	48.05	15.14	70.84		21.32							100.19	1352.25
	Actual Worked (From Ledger)		44.33	37.36	148.25		39.72		47.46		36.45	43.00	42.60	45.14	24.82	22.94	52.06	44.17	38.83	44.28		39.05	31.78	52.68	37.88	39.33	44.19	38.04	47.99	44.85	18.10	31.00	53.66	45.35	16.62	70.47		25.67							94.66	1442.73
	Sickness (%) (April)	R = >4.75. A = 4.2 - 4.75. G = <4.2	5.94%	9.37%	4.65%		9.58%		10.01%		12.56%	3.66%	9.98%	8.56%	1.53%	1.97%	11.61%	3.98%	6.48%	12.96%	4.78%	7.90%	0.39%	3.89%	7.33%	11.06%	11.19%	8.83%	9.95%	2.97%	3.43%	11.04%	8.65%	7.71%	0.43%	7.48%		3.51%		7.62%				6.52%		5.11%
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)		1.56	1.08	-2.26	-	-2.75		-2.59		0.36	0.36	4.61	-3.62	2.18	-0.39	-5.83	-6.56	-5.12	0.26		-2.09	-1.34	0.34	2.05	-1.06	-4.23	-0.99	-0.96	-2.01	-1.46	-0.34	7.81	2.91	0.54	-4.37		2.75							7.08	-13.72
	Pending Appointment				4				1					5			3	0.62	4	1		1			3	2	1.92	2	2	2	1	1		3		0.75				12.1						50.39
	Substantive Staff Turnover Headcount (rolling average 3 months)	10%	19.8%	8.0%	5.2%		15.4%		13.5%		16.0%	8.9%	12.3%	18.1%	0.0%	4.9%	7.5%	17.6%	19.9%	9.0%	21.6%	12.3%	0.0%	11.9%	3.0%	15.5%	4.8%	6.1%	7.6%	6.4%	4.9%	8.1%	11.7%	3.7%	0.0%	11.1%		24.9%		8.5%				10.5%		9.9%

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 (%)		97.30%	100.00%	98.11%	98.67%	96.77%	100.00%	92.86%	98.08%	100.00%	92.86%			97.85%
	Total Monthly New pressure Ulcers (Grade 2)(Lapse in Care + No Lapse in Care)		1	0	1	0	0	1	1	1	0	0			5
	Total Monthly New pressure Ulcers (Grade 3)(Lapse in Care + No Lapse in Care)		0	2	0	0	0	0	0	0	1	0			3
	Total Monthly New pressure Ulcers (Grade 4)(Lapse in Care + No Lapse in Care)		0	0	0	0	0	0	0	0	0	0			0
	Total Monthly New Pressure Ulcers - due to lapses in care		1	0	0	0	0	0	0	0	0	0			1
Audit	Monthly KPI Audit % (Revised Buddy Assessed Audit)		non return	98.71%	97.73%	86.75%	99.55%	97.76%	96.96%	96.38%	96.96%	96.77%	96.92%		
	Bolton System of Care Accreditation (BoSCA)		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 %		42.70%											100.00%	
	Friends and Family Recommended Rate %		100.00%											100.00%	
	Number of Complaints received		0	0	0	0	0	0	0	0	0	0	0	0	0
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	170.69
	Actual WTE In-Post		12.04	16.60	16.30	16.29	7.11	13.60	16.33		13.41	9.80	17.54	24.17	163.20
	Actual WTE Worked		11.14	16.60	16.03	16.70	7.11	14.35	17.43		14.92	10.14	18.42	24.52	167.35
	Pending Appointment														
	Current Budgeted Vacancies (WTE)				1.53	2.00			0.80		1.00	1.00		1.2	6.33
Staff Development	Sickness (%) July 2019		16.65%	0.22%	14.38%	0.19%	0.40%	12.38%	7.16%		0.00%	9.04%	4.81%	14.05%	5.84%
	Substantive Staff Turnover Headcount (rolling average 12 months)		7.36%	5.45%	17.91%	15.72%	0.00%	0.00%	5.00%		6.12%	19.35%	18.75%	6.19%	11.07%
	12 month Appraisal		85.7%	94.7%	80.0%	76.5%	100.0%	88.9%	83.3%		88.2%	88.9%	90.00%	100.00%	90.0%
	12 month Statutory Training		97.4%	98.3%	84.3%	85.2%	100.0%	94.1%	98.0%		97.1%	100.0%	94.09%	98.77%	98.3%
	12 month Mandatory Training		96.08%	96.68%	86.11%	86.11%	100.00%	92.65%	97.01%		97.06%	100.00%	93.55%	96.15%	100.00%

Agenda Item No:	
Meeting:	Board of Directors
Date:	3rd October 2019

NHS Bolton NHS Foundation Trust

Title:	Annual update on the Workforce & OD Strategy

Purpose	The paper is intended to provide assurance to the Trust Board that the Workforce & Organisational Development strategy remains fit for purpose and that traction is being maintained in terms of implementation.

Executive Summary:	The current strategy was approved by the Trust Board in September, 2018 and this report provides an update on the progress against the planned actions detailed within the strategy. It is intended to provide assurance to the Trust Board that the Workforce & Organisational Development strategy remains fit for purpose and that traction is being maintained in terms of implementation.

Previously considered by:	The report has been positively received at the Workforce Assurance Committee and is commended to the Trust Board

Recommendation Please state if approval required or if for information	It is recommended that the current Workforce & OD strategy work-stream action plans continue to be implemented and continue to be evaluated during the 3 year life cycle of the strategy. The Trust Board is asked to accept this report as assurance that the required progress is being made in respect of delivering the Workforce & OD strategy.	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*	*Yes*	*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*	*Yes*	*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*	*Yes*	*To develop **partnerships** that will improve services and support education, research and innovation*	Yes

Negative Impact	Neutral Impact	Positive Impact

Prepared by:	James Mawrey	**Presented by:**	James Mawrey

Introduction

This report provides an annual update on the Workforce & Organisational Development Strategy (attached). The action plan which supports the Strategy's implementation is very detailed and has not been included within this paper but it is monitored very closely by the Senior Workforce & OD team.

The paper is intended to provide assurance to the Trust Board that the Workforce & Organisational Development strategy remains fit for purpose and that traction is being maintained in terms of implementation.

Background

The Workforce & Organisational Development Strategy underpins the Trust's mission, vision and strategic objectives. It sets out an enabling framework to support the delivery of the objectives while ensuring the trust values are embedded in all that we do. It also provides a clear mechanism for engaging and developing Leaders and staff to enable the cultural changes necessary to deliver the Trust's vision. Our aim is to have a healthy organisational culture, a sustainable and capable workforce, working in an integrated manner with partners and where the leadership and management of our people is effective and conducted in a manner that improves staff experience and lets us demonstrate that we have put our values into action. We want to be "an employer of choice" and attract, recruit and retain a compassionate, engaged, skilled and experienced workforce who deliver excellent patient care and who work together to continuously improve the quality of the services and care we provide. The strategy sets out the workforce priorities and framework for delivery to achieve this.

Colleagues will recall that the strategy is delivered through four priorities for action:

1. Healthy organisational culture:- By developing and sustaining a healthy organisational culture (based on VOICE values) we will create the conditions for high quality care. This includes ensuring a clear focus is given on the health and well-being of our workforce to prepare them to meet future service needs.

2. Sustainable workforce - Our workforce will need to change to match new ways of delivering services and new ways of working. Critical will be attracting, recruiting and retaining high calibre skilled staff.

3. Capable workforce - All staff need to be appropriately trained and developed in a positive learning environment. We will ensure our education and development offering delivers a competent workforce who then in turn provide a responsive, equitable, safe and compassionate service.

4. Effective leadership and managers - Our managers and leaders have a key role to play in driving service improvement and cultural change. They need to be valued and supported to flourish in their roles, so that they can support and develop their own teams. Focus will be placed on strengthening the leadership and management interventions and developing improved talent management and succession planning.

The Director of Workforce, Director of Strategy and the Workforce Assurance Committee have fully considered the Workforce & OD Strategy in light of the Trust's new Organisational Strategy and whilst tweaks will need to be made the main body of the Strategy remains unchanged.

Progress to date

The Workforce & Organisational Development action plan is closely monitored by the senior Workforce & Organisational Development team. Due to the breadth of this action plan the fine details are not included within the paper but notable successes include:-

Health Organisational Culture

- The refreshed Freedom to Speak Up approach has seen an increase in the number of staff that feel able to report their concerns through this mechanism.
- A Deeper focus on Workforce Inclusion matters is evident. Including development of BAME Network, Rainbow flag campaign, Inclusion learning Week. Pleasingly the recent Clinical Excellence Awards Round saw a significant number of females receiving these awards which supports the matters previously noted in Board regarding the Gender Pay Gap. An internal 'stepping up' programme has been designed (and will be implemented in this financial year) to help break the 'glass ceiling' which is evident for some of our staff with protected characteristics.
- Roll out of Go Engage programme in advance of NHS Staff Survey 2019. Positive feedback received at all levels. Board members will recall from a recent presentation that the Go Engage framework provides an evidence-based, validated structure for you to explore employee engagement more deeply and gives you the tools to respond in a tailored way to your employee engagement needs. The Go Engage model helps the Trust to analyse our engagement levels in all its constituent parts, helping to customise improvement plans and visibly see the cause and effect of engagement work.
- Sharper focus on Health & Wellbeing: Improved performance of Occupational Health KPI's (albeit further work required); Resilience programmes developed and rolled out throughout the organisation; introduced Neybar (financial assistance support to our staff), VIVUP Portal (Health & Wellbeing portal), launch of Employee Assistance Programme, and additional investment in Mental Health support. This has resulted in some improvements in pockets of the organisation, albeit as noted later in the report not to the required level.
- Increased Organisational Development (OD) interventions have taken place at a local level. OD at Bolton very much starts from the premise that the experts in addressing these issues are the people who face them every day. As such these facilitated interventions have helped to understand what inhibits our staff is often a range of interlinking factors – inability to see underlying problems, breakdowns in relationships, siloed thinking and cultures, cycles of negativity. By gaining this deeper understanding the OD teams have then supported to improve relationships within the service areas, which in turn is key in helping these areas to moves to a stronger footing to meet the ever-evolving challenges in local areas.

Sustainable Workforce

- Recruitment & Retention plan saw a sharper and more innovative focus on many 'hard to fill' posts, this coupled with rolling recruitment events including Bolton locality wide has helped put the Trust in a very strong position for all recruitment metrics. Board members will be aware that as a reduction of these steps there has been significant reductions in Agency spend.
- Introduction of a revised Exit Interview process. The refreshed process will soon help offer a deeper look at workplace culture, day-to-day processes, management solutions, and employee morale.

- Further development of emerging roles has taken place; Training Nurse Associates, Physician Associates, Ward Pharmacists, Advanced Nurse Practioners, MTI Doctors
- Implementation of a refreshed and improved Job Planning Round. The Job Planning reviews has helped to further ensure the efficient and effective use of consultants' time which is critical during a period of operational challenge, change in medical technology and evolving healthcare delivery systems.
- Further 'roll out' of e-rostering and improved reporting. Effective e-rostering is very important as it can influence culture change and give staff the evidence they need to make change happen at the front line. It gives an overview across the organisation, not only month by month but day to day, highlighting hotspots requiring intervention to ensure safe staffing levels and efficient deployment of staff.
- Importantly the Strategy was developed in the knowledge of a changing and emerging landscape. To this end significant input has been provided into the Bolton Locality work programmes. At a very high level the team have led the commissioning of an OD roadmap to support the ICP Executive Steering Group on their cultural journey; Bolton system is pioneering the implementation of a Virtual Workforce Information System (VWIS) which is being designed to help Bolton ICP be sighted on workforce data across the system, which will then help in system-wide Workforce Planning. Workforce Planning has also taken place across the North West Sector to help inform the discussions that are taking place across Greater Manchester.

Capable Workforce

- Implementation of Apprenticeships Plan (exceeded number of targeted apprentices, with over 130 apprentices working within the organisation). Our apprenticeships provide routes into a variety of careers in the Trust and are an excellent opportunity to earn, gain work experience and achieve nationally recognised qualifications at the same time.
- Improvements have been made to the Care Certificate Programme. The Care Certificate is aimed at equipping health and social care support workers, including healthcare assistants, assistant practioners, and nursing associates with the knowledge and skills which they need to provide safe and compassionate care.
- Preceptorship continues to be positively implemented within the organisation. This really is important as the beginning of a newly qualified practitioner's career can be a challenging time. Initial experiences can shape how they develop in their career. To ensure the best possible start for newly qualified nurses, midwives and allied health professionals, a quality preceptorship programme is essential
- Introduction of a Probationary Period. A probation period is a period of time for an employee to demonstrate suitability for their role. It allows both the manager and the employee to take into account the individuals overall capability, skills, performance and general conduct including attendance in relation to the job in question and assess objectively if they meet the requirements.

