Bolton NHS
NHS Foundation Trust

Annual Report and Accounts 2015/16

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Annual Report and Accounts 2015/16

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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Foreword

Foreword

The annual report and accounts have been prepared in accordance with the direction issued by Monitor under the National Health Service Act 2006.

This report is intended to be self-standing and comprehensive in its scope. However where further information is available, for example in the Trust's five year strategic plan, this will be cross-referenced within the report.

For regular updates on our performance and any matters affecting the Trust please refer to our website www.boltonft.nhs.uk

Preparation of Accounts and adoption of going concern

The Accounts provided with the Annual Report have been included under a direction issued by Monitor under the National Health Service Act 2006. After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future.

This judgement was based on the following factors:

- Fundamentally all NHS bodies are financially backed by the government in the form of the Secretary of State for Health so it is not possible for Foundation Trusts to become insolvent in the way that a private company might.
- The DoH operates a formal system to deal with Trusts that are designated as being financially unsustainable. Trusts in this position continue to receive cash support from the DoH and they themselves continue to prepare accounts on a going concern basis. The arrangements in regard of distress funding described above have not been changed by the Greater Manchester Health and Social Care Devolution.
- In addition to the above the Board can be assured that the accounts should be prepared on a going concern basis because of the following:
    - Successful delivery of the 2015/16 financial plan and achievement of the planned Financial Sustainability Risk Rating of two in 2015/16 gives confidence in the organisation's ability to deliver on its financial plans going forward.
    - The Trust ran a successful cash management improvement project in 2015/16 which meant the cash outturn in 2015/16 was better than would have otherwise been expected given the key components of the I&E position.
    - The Board has approved a five year strategic financial plan that shows the Trust generating surpluses going forward.
    - A detailed operational financial plan has been prepared to support the delivery of the planned £11.9m surplus for 2016/17.
    - The planned £11.9m surplus consists of a £2.7m surplus rewarded by a £9.2m payment from the national sustainability and transformation fund. Delivering this surplus will significantly enhance the Trust's cash position meaning that the Trust has been able to plan for a £7.8m cash balance at the end of the 2016/17 financial year.

Foreword

Chairman's Review - April 2016



In every constellation there is a star that shines the brightest and I am delighted to say that during the past twelve months our trust has become that star. You might be forgiven for thinking that the National Health Service is imploding upon itself, given the national headlines, but despite the huge pressures faced, Bolton Foundation Trust has delivered a quite fantastic performance. I couldn't be more proud of every single member of staff and every governor and member of the trust for putting us on the map for all the right reasons. Our patients have been magnificent too, both in the way that they have interacted with us and in the way they have responded to some of the changes we have introduced.

Achievements

2015 was a watershed for us; we were finally released from all the conditions and scrutiny, placed upon us in August 2012 by the health regulator, when we were considered to be in breach of our licence. More remarkably, it transpires that Bolton is the only trust ever to emerge from such conditions without the need for a merger or acquisition. This is indeed testimony to the success of our turnaround plan and the commitment of everyone in the trust. Our success was also highlighted by the Secretary of State for Health at a public forum as a benchmark to others. To put it into perspective, we delivered key performance targets including waiting times, cancer targets, diagnostic tests, stroke targets and many others. Our staff satisfaction scores continued to rise, with the majority now in the top 20% of the UK, and our patient feedback also improved, highlighting the effects of improved care throughout the trust. On the financial side we delivered our plan, a small surplus of £1.9m, and in doing so became the only trust in our peer group within the North West to manage within our budget. In truth, we are amongst the top 10 trusts in the UK for financial performance and we have been recognised nationally for our approach. Exceptionally, this marks the second successive year when we have managed our finances within budget. No other trust in the North West has managed this.

Challenges

We have of course faced very challenging times over the past few months. Our A&E department saw the biggest increase in attendances ever recorded and we were overwhelmed during the winter months. A combination of growing patient numbers, more complex needs and bed shortages in the trust and community all contributed to a massive pressure on our A&E and ward based staff during the winter period. I am eternally grateful for their resilience in dealing with the pressures and keeping patients safe. Unfortunately the impact of these pressures in the latter part of the year resulted in us failing our annual A&E target despite being on track during the first six months of the year. We now plan a radical overhaul of our A&E environment and staffing to tackle the issues faced and a major investment has been agreed by the board which hopefully will place us amongst the best performing trusts for A&E in the country.