Leadership & Development

- The development of a Leadership Framework has been very well received. This clearly articulates the internal and external training offered to our staff at all levels. In addition to this more focused leadership programmes have been developed where the Trust has determined additional focus is required e.g. Operational Managers Leadership programme.
- Introduction of a Shadow Board Programme. The Shadow Board Programme is a leadership development programme for aspirant board members and senior

managers, but it's also much more than that, offering both experiential and modular learning which equips participants with the right level of knowledge and understanding of working at board level.

- The Leadership Master Classes programme in place and very positively received. Having such reputable and renowned speakers has created a real buzz in the organisation and given our leaders the opportunity to learn from experts about how they can further develop in their own leadership journey.
- Working with the Medical Director Consultants within the trust have been surveyed to gain a greater understanding of what Leadership development has been undertaken both internally and externally. The survey results will inform the design of the leadership offer for medical leaders within the trust.

Measuring the progress

A key measure of the success of the strategy is the national staff survey results. Although the formal strategy was approved in September, 2018, the work-streams had already been established and progress was underway. The 2018 staff survey results published in March 2019 indicates that good progress has been made to meeting the objectives of the strategy: Furthermore improvement across a number of key workforce metrics has been demonstrated (Recruitment, Agency, Workforce Inclusion, Appraisal and Mandatory Training).

There does remain though remain further improvement required, most notably sickness absence rates. Interestingly recent data has shown that the Trust has moved from having the worst sickness absence rate amongst the GM Trusts to now having the second best (lowest), worthy of note though is that this has largely been a result of Bolton's absence rate levelling and other Trust's worsening. Given the work that is required on sickness absence a refreshed Health & Wellbeing Action Strategy has been developed and considered at the Workforce Assurance Committee.

Concluding Comments

Committee members will recall the challenge and 'stretch' detailed within the Strategy and pleasingly significant progress has been made by the organisation. This momentum will continue moving into Year 2 of the Strategy and a sharper focus will be given where the required improvements have not been realised.

Recommendation

It is recommended that the current Workforce & OD strategy work-stream action plans continue to be implemented and continue to be evaluated during the 3 year life cycle of the strategy.

The Trust Board is asked to accept this report as assurance that the required progress is being made in respect of delivering the Workforce & OD strategy. The area of concern remains that sickness absence levels are not at the pace anticipated.

NHS
Bolton
NHS Foundation Trust

Workforce and Organisational Development Strategy

2018 – 2021

Contents

Acronyms

AHP	Allied health professionals
BFT	Bolton NHS Foundation Trust
GM	Greater Manchester
HR	Human resources
LDA	Learning and development agreement
OD	Organisational development
PSED	Public Sector Equality Duty
VOICE	Vision, Openness, Integrity, Compassion, Excellence
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Document information

Version	11
Date	September 2018
Audience	Bolton NHS Foundation Trust Board
Status	Final
Authors	James Mawrey – Director of Workforce

1> Foreword and introduction

We are delighted to be introducing our sharpened Workforce and Organisational Development Strategy. This strategy identifies the trust's workforce priorities for the next three years.

Our aim is to deliver high quality patient care which is supported by a workforce who are engaged, highly skilled and competent. The quality of experience and clinical outcomes of the people who use our services are a direct result of interactions with staff.

Our staff really are our greatest asset and this strategy describes the support and opportunities that we will make available to them. The strategy is underpinned by our VOICE values. These values form the basis of our expectations of how we will operate on a day-to-day basis to deliver the highest quality of care for each and every patient we serve.

Our thanks go out to the number of stakeholders that have been involved in the development of this document (staff, staff side partners, managers, and executive / non-executive directors).

We will regularly review progress being made against this strategy at the trust's Workforce Assurance Committee and in doing so updates will be provided to the Trust Board.

NHS Bolton NHS Foundation Trust

Jackie Bene
Chief Executive

James Mawrey
Director of Workforce

VISION OPENNESS INTEGRITY COMPASSION EXCELLENCE

2> Framework for the strategy

The strategy will be delivered through four priorities for action:

1. Healthy organisational culture

By developing and sustaining a healthy organisational culture (based on VOICE values) we will create the conditions for high quality care. This includes ensuring a clear focus is given on the health and well-being of our workforce to prepare them to meet future service needs.

2. Sustainable workforce

Our workforce will need to change to match new ways of delivering services and new ways of working. Critical will be attracting, recruiting and retaining high calibre skilled staff.

3. Capable workforce

All staff need to be appropriately trained and developed in a positive learning environment. We will ensure our education and development offering delivers a competent workforce who then in turn provide a responsive, equitable, safe and compassionate service.

4. Effective leadership and managers

Our managers and leaders have a key role to play in driving service improvement and cultural change. They need to be valued and supported to flourish in their roles, so that they can support and develop their own teams. Focus will be placed on strengthening the leadership and management interventions and developing improved talent management and succession planning.

3> Healthy organisational culture

What we will do

We will:

- Implement the health and wellbeing strategy and ensure that our staff sickness rate is below 4.2%.
- Review and refresh the occupational health specification. This will include developing a more proactive service that delivers improved health awareness programmes such as mental health support, alcohol management, weight management, smoking cessation, mindfulness and resilience programmes.
- Engage and involve staff in decisions and change that affects them. This will include full implementation of *Go-Engage* and the delivery of the staff engagement plan.
- Take action to ensure that staff are clear about the values and behaviours expected of them and align these with HR practices
- Re-energise our *Freedom to Speak Up* approach to ensure that our staff know how to raise concerns and have the confidence that these will be managed in a confidential manner.
- Revitalise our commitment to diversity and inclusion (from Ward to Board) to ensure that our workforce better reflects the community that we serve.
- Ensure that there is a zero tolerance policy in relation to bullying, harassment and discrimination.

How outcomes will be measured

- Sickness absence rates
- National staff survey engagement scores
- *Go-Engage* pulse surveys
- Whistleblowing data
- WRES data
- Reporting of bullying and harassment in the national staff survey

4> Sustainable workforce

What we will do

We will:

- Demonstrate that workforce planning includes a long term perspective and supports new and emerging service delivery models, ensuring that the workforce plan is integrated in to the trust's strategy and financial plans. Where appropriate this will be across the Bolton locality.
- Ensure a refreshed approach to recruitment and retention is undertaken to deliver a strong Bolton brand. This will include innovative plans to address medical, nursing and allied health professional (AHP) staffing pressures.
- Develop a total reward package that provides a positive offering – both pay and non-pay benefits. This includes ensuring that there are appropriately balanced flexible working opportunities to support attracting staff to work within the trust.
- Create a flexible workforce utilising our human resource effectively to provide fully established services and reduce the requirement for temporary staff.
- Ensure consultant job plans match service demand and support 24/7 delivery. Extend the use of job plans to other staff who manage caseloads, for example AHPs and nurse consultants.

How outcomes will be measured

- Recruitment data
- Vacancy rates
- Turnover rates
- Exit interview data
- Bank and agency usage data
- E-Rostering key performance indicators
- NHS staff survey data

5> Capable workforce

What we will do

We will:

- Maximise sources of funding to support our commitment to learning and development.
- Maintain and improve the quality and compliance levels of appraisal, mandatory training and statutory training.
- Further enhance working relationships with local education providers, to ensure strong academic links and the translation of new clinical roles into service delivery.
- Develop a more bespoke approach to learning and development that recognises the local challenges the organisation faces. This will include ensuring that all divisions have developed a training needs analysis.
- Provide a suite of multidisciplinary clinical skills training to ensure clinical competency in practice.
- Expand and develop the apprenticeship workforce in all areas creating roles that are patient centred and provide a career structure.

How outcomes will be measured

- Increase in learning and development agreement (LDA) funding
- National staff survey engagement scores
- Appraisal, mandatory and statutory training data
- Apprenticeship data
- Learning and development outcomes– including short / long term benefits realised as a result of L&D intervention

6> Effective leadership and managers

What we will do

We will:

- Develop a robust talent and succession planning programme that identifies future leaders. This will include a bespoke Trust succession plan for business critical roles.
- Build leadership capacity and capability as part of our workforce plan. This will involve developing a breadth of leadership development opportunities both internally and externally to the organisation.
- Develop a transformational leadership framework that ensures a robust process of coaching, mentoring and supervision for leaders at all levels.
- Implement the *Trust Alumni* made up of staff who have been supported through various development programmes to support other staff and trust projects

How outcomes will be measured

- NHS staff survey data
- Internal promotion
- Leadership and development data – including short / long term benefits realised as a result of L&D intervention
- Well Led Inspection

7> Delivering the strategy

Infrastructure

Appropriate infrastructure is required to support the delivery of the strategy and plans include:

- Active engagement of the Trust Board, clinical and managerial leadership.
- Effective workforce systems and processes that utilise latest technology to support, measure, and assure.
- Productive, proactive workforce and organisational development professionals.
- Targeted communication that effectively utilises technology and social media.
- Effective partnership working with trade unions.
- Productive partnerships with universities, further education providers, schools and wider local and national networks.

Risks

It is important to note that there are workforce and organisational development risks that could pose a risk to delivery of business outcomes and outputs. These key workforce risks are included on risk register and to avoid duplication are not included within this document. The work programmes associated with the workforce and organisational development strategy will aim to mitigate these risks.

High level Strategic targets

The key workforce and organisational development targets that the strategy will aim to deliver are:

- To be in the top 20% of NHS organisations for staff engagement scores (as measured by NHS staff survey)
- To have a workforce which reflects the population that we serve – specifically ensuring that the organisation is as diverse as the population we serve (as measured by the Workforce Race Equality Standard)
- Reduced reliance on premium variable spend – specifically delivering the agency forecast set out in the trust's annual plan
- An achieved sickness rates of under 4.2%
- An achieved and sustained appraisal rate of 85% (88% from 1st April, 2018).
- An achieved mandatory training rate of 92%.
- An achieved statutory training rate of 95%
- An achieved turnover rate of 8-10%

7> Delivering the strategy

Monitoring the targets

The workforce and organisational development senior management team will lead the implementation of the workforce and organisational development strategy, ensuring that the strategic workforce plans are converted into deliverable operational actions. A very detailed year one monitoring action plan has been presented to the Workforce Assurance Committee. This action plan will be finalised subject to Trust Board approval.

Delivery against the strategy and related action plan will be formally monitored through the Workforce Assurance Committee with an annual report to the Trust Board.

8> Concluding comments

There is no doubting the challenge and 'stretch' detailed within this document but committing to meeting this challenge will in itself send a message to staff about our determination to continue to provide safe effective services in which there is a recognition of the importance of every individual.

This is not just a strategy or work programme for the workforce and organisational development department – it requires real commitment and input from the whole organisation, particularly those in a leadership position.

Agenda Item No:	**16**
Meeting:	Board of Directors
Date:	3rd October 2019

NHS Bolton NHS Foundation Trust

Title:	Annual Complaints Report
Purpose	This is to provide the Board with a copy of the Complaints and PALS Annual Report for the period 1st April 2018 to 31st March 2019.
Executive Summary:	The Trust has achieved the following since the publication of the last report: • A 6% reduction in the number of formal complaints received • An 11% increase in the number of PALS concerns raised • Performance above the Trust trajectory of 95% responses issued within timescales (96%) • A 24% reduction in the number of cases re-opened • No complaints upheld by the Parliamentary and Health Services Ombudsman
Previously considered by:	Quality Assurance Committee
Recommendation Please state if approval required or if for information	To note

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:		**Presented by:**	Trish Armstrong-Child, Director of Nursing

Annual Complaints & Patient Advice and Liaison Service (PALS) Report

1st April 2018 – 31st March 2019

Bolton NHS Foundation Trust

Content

1.0 Introduction

Bolton NHS Foundation Trust is an integrated organisation providing acute hospital services; specialist and general out patients; Maternity and Women's Health; Emergency Department; and Community Services which are continuing to be developed many as shared services across health and social care (Local Authority).

2.0 Purpose

The Trust is required to publish an Annual Complaints report in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and this report sets out a detailed analysis of the nature and number of complaints and concerns received by Bolton NHS Foundation Trust from 1st April 2018 to 31st March 2019. It provides key information of our performance in responding to complaints and concerns; what learning has been identified as a result of investigations undertaken and how practice has changed in response to the issues raised through the complaints process.

The report also references other Patient Experience intelligence and activity.

3.0 Key successes/progress since 2017/2018

A number of challenges were set from the previous report and the progress towards these is set out below:

Challenge	Progress
Increase the number of complaints training sessions provided to a minimum of 12 per year.	20 training sessions for a variety of staff on the principles of the complaints and PALS process and for lead complaints investigators have been provided this year across each of the Clinical Divisions.
Review and strengthen the process to evidence learning from complaints.	This work is ongoing following the development of an improvement plan to identify and monitoring learning. This will continue to be a challenge going into 2019/20 with the development of the Safeguard database.
Maintain the Trust's response rate of 95% or above in year	96% performance achieved for a second consecutive year.
Further develop the role of PALS to achieve a 2% decrease in the number of formal complaints and a 5% increase in the number of PALS concerns	The Trust has seen an 11% increase in PALS and a 6% reduction in formal complaints when compared with 2018/19
Develop the Trust's database for complaints management (Safeguard) to include a review of the categories used to record complaints, improve the recording and monitoring of evidence of learning and access for Divisional complaints leads.	The progression of this work has been slower than anticipated and this will be an action to be completed during 2019/20
To develop a method of analysis for all patient experience data i.e. FFT, National Survey results, NHS Choices; to include complaints and PALS	In 2018/19 a Patient Experience Report was developed and has been presented at Patient Experience Inclusion Partnership Committee each quarter which includes a triangulation of all Patient Experience intelligence to identify themes etc.,

There were a number of successes from 2018/19:

- A 6% reduction in the number of formal complaints received
- An 11% increase in the number of PALS concerns raised
- Performance above the Trust trajectory of 95% responses issued within timescales (96%)
- A 24% reduction in the number of cases re-opened
- No complaints upheld by the Parliamentary and Health Services Ombudsman

4.0 Number of complaints received

From 1st April 2018 to 31st March 2019, the Trust received 275 written complaints that were responded to under its Complaints and Concerns Policy. The table below provides details of how these compare with episodes of care with comparative data for the previous year.

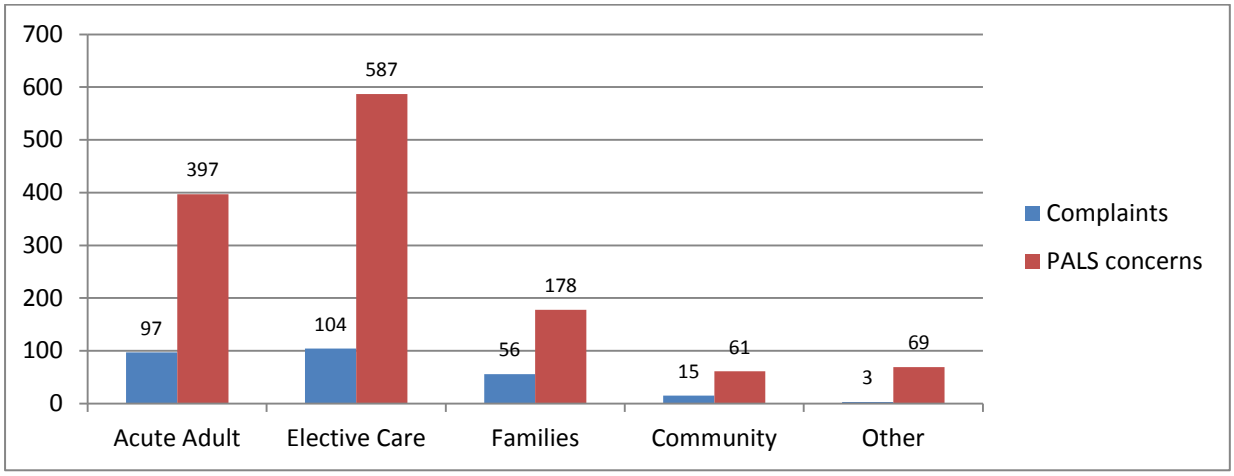
	2015/2016	2016/2017	2017/2018	2018/2019
Complaints	398	305	294	275
PALS	942	1190	1158	1292
Patient activity*	1,232,422	1,194,472	1,193,718	1,147,705
Ratio complaints/PALS concerns v episodes of care delivered	1:919	1:1003	1:822	1:732

- *This includes in-patient spells, community activity, outpatient attendances*

The above information shows:

- That although there has been a reduction in the number of formal complaints and an increase in PALS contacts, there has been a slight increase in the ratio of patients making a complaint or contacting PALS which could indicate that more patients etc., have access to our service.

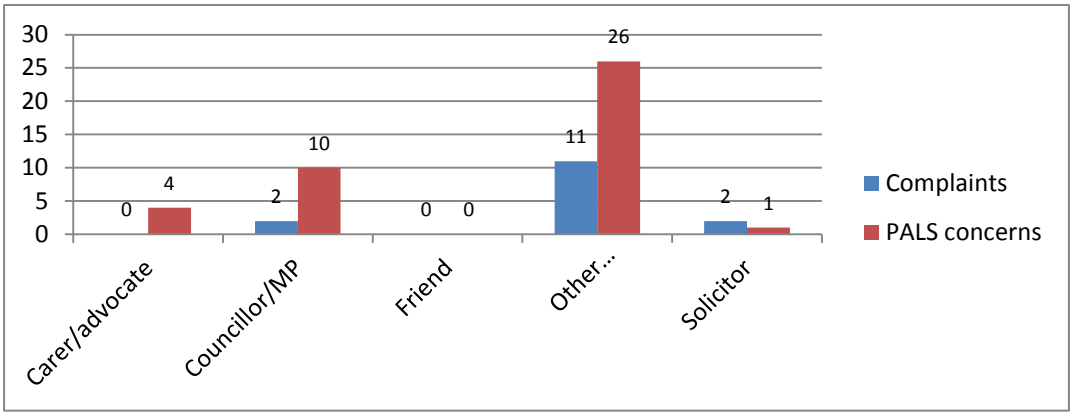
The tables below show the complaints and PALS concerns received by Division.

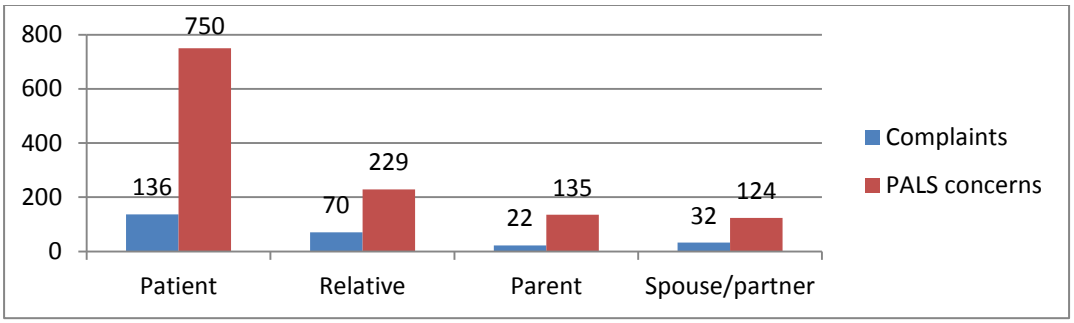


- *Other relates to none clinical services including corporate, finance and iFM*

5.0 Source of complaints

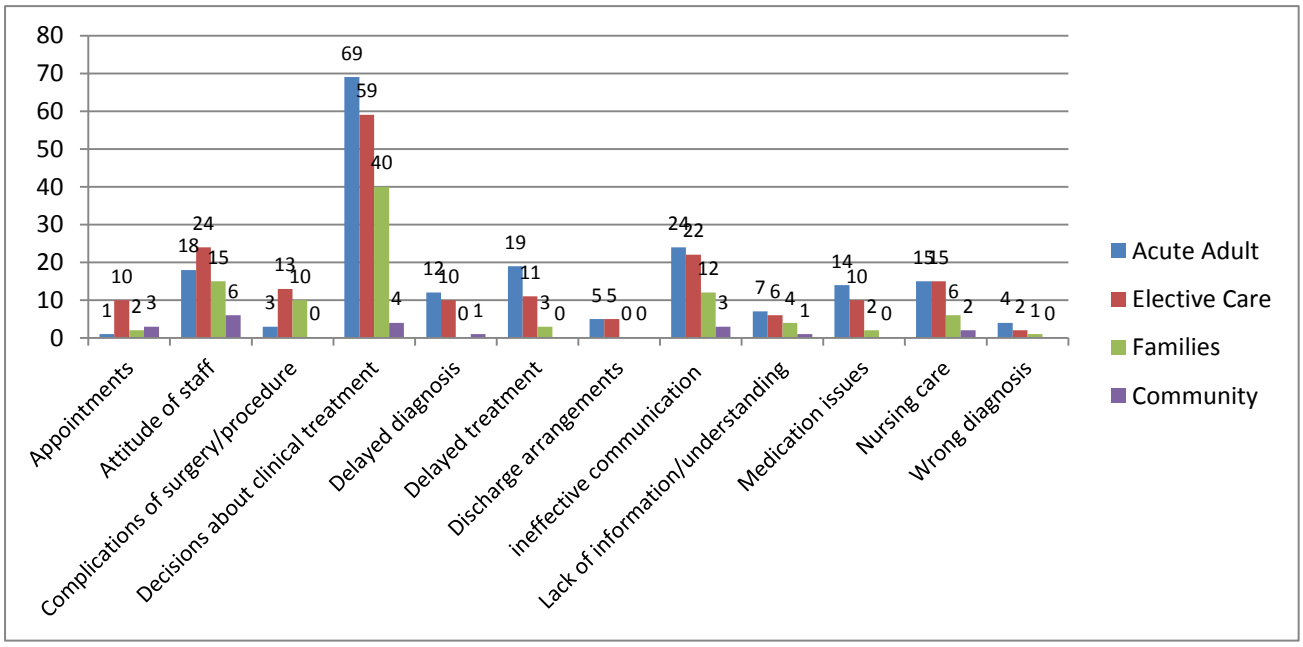
The Trust receives complaints and PALS from a variety of sources and the charts below provide details of this:





6.0 Analysis of themes

Previous reports have shown the categories of complaint by main issue recorded. This report and the graph below provide an analysis of all categories recorded (*this will be greater than the number of complaint letters received as each complaint may have more than one category recorded against it).*



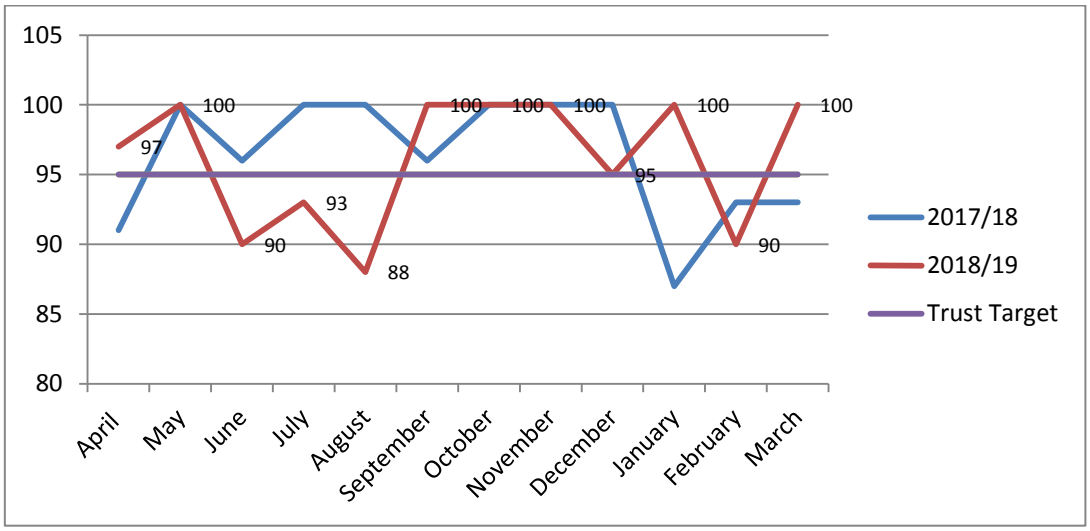
**the category of all aspects of clinical treatment includes decisions made by doctors and outcomes from care and treatment*

7.0 Response rates

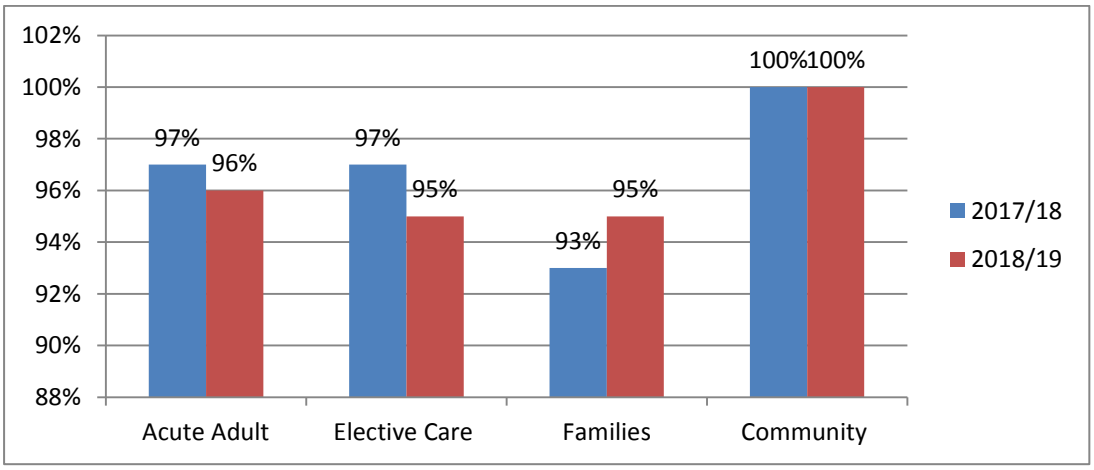
The Trust Policy is that complainants will be sent a written response from the Chief Executive within 35 working days or longer at the complainant's request or where the complaint relates to other NHS providers or is complex in nature.

The Trust aims for an overall annual response rate of 95% and in 2018/2019 the Trust was successful in achieving a 96% performance. The Trust breached on only 12 occasions. Most breaches occurred as a result of delays within the process often where there was a need to seek clarification/information to ensure the response met the needs of the complainant.

The chart below shows the % target achieved by month with comparisons for the previous year.



The chart below shows performance by Division with a comparison for the previous year:

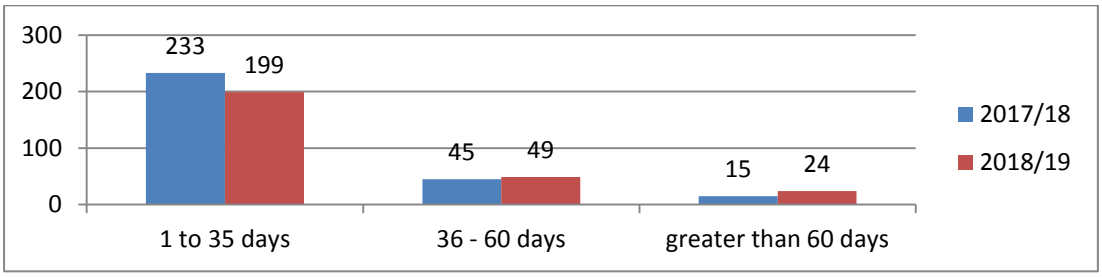


Each Division has continued to meet the Trust trajectory of 95% during 2018/2019 with an improvement seen in the Families Division.

8.0 Days to respond

During 2018/19 the Trust had 24 complaints exceeding the 6 month target set out in the Local Authority Social Services and National Health Service Complaint (England) Regulations 2009. These were with the agreement of the complainant and due to the complexities of the cases that crossed a number of organisations and where meetings were required.

The table below shows the days to respond compared with the previous year and demonstrates the improvements that have been made.

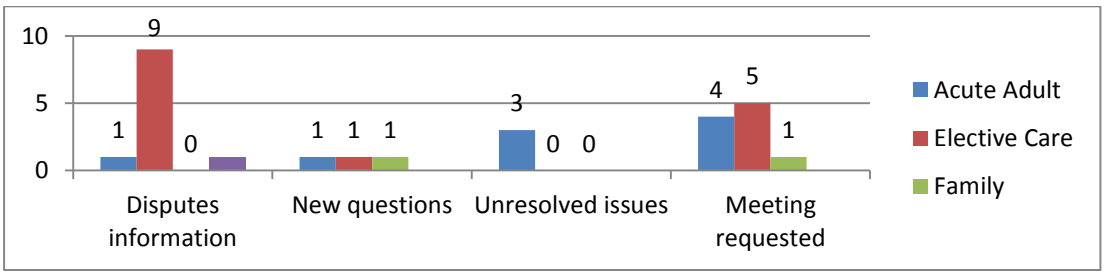


In addition, we have continued to see the number of complaint responses issued on the due date or the day before reduce to 98 when compared with 125 in 2017/18 and 157 during 2016/17.

9.0 Re-opened cases

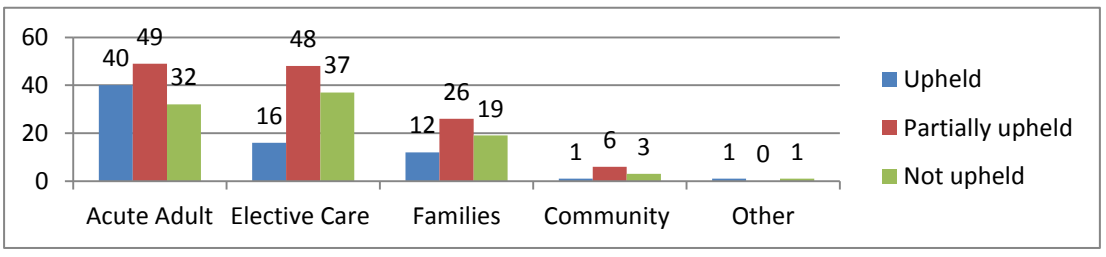
The Patient Experience Team contacts each complainant on receipt of their complaint to discuss their concerns and to establish an understanding of their issues and the outcome they are looking for. This is felt to be one of the reasons for the reduction in re-opened cases.

During the period 2018/19, 16 complaints were re-opened (*excluding meeting requests and PHSO cases*) compared with 21 the previous year. There are often a number of reasons why complaints are not resolved initially. The Trust proactively offers a meeting which allows a further opportunity to provide an explanation and achieve a resolution. The charts below provide details of the reasons the cases were re-opened and which Division they related to (*there were no re-opened cases in ICC*):



10.0 Outcomes

Of the 275 complaints received during the year 2018/19, 272 have received a response at the time of this report. The table below indicates whether they have been upheld, partially upheld or not upheld based on the outcome of the investigation and are shown by Division.



11.0 Learning/Service Improvements

The Trust is committed to learning from complaints received regardless of whether they are considered to be upheld or not. The outcome of the investigation which includes details of the actions and learning identified are monitored alongside incidents and claims to ensure governance arrangements are robustly embedded to improve patient safety. Monthly reports on outstanding actions from complaints are monitored in this way. To ensure that Trust wide learning is shared, monthly slides are produced and circulated across the Organisation providing details of examples of learning from complaints. All Divisional specialties discuss the outcomes of their complaints to also share learning across teams.

What have we changed as a result of complaints in 2018/19:

- We have listened to the needs of our Carers and introduced open visiting in line with John's Campaign
- We have provided training to staff on the needs of patients with Learning Difficulties
- We have involved relatives in the care of patients with Dementia
- We have asked our Tissue Viability Team to provide additional training to staff so that they can educate patients on the appropriate use of hosiery on discharge
- We have amended patient information leaflets to include additional conditions to support our patients
- We have provided additional training to staff regarding Best Interests Meetings
- We have worked with our bereavement team to improve staff skills on the care of the dying
- We have developed a welcome pack on our surgical wards
- We have worked with our commissioners and now provide a Tongue Tie Clinic at Bolton FT
- We have introduced an early baby bereavement nurse to support both families and staff
- We have improved our infant feeding training program
- We have agreed a new process following still birth relating to analysis with Manchester to include improved communication between providers
- In Podiatry we have amended our letters to patients who have not attended their appointment
- We have further trained our staff on our children's ward about the facilities/support available for parents/carers who provide 1:1 care for their child

12.0 Parliamentary and Health Service Ombudsman (PHSO)

There were 3 cases accepted by the PHSO for investigation between 1 April 2018 and 31 March 2019 compared with zero for the previous year. Two of these were not upheld. In the third case, the complaint was partially upheld as they considered the patient to have suffered an injustice due to a delay in an investigation but made no recommendations for action as they were assured by the actions already taken by the Trust.

13.0 PALS

The Trust acted upon 1292 PALS concerns during 2018/19 showing an increase of 134 when compared with the previous year. This is reassuring and demonstrates the work undertaken in year to promote the PALS service.

The Divisional breakdown can be seen at section 4. All concerns are dealt with quickly by telephone or in person by senior staff visiting the patient or relative on a ward. There are however occasions when it is not possible to resolve a concern to the patient's satisfaction and in these instances, the complaints process will be offered to allow for a thorough investigation and written response to be provided. The table below shows how many PALs concerns were escalated during 2018/19 by Division:

Acute Adult Care	2
Elective Care	2
Family Care	2
Integrated Community Services	1

In order to manage patient expectations, during the winter months, the PALS team maintained a presence in our Emergency Department to support patients whilst waiting to be seen and to resolve any issues that arose at the time. The PALS team also supported our Elective Care Division by providing patients who contacted them in relation to cancellations of elective surgery with a full explanation.

14.0 Good Practice

The Patient Experience Team, working in conjunction with Divisional colleagues have facilitated 40 meetings this year with complainants either to share the findings of the investigation or subsequent to a written response to provide further clarification. These have proven successful with none of the cases being re-opened.

In addition, the Patient Experience Team also takes into consideration the needs of the complainant by avoiding contact either in writing by letter or email or my telephone around key dates including the anniversary of a patient's death and for example the first Christmas time to avoid causing additional upset for them.

15.0 Compliments

During this financial year, the Trust has developed a system of capturing expressions of gratitude from our service users starting with our inpatient areas. During the period 1st April 2018 to 31st March 2019, the Trust recorded 9713 expressions of gratitude which included, thank you cards and letters, gifts including chocolates and biscuits and donations to our charitable funds. All of these were shared with the staff involved and were gratefully received.

16.0 Benchmarking

The Trust provides data quarterly to the NHS Digital Strategic Data Collection Service on the number of complaints it has received in that period. This is the statutory based mechanism for collating written complaints data about NHS care and treatment across all NHS organisations in England. There are some exceptions to the criteria; such as if a complaint investigation is led by another Trust and therefore the numbers do not assimilate to the total number. The table below provides some level of benchmarking in relation to other North West Acute Trusts that has been published:

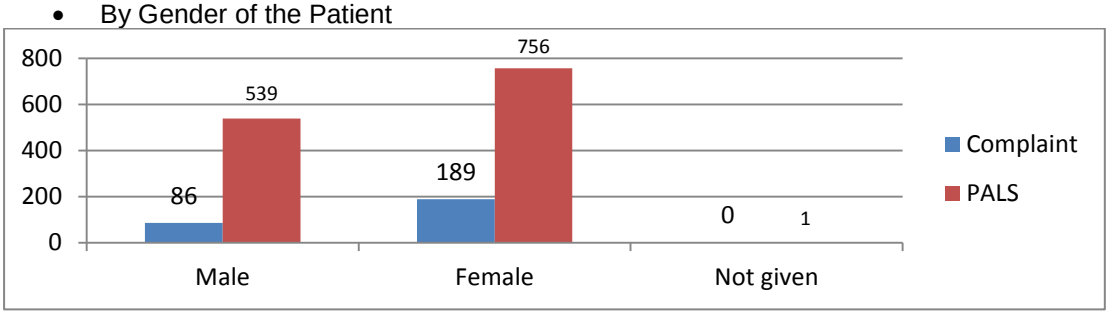
Financial year	Bolton FT	Trust 1	Trust 2	Trust 3	Trust 4	Trust 5
2013/14	562	391	383	1192	813	708
2014/15	467	377	418	1035	756	775
2015/16	398	365	319	1152	607	771
2016/17	305	337	288	743	491	521
2017/18	294	480	378	482*	761	476
2018/19	275	563	354	1517	1049	415

The table above demonstrates a continuous reduction in the number of formal complaints at Bolton FT and is favorable when compared with similar sized Trusts in the Region with only two other Trust's seeing a reduction.

17.0 Equality Monitoring

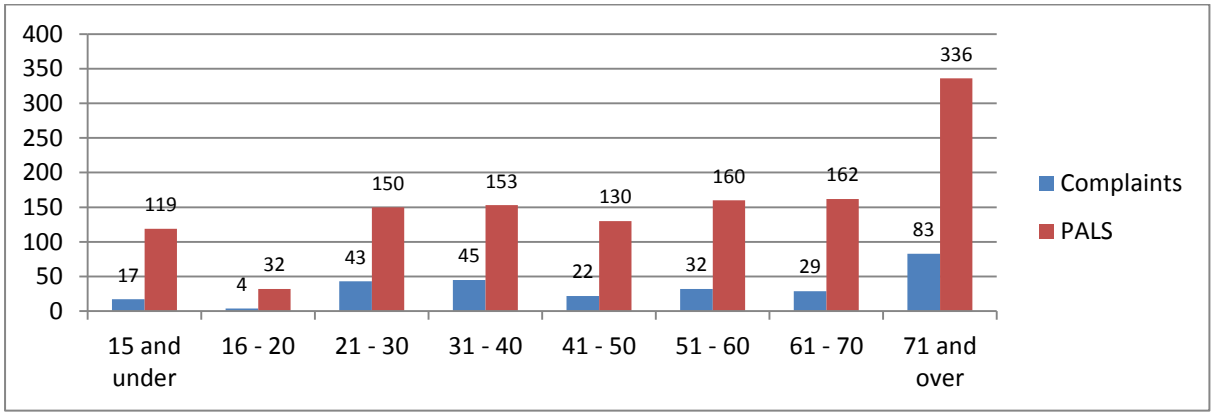
Complaints and PALS concerns are currently monitored against the age, ethnicity and gender of the patient in order to assist the Trust in establishing whether the services provided meets the needs for all. These are recorded on our Safeguard complaint database and shared with our Equality, Diversity and Involvement Lead. The Trust commenced routinely collecting age and ethnicity data for PALS during 2018/19 and this is included in this report.

- By Gender of the Patient



** The 1 not given was an anonymous case where patient details were not provided.*

By the Age group of the patient



- By Ethnicity of the patient

ETHNICITY	No. of patients	% of patients	PALS	% of total PALS concerns	Complaints	% of Total complaints
White British	**209555**	62.4%	1043	81%	217	74%
White Irish	721	0.40%	0	0.00%	10	3%
Any other White background	2,857	1.40%	2	0.15%	1	0%
Bangladeshi (Asian or Asian British)	259	0.10%	2	0.15%	0	0%
Indian (Asian or Asian British)	7,984	4.00%	40	3.10%	10	3%
Pakistani (Asian or Asian British)	7,597	3.80%	24	1.86%	6	2%
Any other Asian background	2,222	1.10%	33	2.56%	5	2%
African (Black or Black British)	2,204	1.10%	8	0.62%	2	1%
Caribbean (Black or Black British)	324	0.20%	5	0.39%	2	1%

ETHNICITY	No. of patients	% of patients	PALS	% of total PALS concerns	Complaints	% of Total complaints
Any other Black background	385	0.20%	0	0.00%	0	0%
Chinese (any other ethnic group)	394	0.20%	0	0.00%	10	3%
Any other ethnic group	2,493	1.30%	9	0.70%	2	1%
White and Asian (Mixed)	614	0.30%	4	0.31%	0	0%
White and Black African (Mixed)	344	0.20%	0	0.00%	0	0%
White and Black Caribbean (Mixed)	478	0.20%	0	0.00%	0	0%
Any other mixed background	643	0.30%	1	0.08%	3	1%
Not asked			26	2.01%	1	0%
Not given			94	7.28%	26	9%
	29519		1291	100.00%	295	100.00%

The equality monitoring data demonstrates the following:

- There is an over representation of the White British community accessing both PALS (81%) and complaints (74%) services when compared to the overall patient profile (62%).
- Ethnic groups with highest usage of pals when compared with total patient profile are White British, Any other Asian background, Caribbean and Any Other Mixed background respectively. Groups with the highest usage of the complaints service are the same with the addition of White Irish and Chinese. It is to be noted, both the latter ethnic groups have not used PALS but have the highest level of complaints service when compared with the total patient profile by ethnicity. There is a disproportionately lower representation of services being accessed by the remaining groups
- 8% of pals data and 9% of complaints data is not recorded where patients have not given the information

A number of actions/recommendations from this have been made which are:

- Increase awareness of PALS and complaints service amongst BME communities and identify barriers to access.
- Publicity materials to be reviewed and include information available in different languages
- Reach out to communities to promote the service

**** Equality Impact Assessment attached***

18.0 Additional Patient Experience Activity/Updates

In this last financial year, the Patient Experience Team has been working on a number of initiatives and made improvements to processes, including:

- Introduction of an “easy read” complaints policy/leaflet available on Trust internet
- Always Events – first project commenced relating to Pre-Operative Assessment
- Celebration Event planned for December 2019 to say “thank you” to members of the public who have supported us with patient experience and an opportunity for staff to showcase the improvements made
- Patients have attended our Trust Board to tell their story
- Patient stories told at Quality Assurance Committee, Patient Experience Involvement Partnership Committee, Infection Prevention and Control Committee and Divisional Board meetings each month
- Strengthened relationships with Bolton Carers Partnership Board to improve services and support offered to Carers
- Commenced a “Please Write to me Project” in collaboration with our Out-Patients Service review
- We have reviewed and streamlined our Patient Information Leaflet process
- We have commenced 4 projects on themes from our 2018 Adult In-Patient Survey results
- We have refurbished our PALS office to provide a more welcoming environment for members of the public to share their concerns with us

It was also a time for celebration as the Patient Experience Team were awarded Team of the Tear in the Corporate Division having been nominated by colleagues in each of the clinical Divisions for which we were immensely proud.

19.0 Challenges for 2019/2020

Although this has been a successful year, there is always room for improvement and there are a number of challenges that have been set going into 2019/2020:

Challenge
Review and strengthen the process to evidence learning from complaints.
Maintain the Trust’s response rate of 95% or above in year
Further develop the role of PALS to achieve a 2% decrease in the number of formal complaints and a 5% increase in the number of PALS concerns.
Develop the Trust’s database for complaints management (Safeguard) to include a review of the categories used to record complaints, improve the recording and monitoring of evidence of learning and access for Divisional complaints leads.
Strengthen equality monitoring and improve access to PALS and complaints process for all patient groups

Agenda Item No:	**17**
Meeting:	Board of Directors
Date:	3rd October 2019

NHS Bolton NHS Foundation Trust

Title:	Medical Appraisal and Revalidation Annual Organisation Audit and Board Report
Purpose	An annual return is made to NHS England regarding our appraisal and revalidation programme, using a specified template
Executive Summary:	The appraisal and revalidation system is performing to a high level of assurance at Bolton FT and there is a comprehensive plan for the coming year to enhance the process further
Previously considered by:	N/A
Recommendation Please state if approval required or if for information	The board is asked to approve the board report The AOA is for information.

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*	*y*	*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*	*y*	*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*	*y*	*To develop **partnerships** that will improve services and support education, research and innovation*	
Negative Impact	**Neutral Impact**	**Positive Impact**	

Prepared by:	Rabeya Rashid Francis Andrews	**Presented by:**	Dr F Andrews

Dr Mike Prentice
Revalidation Lead
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

PA Contact Details:
Tracy.calvert@nhs.net
Tel: 0113 825 3052
18 July 2019

Our Ref: 74
Publications Approval 000740

Dr Francis Andrews
Responsible Officer
Bolton NHS Foundation Trust

Dear Dr Andrews

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 74 - Bolton NHS Foundation Trust

I am writing to thank you for submitting a return to the NHS England 18/19 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report setting out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The 2018/19 slimmed down version of the AOA was designed to concentrate primarily on the quantitative measures of previous AOAs, the number of doctors with a prescribed connection and their appraisal rates. In this the sixth year of the AOA, I am pleased to report a continuing upward trend in the overall appraisal rate. This is extremely reassuring and I would like to thank you once again for your continued work. There is emerging evidence that creating the right environment for doctors to reflect on their clinical practice through appraisal is one which enables them to thrive and develop professionally. This benefits the patients that they look after and allows doctors to have confidence in their professional practice.

As well as revising the AOA, a review of reporting the other important aspects of the responsible officer function (monitoring of practice, responding to concerns, and identity/language checks) have moved to the annual Board report. The Board report, combined with the annual Statement of Compliance, has been re-designed to support a conversation within the designated body to review all the responsible officer's obligations and to agree an action plan for areas where further development is identified.
Assurance of the totality of the designated body's work on the responsible officer's duties will therefore be provided to the higher level responsible officer through both completion of the AOA and the statement of compliance, as signed off by the designated body's Board or equivalent management body.

Board-level accountability for the quality and effectiveness of appraisal rates is extremely important and this report, along with the resulting action plan, should be presented to your board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account.

If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Dr Mike Prentice
Your local revalidation team's lead contact	Rachel Stephenson
Your local revalidation team's contact details	england.revalidation-north@nhs.net

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2019. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing the required assurance to your higher level RO, and to NHS England.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Mike Prentice

Doctor Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer
cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 862 returns from designated bodies (DBs) to the 2018/19 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2019

The following information is presented as per your own AOA submission.

Name of designated body:	Bolton NHS Foundation Trust
Name of responsible officer:	Dr Francis Andrews
Sector:	Acute hospital/secondary care foundation trust
Prescribed connection to:	NHS England (Regional Team - North)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Rachel Stephenson at england.revalidation-north@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2018/19 for the full indicator definitions if required.

2018/19 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	94 (97.9%)	851 (98.7%)

2018/19 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2019**	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	207	28190	53177
2.1.2	Staff grade, associate specialist, specialty doctor	78	5592	12543
2.1.3	Doctors on Performers Lists	0	35	47422
2.1.4	Doctors with practising privileges	0	1	1870
2.1.5	Temporary or short-term contract holders	10	8870	22314
2.1.6	Other doctors with a prescribed connection to this designated body	0	689	7128
2.1.7	**Total number of doctors with a prescribed connection**	295	43377	144454

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Completed appraisals (1)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	186 (89.9%)	93.5%	93.7%
2.1.2	Staff grade, associate specialist, specialty doctor	66 (84.6%)	88.8%	88.2%
2.1.3	Doctors on Performers Lists	N/A	91.4%	95.2%
2.1.4	Doctors with practising privileges	N/A	100.0%	92.7%
2.1.5	Temporary or short-term contract holders	7 (70.0%)	77.8%	81.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	72.1%	87.9%
2.1.7	**Total number of doctors who had a completed annual appraisal**	259 (87.8%)	89.3%	91.5%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Approved incomplete or missed appraisal (2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Approved incomplete or missed appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	20 (9.7%)	4.4%	4.2%
2.1.2	Staff grade, associate specialist, specialty doctor	9 (11.5%)	8.8%	8.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	4.2%
2.1.4	Doctors with practising privileges	N/A	0.0%	5.1%
2.1.5	Temporary or short-term contract holders	1 (10.0%)	17.1%	13.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	22.5%	10.5%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	30 (10.2%)	7.9%	6.4%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Unapproved incomplete or missed appraisal (3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Unapproved incomplete or missed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	1 (0.5%)	2.1%	2.2%
2.1.2	Staff grade, associate specialist, specialty doctor	3 (3.8%)	2.4%	3.2%
2.1.3	Doctors on Performers Lists	N/A	8.6%	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	2.2%
2.1.5	Temporary or short-term contract holders	2 (20.0%)	5.1%	4.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	5.4%	1.6%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	6 (2.0%)	2.8%	2.1%

2018/19 AOA indicator **SECTION 3:**		**Your organisation's response**
3.1	The last Annual Board report was signed off on:	27/09/2018 00:00:00
	The last Statement of Compliance was signed off on:	28/09/2018 00:00:00

2018/19 AOA indicator SECTION 4: Comments		Your organisation's response
4.1		

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Bolton NHS Foundation Trust

Designated Body Annual Board Report

Section 1 – General:

The Board of Directors of Bolton NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission:

6th June 2019

Action from last year:

1. Prevent appraisals taking place in the month of March to ensure completion and final sign off within the financial year.
2. Update and ratify Medical Appraisal Policy
3. Capture new starters in a timely manner
4. Better engagement for short term appointees, otherwise known as 'agile' doctors.
5. Recording of reasons for delayed/missed appraisals including sickness & maternity.

Comments:

All actions above have been implemented or completed. There are areas where we are constantly trying to improve our service, and increase appraisal compliance, such as engagement of agile doctors therefore work is ongoing.

A separate AOA was submitted for ABL Health.

Action for next year:

1. Completion of the Revalidation Entry form and its journey to the MA&R (Medical Appraisal and Revalidation) team at the recruitment stage

2. Monitoring and supporting the agile doctors including additional training/technical support as and when required.

3. Introduction of 'Priming' appraisals - A&R Officer will plan to meet new starter within 1 month of commencement to develop individualised plan to support doctor requirements.

4. Supporting Doctors with varied Job Plans – To develop a pathway between Trusts for information sharing RO to RO to enable ease of sharing concerns, inclusion of complaints/SI's etc.

5. Patient Activity Reports – Increasing quality of appraisal portfolios and supporting our doctors especially our Staff grade doctors in obtaining their information in a timely manner. Reducing the administrative burden for doctors.

6. Inclusion of never events and Serious Incident reporting within appraisal portfolios.

7. Implementation of The Appraisal Summary and PDP Audit Tool (ASPAT) - A tool that may be used to audit the appraisal summary and PDP of all doctors.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:

No action from last Board Report

Comments:

There was since a change in Medical Director and Responsible Officer who is appropriately trained.

The RO for Bolton NHS Foundation Trust is also the RO for a company called ABL Health and for Bolton Hospice. There is a Service Level Agreement (SLA) in place for ABL Health.

Action for next year:

SLA for ABL Health is due for renewal in July 2020.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year:

None

Comments:

There was a change in roles and responsibilities in November 2018 within the A&R team. Where previously there were 2 part time A&R Officers (Band 5-job share), there is now a Band 5 A&R Officer and a Band 3 A&R Administrator (semi-retired). Both roles are part time. However, in view of the growing A&R agenda, an increase in the medical workforce along with the improvements in service we are seeking to implement, there is an increasing requirement to have adequate support/cover throughout the week.

Action for next year:

To support an increase in hours for the A&R Officer in terms of funding for the increase in hours and ability to work flexibly.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:

1. Incorporate Revalidation Entry Form in pre-employment packs.
2. Establish monthly ESR reports for starters and leavers for medics

Comments:

The entry report was included in the pre-employment packs in May 2018 however the forms are seldom received but this impact has been mitigated by making use of the fortnightly induction registers.

Monthly ESR reports are used as backup to ensure all new starters have been captured. This is used as a backup because ESR reports are usually 1-2 months behind and delays first contact with a doctor.

The portal for maintaining prescribed connections, GMC Connect sends notification emails whenever a doctor connects or removes from our Designated Body. This assists the MA&R team to maintain an accurate record of all prescribed connections. Every connection/removal is reviewed to ensure accuracy of our list.

Action for next year:

Monitoring completion of the Revalidation Entry form and its journey to the MA&R team at the recruitment stage.

Continue to regularly review GMC Connect list.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:

Medical Appraisal due for review an

d for ratifying at appropriate committees.

Comments:

Policy was ratified and signed off at Executive level in January 2019

Action for next year:

Medical Appraisal and Revalidation Policy is not due for review or renewal till December 2021 but any updates or significant changes to systems and protocols will be updated and reviewed accordingly within correct channels

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year:

Peer review was undertaken in Summer 2017

Comments:

Actions from the Peer review have been implemented

A separate meeting took place between the A&R Officer and her counterpart at Pennine Acute Trust in November 2018. The objective of this meeting was entirely for sharing best practice.

Action for next year:

To continually review internal processes and how they can be improved

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:

Better engagement for short term appointees who in the past have not had access to our electronic systems. They were supported via the MAG form if they held contracts for duration of less than 12months.

Comments:

We accept that this group may benefit from our current processes and therefore access to electronic appraisal system is now given for short term doctors that hold 6m+ contracts with the Trust. Shorter term contract holders are offered appraisal support via the MAG form.

Access to completing patient and/or colleague feedback is always accessible.

Following the Annual Organisational Audit for 2017-18, it was clear that engagement for our short term/agile doctors needed to be improved. The MA&R team were invited to attend a network meeting in January 2019 where strategies and ideas were shared and will be implemented in the forthcoming months.

In the North sector alone, there has been a 15% increase of Short Term Contract/Locally employed doctors. Unfortunately this does impact on the Appraisal & Revalidation resources i.e. Difficulty for the admin team to support their induction to the Trust, Appraiser capacity, training etc.

Action for next year:

1. Priming Appraisals – A&R Officer will plan to meet new starter within 1 month of commencement to develop individualised plan to support doctor requirements.
2. Further communication/invitation will be emailed to the doctor 4-5 months after commencement to ensure they are engaging in the appraisal process, but to also offer advice/assistance as and when required. This

will encourage timely appraisals and highlight the importance of appraisals.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:

The Trust uses the appraisal system, Premier IT. The appraisal portfolio is compliant with national requirements and is based on the GMC framework for good medical practice.

Inclusion of Complaints reports within the appraisal portfolio commenced in April 2018 for all doctors. The report includes complaints where a doctor has provided information or has been directly involved. If a doctor has not been involved then a nil return report is uploaded.

Comments:

There was a marked improvement in appraisal quality and timeliness for the year 2017-18 compared to the previous year but also against the national average. There was also a notable increase in SAS doctors performance at 96% which was an 8% above the national average for this group.

Work continues to progress to ensure increased appraisal compliance however it was accepted this may be difficult for the year 2018-19 due to the decision to change appraisal month from March to April for 8 of our doctors.

Action for next year:

To develop a pathway between Trusts for information sharing RO to RO to enable ease of sharing concerns, inclusion of complaints/SI's etc.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

Good escalation protocol in place with clear pathway but requirement to increase monitoring of slow/non-engagers.

Require detail for all missed/delayed appraisal reasons.

Comments:

Reasons are recorded on Premier IT for all doctors where a specific reason has been given. Where a specific reason has not been stated, a record of any letters/communication is kept that follows local non-engagement processes.

The A&R team have also enlisted the help of the MSC to support slow/non-engagers. The Chair of this committee is an Appraiser.

The A&R Team also receive monthly ESR reports regarding medical sickness and maternity absence. These are recorded on the Premier IT system.

Action for next year:

To continue to record any reasons for delayed appraisals, record approved postponements and any absence as a special circumstance on their electronic appraisal portfolio.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

Ratification of Appraisal Policy

Comments:

Ratified at JLNC and relevant Executive Committee in December 2018

Action for next year:

No action required for next year. Next review date is December 2020.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

We have a total of 55 trained appraisers. All our appraisers have received a one day face-to-face training at Arrowe Park Hospital, Wirral.

Comments:

Implementation completed in 2 phases: 1- reallocating doctors that require change of appraiser and 2- shifting appraisee connections away from oversubscribed appraisers.

This has eased the administrative burden for oversubscribed doctors and encouraged timelier appraisals.

Unfortunately, due to the changes in pensions/taxation currently affecting medical staff across the NHS, there is a concern that doctors may cut down their work/PA's. It is expected that non-clinical roles such as an Appraiser could see an impact thus affecting quality and timeliness and overburdening the Appraisers that do continue.

Following the National trend, there has been a 15% increase of Locally Employed Doctors in the North sector alone. This contributes to the impact on the Appraisal & Revalidation resources and the burden on existing Appraisers.

Action for next year:

On-going allocation process - requirement to change appraiser after 3 consecutive appraisals. Appraiser allocation is also required for new starters.

To explore incentives to recruit more Appraisers (including SAS Doctors).

5. Medical appraisers participate in on-going performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year and Comments:

Appraiser performance is monitored by inspection of the appraisal output forms by our Appraisal and Revalidation Clinical Lead. Our electronic appraisal system provides the opportunity for appraisee feedback. This information is collated, and a report generated for each appraiser prior to their own appraisal meeting for discussion and reflection. The Appraisal & Revalidation Clinical Lead chairs the Appraiser Network Meetings which is held every 6 months. These meetings are aimed at continuous improvement in the quality and consistency of appraiser performance and an opportunity to discuss topical issues.

Action for next year:

To continue as above.

To implement the ASPAT (The Appraisal Summary and PDP Audit Tool). This is a generic tool that may be used to audit the appraisal summary and PDP of all doctors.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

Monthly meetings take place between the Medical Director/Responsible Officer (RO), Clinical Lead for A&R (CLAR) and A&R Officer where issues and concerns are discussed and where revalidation recommendations are signed off by the RO

While the CLAR reviews all appraisal Output forms to quality assure appraiser summary outputs, a review of the appraisee input forms and portfolios are often also reviewed. This is done for atleast 20 portfolios annually.

Comments:

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Appraisal has moved from being a 'tick box' exercise to a more robust process where the focus is on quality supporting information to encourage better patient care and personal development.

All Appraisers are assessed by their appraisees after each completed appraisal. This is then collated in to an anonymised feedback report which the appraisers receive prior to their own appraisal meeting. The current performance is very satisfactory and no concerns have been raised to date. All appraisal outputs are reviewed by the Clinical Lead to monitor the quality of appraisal documentation.

The CLAR will be introducing the ASPAT tool (The Appraisal Summary and PDP Audit Tool) in the coming months. This will further enhance the quality assurance by feeding directly back to the appraisers regarding their output summaries and PDP completion. This is quite a lengthy process so the aim is to do a subset of appraisers each year (15-20).

Reporting in to the Workforce Committee will occur biannually to ensure oversight of MA&R processes and reporting in to the Board of Directors occurs annually.

Action for next year:

To continue reporting as above in to the Workforce Assurance Committee and Board of Directors.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Revalidation Recommendations made to the GMC between the period 01/04/2018 – 31/03/2019 are detailed below:

Positive Recommendation – 49 (including 1 ABL Health Doctor)

Deferral Recommendation – 10

Non-engagement Recommendation – 0

Late Recommendations – 2

Incorrect Recommendation – 1

Comments:

The late and incorrect recommendations were due to an administrative error. These were rectified immediately and the process for making recommendations was reviewed.

Action for next year:

To ensure all recommendations are made timely and accurately. The A&R Officer will work closely with the administrator that submits the recommendations to ensure the process is maintained.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

Every doctor is kept fully abreast with recommendations where it is likely that a deferral or non-engagement recommendation will be made.

Comments:

A plan is put in place to ensure the doctor achieves the necessary requirements for a positive recommendation for their new revalidation date.

Action for next year:

To continue as above and minimise the number of deferral recommendations made. It is recognised that this is not always possible and sometimes the best course of action in order to support a doctor, is to defer their revalidation date particularly in cases of absence due to ill health/sickness.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

None

Comments:

The board has medically qualified non-executive board director who takes a lead interest in matters relating to clinical governance for doctors. The board is sighted on appraisal information and also clinical indicators. The Medical Director reads all clinical incident reports and chairs scoping panels to determine how serious issues are dealt with within 72 hours of reporting. The Trust was rated for its CQC well led domain and encourages staff to speak openly and there is in addition an active speak up Guardian.

Action for next year:

We will review the document “effective clinical governance for the medical profession” and use the accompanying checklist as a tool to support the development of further good practice

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

None

Comments:

Any concerns regarding conduct or performance are collated by the MD from a number of sources. These include complaints (where a system has been put in place to monitor the frequency of complaints against individual doctors), involvement in serious incidents and never events, and conduct concerns raised by staff, patients, relatives and external agencies. The MD meets regularly with the deputy director of HR to review all concerns regarding conduct and performance and these are tracked. Advice is sought from NHS resolution on all cases and the GMC liaison officer holds quarterly discussions with the MD on cases of concern. Issues with trainees are dealt with through the Lead Employer with support from HR. Relevant information around complaints and involvement in serious incidents/never events is fed back to the appraisal lead to ensure that they are included in appraisal discussions.

Action for next year:

1. Formation of an HR tracker to provide a better evidence base for timeliness of actions and decisions

2. Audit to ensure that relevant complaints and serious incidents are being declared in appraisal discussions

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

None

Comments:

There is a well-established process including capability, conduct and remediation policy and disciplinary policy.

Action for next year:

None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year:

None

Comments:

This is an area which will be looked at closely with HR.

Action for next year:

To devise a quality assurance process with the required metrics and analysis and outcomes, with agreed reporting timescales to Workforce Assurance Committee

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year:

None

Comments:

The MD has liaised rapidly with other responsible officers over the last year, for example concerns about a locum doctor. Where doctors work in addition for other organisations then these issues are rapidly communicated to the relevant responsible officer.

Action for next year:

Development of a more formal process working with the A&R team to support RO to RO communication.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

None

Comments:

The capability, conduct and remediation policy and disciplinary policy are subject to an equality analysis before approval. The Trust has a new Workforce racial equality standards document approved by the Trust Board with a supporting action plan. The RO (medical director) has received full RO training which includes ensuring responses to concerns are free from bias and discrimination

Action for next year:

Ensure a framework is in place to ensure that decision making is free from bias and discrimination and provide evidence for application of this

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

None

Comments:

The Trust uses an e-Recruitment system which supports completion of all required pre-employment checks (in line with NHS Employment Check Standards). This system is used to check all substantive and bank medical staff, and all Foundation Doctors, before they commence work for the Trust.

All agency medical staff are sourced through accredited (through NHS Framework agreements) agency partners and the Trust receives confirmation that all appropriate checks are in place before work is permitted. NHS Frameworks regulate agency partners on their frameworks with regular compliance audits.

Action for next year:

None

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

It has been a busy and successful few years for Medical Appraisal & Revalidation with the implementation of the online system. It has allowed the team to monitor the progress in a more efficient manner. As Medical Appraisal and Revalidation evolves, there are always areas to improve or implement and some of the key areas for development have been discussed.

As mentioned in Section 2, question 4, there is a genuine concern that Appraisers will give up their role in order to reduce their PA's and workload.

Overall conclusion:

Appraisal and Revalidation at Bolton FT is carried out to a high standard and robust processes are in place to ensure that all doctors are supported to achieve appropriate appraisal in a timely manner to ultimately support successful revalidation. Work particularly needs to be undertaken to provide evidence for the new GMC Good governance principles.

Section 7 – Statement of Compliance:

The Board of Directors of Bolton NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Bolton NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Agenda Item No:	**18**
Meeting:	Board of Directors
Date:	3 October 2019

NHS Bolton NHS Foundation Trust

Title:	Standing Orders
Purpose	NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.
Executive Summary:	On authorisation as a Foundation Trust in 2008, the Trust adopted a new set of Standing Orders based on "Model documents" provided as a template. These have been reviewed on a regular basis but with minimal changes. The attached document has now been reviewed in detail and revised to reflect the current governance framework for the Trust. Revisions have also been made to the language used throughout making the document gender neutral and where possible easier to read.
Previously considered by:	
Recommendation Please state if approval required or if for information	Board members are asked to note and approve the proposed changes

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:**	Esther Steel Trust Secretary

Bolton
NHS Foundation Trust

STANDING ORDERS

August 2019

FOREWORD

NHS Foundation Trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. The Board of Directors are also required to adopt schedules of reservation of powers and delegation of powers.

The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

~~The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework.~~ All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

It is acknowledged within these Standing Orders and the Standing Financial Instructions of the Trust that the Chief Executive and Director of Finance will have ultimate responsibility for ensuring that the Trust Board meets its obligation to perform its functions within the financial resources available.

P*rovisions within the Standing Orders which are not subject to suspension under SO 3.32 are indicated in italics.*

CONTENTS

INTRODUCTION

Statutory Framework

Bolton NHS Foundation Trust (the Trust) is a Public Benefit Corporation which was established under the granting of Authority by the Independent Regulator for NHS Foundation Trusts. The principal place of business of the Trust is:

Royal Bolton Hospital, Minerva Road, Bolton, BL4 0JR

NHS Foundation Trusts are governed by statute, mainly the Health and Social Care (Community Health and Standards) Act 2012 and the National Health Service Act 1977 (NHS Act 1977). The statutory functions conferred on the Trust are set out in the Health and Social Care (Community Health and Standards) Act 2006 as amended by the Health and Social Care Act 2012 and in the Trust's terms of authorisation issued by the Independent Regulator.

As a public benefit corporation the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Independent Regulator. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The Health and Social Care (Community Health and Standards) Act 2012 requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Independent Regulator requires NHS Foundation Trusts to adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals.

NHS Framework

In addition to the statutory requirements further guidance has been issued, many of these are contained within the NHS Finance Manual. The manual also contains a list of the main statutes and legislation relevant to NHS Foundation Trusts.

Included in the Manual, are the Codes of Conduct and Accountability for NHS Boards. The Code of Accountability requires that, inter alia, boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of board directors.

Also included in the Corporate Governance Framework Manual (Finance) is the Code of Practice on Openness in the NHS, which sets out the requirements for public access to information on the NHS and is considered good practice by the Trust.

Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board of Directors exercises its powers to make arrangements

for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). That document has effect as if incorporated into the Standing Orders.

Wherever the title Chief Executive, Chief Finance Officer, or other nominated Officer is used in these instructions, it shall be deemed to include such other directors or employees as have been duly authorised to represent them,

1 INTERPRETATION

1.1 Save as permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders ~~(on which the Chief Executive should advise him).~~

1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

"ACCOUNTABLE OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust~~. He shall be responsible~~ with responsibility for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"ACT" means the NHS Act 2006 as amended by the Health and Social Care Act 2012

"TRUST" means Bolton NHS Foundation Trust.

"BOARD OF DIRECTORS" shall mean the Chair and non-executive directors, appointed by the Governing Body, and the executive directors appointed by the relevant committee of the Trust.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"CHAIR" is the person appointed by the Governing Body to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Senior Independent Director of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" shall mean the chief officer and accounting officer of the Trust.

"COMMITTEE" shall mean a committee appointed by the Board of Directors.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"CONSTITUTION" shall be the Constitution of Bolton NHS Foundation Trust.

"DEPUTY CHAIR" shall be the Senior Independent Director of the Trust.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution section 20.1 for the appointment of the Chair, section. 20.1 for the appointment of non-executive directors, section 23.1 for the appointment of the Chief Executive and section 23.4 for the appointment of all other directors. Directors for

the purpose of SO/SFI and Scheme of Delegation are those reporting directly to the Chief Executive, including executive board members.

"DIRECTOR OF FINANCE" shall mean the chief finance officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"OFFICER" means an employee of the Trust.

"SECRETARY" means the Trust Secretary or any other person appointed to perform the duties of the secretary to the Board, including a joint, assistant or deputy secretary, hereinafter to be referred to as the Trust Secretary.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

2. THE BOARD OF DIRECTORS

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 The Trust has the functions conferred on it by the Health and Social Care (Community Health and Standards) Act 2006 as amended by the Health and Social Care Act 2012 and its terms of authorisation issued by the Independent Regulator.

2.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Independent Regulator. Accountability for non-charitable funds held on trust is only to the Independent Regulator.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

2.6 Composition of the Board of Directors - In accordance with the Health and Social Care (Community Health and Standards) Act 2006 and the constitution section 18 composition of the Board of Directors of the Trust shall be:

The Chair of the Trust

At least 5 non-executive directors

At least 5 executive directors including:

- *the Chief Executive (the Chief Officer and Accounting Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *the Medical Director*
- *the Director of Nursing*

The number of Executive Directors must not be greater than the number of Non-Executive Directors

2.7 **Appointment of the Chair and Directors** - *The Chair and non-executive directors are appointed by the Governing Body and the appointments will be in accordance with section 20.1 of the constitution.*

2.8 **Terms of Office of the Chair and Directors** - The regulations governing the period of tenure of office of the Chair and directors will be in accordance with section 9.5 of the constitution.

2.9 **Appointment of Senior Independent Director** – *the appointment of a Senior Independent Director (Deputy Chair) of the Trust is as prescribed in section 22 of the constitution.*

2.10 **Powers of Senior Independent Director** - *Where the Chair of an NHS Foundation Trust has died or has otherwise ceased to hold office or where ~~he has~~they have been unable to perform ~~his~~ their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform ~~his~~ their duties, be taken to include references to the Senior Independent Director*

2.11 **Joint Directors** - *Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for executive directorship or in relation to which an executive director is to be appointed, those persons shall become appointed as an executive director jointly, and shall count for the purpose of Standing Order 2.6 as one person.*

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1 **Admission of the Public and Press** – The public shall be admitted to all formal meetings of the Board, but shall be required to withdraw upon the Board of Directors resolving as follows: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

3.2 Without prejudice to the generality of the right of the Board to exclude the public in accordance with Standing Order 3.1 above, the Board may treat the need to receive or consider recommendations or advice from sources other than Directors, Committees or Sub-Committees of the Board as a special reason why publicity would be prejudicial to the public interest, without regard to the subject or purpose of the recommendation or advice and may treat as a special reason for excluding the public any matter arising as to the appointment, promotion, dismissal, salary or conditions of service or as to the conduct of any person employed by the Board..

3.3 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner

3.4 **Calling Meetings** - Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.5 *The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented ~~to him~~, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented ~~to him~~,* at the Trust's Headquarters*, such one third or more directors may forthwith call a meeting.*

3.6 **Notice of Meetings** - *Before each meeting of the Board of Directors, a notice of the meeting, ~~specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on his behalf~~ shall be delivered to every director, ~~or sent by post to the usual place of residence of such director, so as to be available to him~~ at least three clear days before the meeting.*

3.8 In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.9 Public notice of the time and place of any meeting of the Board (open to the public) shall be given by posting such notice on the Trust's seb site~~at the Offices of the Board~~ at least three clear days ~~at least~~ before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened. Such notice, together with a copy of the agenda, shall be supplied, on request to the press.

3.10 **Setting the Agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

3.11 A director desiring a matter to be included on an agenda shall make this request in writing to the Chair at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

3.12 **Chair of Meeting** - *At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and they are ~~he is~~ present, shall preside. If the Chair and Deputy-Chair are absent such non-executive director as the directors present shall choose shall preside.*

3.13 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

3.14 **Annual Public Meeting** - The Trust will publicise and hold an annual public meeting in accordance with the constitution and the ~~Health and Social Care (Community Health and Standards) Act 2006~~Act.

3.15 **Notices of Motion** - A director of the Trust desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 3.8.

3.16 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.17 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signatures of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if ~~he considers it~~considered appropriate.

3.18 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.19 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)

- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.20 **Chair's Ruling** - The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and ~~his~~ their interpretation of the Standing Orders, shall be final.

3.21 **Voting** - *Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.*

3.22 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.23 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.24 If a director so requests, ~~his~~ their vote shall be recorded by name upon any vote (other than by paper ballot).

3.25 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

3.26 An officer who has been appointed formally by the Board of Directors to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

3.27 **Non – Voting Directors** - Non Voting Directors are ones who Board members have determined should attend the Board in order to provide it with particular expertise on a continuing basis. They are expected to attend all Board meeting whether held in public or private.

They will receive all board papers for agenda items against which their contributions are required. They will have the opportunity to participate in all board discussions but may not take part in any voting and may be excluded from any part of a Board meeting at the request of the Chair.

All matters discussed or witnessed by attendees shall be regarded as confidential to the board save for those where actions are agreed otherwise.

In order that they do not become liable for decisions made, the Chair will make clear that they are being invited to comment upon items for debate but not take part in any vote should one occur

3.28 **Minutes** - *The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.*

3.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.30 Minutes shall be circulated in accordance with directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.31 **Joint Directors** - *Where a post of executive director is shared by more than one person:*

(a) both persons shall be entitled to attend meetings of the Trust:

(b) either of those persons shall be eligible to vote in the case of agreement between them:

(c) in the case of disagreement between them no vote should be cast;

(d) the presence of either or both of those persons shall count as one person for the purposes of SO 3.38 (Quorum).

3.32 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any direction made by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least half (normally six) of the Board of Directors are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.33 A decision to suspend SOs shall be recorded in the minutes of the meeting.

3.34 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

3.35 No formal business may be transacted while SOs are suspended.

3.36 The Audit Committee shall review every decision to suspend SOs.

3.37 **Variation and Amendment of Standing Orders** - These Standing Orders shall not be revoked, varied or amended except upon:

a) A report to the Board by the Chief Executive or the Trust Secretary acting on their behalf.

b) A notice of motion under Standing Order 3.15, such revocation, variation or amendment having to be approved by a number of Directors equal to at least two-thirds (normally eight including the

Chair) of the whole number of Directors of the Board, and provided that any revocation, variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.38 **Record of Attendance** - *The names of the directors present at the meeting shall be recorded* in the minutes.

3.39 **Quorum** - *No business shall be transacted at a meeting of the Board of Directors unless at least one-third (normally four) of the whole number of the directors are present including at least one executive director and one non-executive director.*

3.40 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

3.41 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) ~~he shall~~they will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration Committee).

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to SO 2.7 and such directions as may be given by the Independent Regulator, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

4.2 **Emergency Powers** - The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 **Delegation to Committees** - The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or subcommittee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions ~~he will~~to perform personally and shall nominate officers to undertake the remaining functions for which ~~he~~ the CEO will still retain an accountability to the Board of Directors.

4.5 The Chief Executive shall prepare a Scheme of Delegation ~~identifying his proposals~~, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance and Commissioning or other executive director to provide information and advise the Board of Directors in accordance with any statutory requirements.

4.7 The arrangements made by the Board of Directors as set out in the "Reservation of Powers to the Board and Delegation of Powers" shall have effect as if incorporated in these Standing Orders.

5. COMMITTEES

5.1 **Appointment of Committees** - *Subject to SO 2.7 and such directions as may be given by the Independent Regulator, the Board of Directors may and, if directed ~~by him~~, shall appoint committees of the Board of Directors, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust.*

5.2 *A committee appointed under SO 5.1 may, subject to such directions as may be given by the Independent Regulator or the Board of Directors appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).*

5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board of Directors.

5.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

5.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined.

5.7 Where the Board of Directors is required to appoint persons to a committee and/or to undertake statutory functions as required by the Independent Regulator, and where such appointments are to operate independently of the Board of Directors such appointment shall be made in accordance with the regulations laid down by the Independent Regulator.

5.8 The committees and sub-committees formally established by the Board of Directors are:

Audit

Quality Assurance

Finance and Investment

Workforce Assurance

Nomination and Remuneration

Charitable Funds

5.9 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.10 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Pursuant to Section 20 of Schedule 1 of the Health and Social Care (Community Health and Standards Act 2006), a register of Director's and Governor's interests must be kept by the Trust

6.1 **Declaration of Interests** - The Code of Accountability requires board directors (including for the purposes of this document Non-executive Directors) and Governors to declare interests, which are relevant and material. All existing board directors should declare relevant and material interests. Any board directors or governors appointed subsequently should do so on appointment or election.

6.2 All employees of the Trust who have a direct financial interest in a private company of any description which may be engaged in the provision of goods or services to the NHS, must declare that interest in ~~writing to the Chief Executive~~in accordance with the "*Standards of Business Conduct Policy"* at the time of appointment or commencement of any such interest**.**

6.3 Interests which should be regarded as "relevant and material" and which, for the avoidance of doubt, should include in the register are:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) [A position of authority] in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

6.4 If board directors or governors have any doubt about the relevance of an interest, this should be discussed with the ~~Chair~~Trust Secretary.

6.5 At the time the interests are declared, they should be recorded in the Board of Directors minutes or Governing Body minutes as appropriate. Any changes in interests should be declared at the next Board of Directors meeting or Governing Body meeting as appropriate following the change occurring. It is the obligation of the director or governor to inform the Secretary to the Board in writing within 7 days of becoming aware of the existence of a relevant or material interest. The Secretary to the Board will amend the Register upon receipt within 3 working days.

6.6 Directors directorships of companies in 6.3(a) above or in companies likely or possibly seeking to do business with the NHS (6.3(b) above) should be

published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.7 During the course of a Board of Directors meeting or Governing Body meetings, if a conflict of interest is established, the director or governor concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, majority will resolve the issue with the Chair having the casting vote.

6.8 Register of Interests - The details of directors and governors interests recorded in the Register will be kept up to date by means of a quarterly review of the Register by the Trust Secretary, during which any changes of interests declared during the preceding quarter will be incorporated.

6.9 Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge. The Chair will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 *Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, ~~he shall~~they will at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.*

7.2 The Independent Regulator may, subject to such conditions as ~~he~~ they may think fit to impose ,remove any disability imposed by this Standing Order in any case in which it appears ~~to him~~ in the interests of the National Health Service that the disability shall be removed.

7.3 The Trust shall exclude a director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which ~~he has~~they have a pecuniary interest, is under consideration.

7.4 *Any remuneration, compensation or allowances payable to a director by virtue of paragraph 9 of Schedule 2 to the NHS & CC Act 1990 shall not be treated as a pecuniary interest for the purpose of this Standing Order.*

7.5 For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 7.2 and SO 7.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) ~~he, or a nominee of his~~they or a close associate of theirs, is a director of a company or other body, not being public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or*

b) ~~he is~~they or a close associate of theirs is a business partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; ~~and in the case of married persons or cohabiters the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other~~.*

7.6 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) of ~~his~~ membership of a company or other body, ~~if he has~~with no beneficial interest in any securities of that company or other body;

b) of an interest in any company, body or person ~~with which he is connected~~ as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.7 *Where a director:*

a) *has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and*

b) *the total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and*

c) *if the share capital is of more than one class and~~,~~ the total nominal value of shares of any one class ~~in which he has a beneficial interest~~ does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit ~~him~~ them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to ~~his~~ the duty to disclose ~~his~~ an interest.*

7.8 Standing Order 7 applies to a committee or sub-committee of the Board of Directors as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not ~~he is~~ they are also a director of the Trust) as it applies to a director of the Trust.

For the purposes of these Standing Orders a "Close Associate" is taken to cover the following:

- *Married persons and those in Civil partnerships or cohabiting. In which case, the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.*
- *Interests of parents, siblings or children*
- *Interests of current and former business partners*

8. STANDARDS OF BUSINESS CONDUCT

8.1 **Policy** – The Trust has adopted a Standards of Business Policy and staff must comply with this guidance and guidance in the 2010 Bribery Act. The following provisions should be read in conjunction with these documents.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which ~~he~~ they ~~has~~ have any pecuniary interest not being a contract to which ~~he is himself~~they are a party, has been, or is proposed to be, entered into by the Trust ~~he~~ they shall, at once, give notice in writing to the Chief Executive of the fact ~~that he is interested therein~~. In the case of married persons [or persons] living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare ~~to the Chief Executive~~ any other employment or business or other relationship of theirs or a close associate as previously defined,~~his, or of a spouse or cohabiting partner~~, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Trust shall require interests, employment or relationships so declared by staff to be entered in a register of interests of staff.

8.4 **Canvassing of and Recommendations by, Directors in Relation to Appointments** -Canvassing of directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.5 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render ~~him~~ them liable to instant dismissal.

8.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors any such disclosure made.

8.9 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office under the Trust.

8.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

8.11 Any Board member or member of staff who receives or is offered and declines hospitality in excess of £50.00 is required to enter the details of the hospitality in the Trust's Hospitality Register.

8.12 The Board recognise the 2010 Bribery act which introduces new bribery offences:

- to give, promise or offer a bribe,
- to request, agree to receive or accept a bribe either in the UK or overseas
- A corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the ~~Chair~~ Trust Secretary in a secure place in accordance with arrangements approved by the Board.

9.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by ~~a resolution of~~ the Board of Directors, a Board Committee or ~~or of a committee, thereof~~ or where the Board of Directors has delegated its powers.

9.3 On approval by the Board, or by the Chair or the Chief Executive under delegated powers, to a transaction in pursuance of which the Common Seal of the Board is required to be affixed to appropriate documents, shall be deemed also to convey authority for the use of the Common Seal.

9.4 Where approval to the sealing of a document has been given specifically in pursuance of a resolution of the Board or in accordance with Standing Order No.9.3 above, the Seal shall be affixed in the presence of the Chair, or other Officer duly authorised ~~by him~~ and an Executive Director of the Trust, and shall be attested by them.

9.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Audit Committee at least ~~quarterly~~annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

10. SIGNATURE AND INSPECTION OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

10.3 A Director of the Board may for purposes of their duty ~~such~~ as a Director, but not otherwise, inspect any document which has been considered by the Chair or Chief Executive or senior officers under the terms of their delegated powers, or by the Board, ~~and if a copy is available shall, on request, be supplied for the like purpose which a copy of such document~~ provided that the Director shall not knowingly inspect ~~and shall not call for~~ore request a document relating to a matter in which ~~he is~~they are professionally interested or in which ~~he has~~they have directly or indirectly any pecuniary interest. ~~, and that this~~

This Standing Order shall not preclude the Chief Executive ~~to the Board~~ from declining to allow inspection of any document which is, or in the event of legal proceedings would be, protected by privilege.

10.4 Nothing in the above paragraphs of this Standing Order 10 shall be interpreted as giving the right to Directors to have access to ~~personal medical information relating to patients or to the examination of~~ confidential patient records.

11. MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within the Standing Orders and SFIs. ~~Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs~~.

11.2 **Documents having the standing of Standing Orders** - Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have the effect as if incorporated into SOs.

11.3 **Review of Standing Orders** - Standing Orders shall be reviewed bi-annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

Agenda Item No:	**19.**
Meeting:	Board of Directors
Date:	3rd October 2019

NHS Bolton NHS Foundation Trust

Title:	Planning for the new format board performance report
Purpose	To inform the Board of the proposed changes to the performance report and to seek approval on the proposed methodology and timescales.
Executive Summary:	Following a presentation to the Board by NHS Improvement, the Board have requested that the current Performance report moves away from Red, Amber, Green (RAG) ratings and 2-point comparisons and into using Statistical Process Control (SPC). SPC is a way to visualise variation within an indicator, showing when there is statistical significant improvement or decline. This approach allows more context rather than whether an indicator is simply Red or Green (as an indicator could be Green and therefore showing assurance, but may actually be declining over time and may need some further investigation). This paper proposes that the board report is upgraded, rather than rewritten in the first instance, because of the time constraints. It is proposed that the RAG ratings and trend arrows are replaced by SPC icons and the exception charts, replaced by SPC charts. This will be done by the January board, using December's data.
Previously considered by:	N/A
Recommendation Please state if approval required or if for information	The Board approve the approach and the timescales suggested. The Board are also asked to provide future feedback on iterative designs to ensure suitability and ease of use.

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:	Julie Ryan, Head of Business Intelligence	**Presented by:**	

Planning for new format Board performance report
Julie Ryan, Head of Business Intelligence
24/09/2019

1.0 Introduction

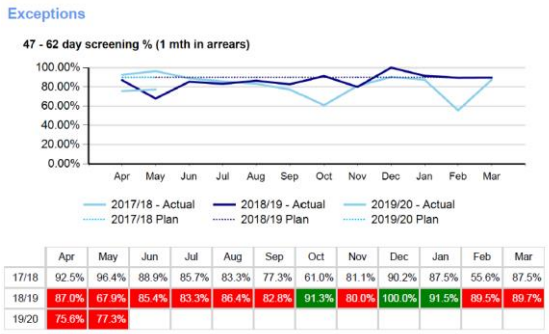
The Foundation Trust's Board performance report (Integrated summary dashboard), is a monthly formal update comprising of approximately 112 key performance indicators split across four domains (Quality and Safety, Operational Performance, Workforce and Finance). The indicators are designed to provide a full balanced view of FT performance, highlighting areas that are performing well, those with challenges and also the movement across months. Integral to this is the format in which the report is presented. The main aim of the board report design is to provide information that:

1) Is presented in a clear, understandable, consistent format
2) Allows for quick assimilation of the information contained within, without diluting the message
3) Is balanced, with a range of indicators to show context and consequences
4) Draws the eye to indicators that require attention
5) Highlights trends and gives supporting information

Currently the board report is in the format shown below,

	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%	85.0%	May-19			>= 85%	88.5%	Apr-19		>= 85%	86.9%		85.0 - 95.4%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	77.3%	May-19			>= 90%	75.6%	Apr-19		>= 90%	76.5%		75.6 - 100.0%	

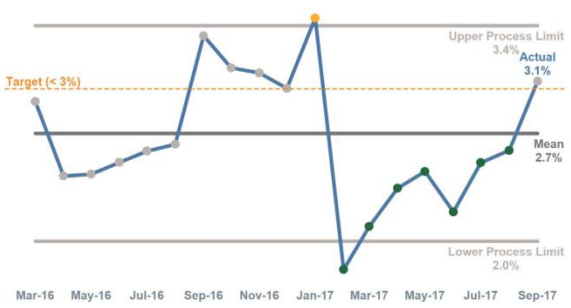
Exceptions are defined as those indicators that are "red", i.e. not achieving the target. These exceptions are then shown underneath the measures table, in a run chart, as per the below example.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.5%	96.4%	88.9%	85.7%	83.3%	77.3%	61.0%	81.1%	90.2%	87.5%	55.6%	87.5%
18/19	87.0%	67.9%	85.4%	83.3%	86.4%	82.8%	91.3%	80.0%	100.0%	91.5%	89.5%	89.7%
19/20	75.6%	77.3%										

2.0 Statistical Process Control

In a guide for assessing quality improvement in a health care provider, the Care Quality Commission (CQC) stated that one of the signs of a mature quality improvement approach across an organisation was *"the Board looks at data as time series analysis, and makes decisions based on an understanding of variation".* [1]It goes on to clarify that "*data are presented as run or control charts, instead of bar graphs, pie charts or RAG rated*". NHS Improvement also started a campaign back in May 2018 to change reporting away from RAG (Red, Amber, Green) ratings to statistical process control charts.[2]



Statistical Process Control (SPC) charts are essentially run charts that contain of measure of variation within a system. All systems and environments contain a level of variation, the key is to identifying when something is "in control" or "out of control". The example on the left (taken from the aforementioned NHS I guide) shows an example of an SPC chart.

[1] ssessing_quality_improvement_in_a_healthcare_provider.pdf

[2] https://improvement.nhs.uk/documents/2748/NHS_MAKING_DATA_COUNT_FINAL.pdf

This chart contains data over time, with the addition of three lines; the mean (average), the upper process limit and the lower process limit. The process limits are calculated specifically for each indicator and are designed so that 99% of the indicators values should fall within them. Anything that is outside of these limits, is classed as "special cause" variation i.e. variation that wasn't expected and warrants further investigation. It's also possible to identify "runs" of points in a chart to show improvement or decline (the green dots on the above show an improvement run), without resorting to a 2-point comparison.

Note that an indicator can be "in control" but not hitting a target, as you can see on the example above, there are only certain months that the target has been hit. This is because this particular process has been designed so that a wide range of values are possible, it's more to chance whether an indicator will achieve or not achieve the target.

3.0 Proposal

Following a presentation by NHS I to the Board, the Board have requested that the current Board performance report moves away from Red, Amber, Green ratings and 2-point comparisons to utilise SPC as standard.

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

The Board performance report is already quite lengthy with over 112 indicators, so we propose to follow some of the NHS I recommendations to utilise icons for each indicator to show both whether there is any significant variation that the Board needs to be aware of, and also a measure of assurance. The assurance indicator is similar to the RAG ratings in that is linked to a target to show whether passing or failing a target, but over time. The symbols shown on the left are illustrative only, and the actual symbols within the Bolton version of this may change, as explained below.

The current Board performance report is a semi-automated report utilising a technology called SQL Server Reporting Services (SSRS), done in this way in order to reduce the amount of time taken to produce the report and provide a consistent format each month. Ideally, the best course of action would be to build up to the Board performance report again, almost from scratch, to build it specifically around the usage of SPC charts. However, it has been requested that the report be ready for December (December data, presented in January), which would make this request impossible without needing to redirect resource away from existing projects.

As an interim, we propose to build on what we have already, and replace the current RAG icons and the trend arrows, with the SPC icons. The exception charts, would then be SPC charts. This would keep the new report around the same size as the existing one, whilst giving the added advantages of SPC. The charts, RAG icons and trend icons are currently "triggered" by the data itself, meaning that someone does not add these features in manually – the report has been built with a set of rules that creates these elements, depending on the data itself. These rules will be rewritten programmatically to instead generate SPC icons and SPC charts. This means that there will be work required to the underlying infrastructure of the report, as well as the actual design of the report itself. We propose that this is not done in a phased way, and that all elements are replaced all at once, to phase this work may cause confusion to the reader and from a technical perspective would actually be more complex to implement.

Charts that do not contain at least 20 data points would remain as standard run charts without the SPC elements.

Over time, we would look to rebuild the report itself around SPC.

4.0 Timescales

We propose that the report in its current format, with the RAG and trend arrows replaced with SPC icons and the exception charts will be released in the Board report in January 2020, for December's data.

We aim to produce a "mock-up" design of what this might look like, alongside options for the SPC icons by the end of October 2019.

In order to approve and advise on this piece of work, we request the assistance of a few volunteer Board members to join a small, virtual, task and finish group in order to approve and

iterate through design options, ensuring that the resulting report adheres to the design principles outlined in the introduction.