Investment

In terms of investment, the good news is that the Trust also secured £30m during 2015 to cover developments required in our estate and IT. Over the next two years we will finally address some of the long term deficiencies suffered by staff and patients alike in parts of our estate that

were built in the 1800s. Our IT infrastructure has lagged behind many of our neighbours for several years and our investment marks the first instalment of a long term strategy to improve the efficiency and effectiveness of our systems.

During the last year we were also involved in a review undertaken nationally by Lord Carter to identify the efficiency opportunities available to Trusts across the UK. We were delighted to discover that Bolton was hailed as a high performer and a benchmark for others. This was evidence of the successful turnaround during the last two years but also to the innovative approach adopted by the trust in the delivery and procurement of services.

Awards

Further good news was received with the nomination and shortlisting of Dr Jackie Bene in the HSJ's CEO of the Year awards and the award of Finance Director of the year to Simon Worthington. Everyone in the trust can be rightly proud of them for their leadership and determination to do the right things for patients and for putting Bolton amongst the best Trusts in the country.

I was also delighted with the opening of our new Bluebell ward, our first dementia friendly ward, and feedback from patients and families highlights that this approach should be the way forward for us. During the coming months we will continue to canvas for much needed funds to further improve the environment.

The long awaited Care Quality Commission (CQC) review took place in March and although it will be several months before we receive the formal report the initial feedback was very good. I am keenly aware of how much work went in to preparing for the visit and I would like to publically thank everyone for their contributions. I must also single out our Trust Secretary, Esther Steel, for the preparation work and to Trish Armstrong-Child, our Director of Nursing for the direction and leadership throughout the process.

Governors

I would like to personally thank our Governors for their on-going help and support. Their involvement in unannounced ward visits, board meetings and walkabouts and their feedback to the management team all add hugely to our service improvement plans and their engagement with the board has been critical in helping us to focus on what is important to the Bolton population. The role of Governor is rarely understood or fully appreciated by the general public but they play a vital part in the development of the Trust's long term strategy and in calling Board members to account. They meet the Board on regular occasions and they champion developments and improvements required for patient comfort and experience. Throughout the past year they have been active and engaged. Over the last twelve months we had a number of retirements and I would like to express my thanks to those who have left us for their unstinting support. Unfortunately we also lost Jeffrey Magnall who passed away after a short illness. He made a huge contribution as a Governor and we shall miss him.

The Year Ahead

The priorities for our trust are very clear. We must continue to deliver on the here and now; delivering great care efficiently and effectively to all the patients under our care. We must also play our part in Devolution Manchester and we must make closer collaboration with neighbouring trusts a reality. None of this is easy. Despite the promise of additional funding from Government, many trusts are forecasting continued deficits as they struggle with recurrent losses. Within Bolton we have signed a unique contract with our commissioners and we have agreed a Locality Plan encompassing the Trust, Commissioners, Mental Health and our local authority. Our aim is to work together to secure the best outcomes and to achieve the

Foreword

best value for every pound spent in Bolton. It is important that we pull this off. Under Greater Manchester Devolution, Health and Social Care budgets will face a financial gap of £2bn by 2020. This represents a reduction of 33%. We must all therefore work towards eradicating waste, reducing overlaps and investing in new models of care. The Bolton Locality plan is the foundation stone for this but we will also have to work with other Trusts on finding ways to improve the efficiency of our services.

Our plans for A&E must be progressed quickly. Bolton has one of the busiest A&Es in Greater Manchester but we are now seeing almost twice the 60,000 patients per year it was designed for. The last two winter periods have demonstrated the pressures we can expect in future years and we must be ready to handle them. Within our plans we intend to invest over £4m on re-fitting A&E, making it fit for purpose, and to address the current staffing levels. On top of this we must ensure that our other investment plans are undertaken on time and to specification.

At the time of writing, we have faced a number of strikes by our junior doctors. I am extremely grateful for the reaction and support of everyone in the trust during the days affected by strike. The on-going uncertainty and the proposed imposition of a new contract pose significant risks to both patients and the trust and, like everyone else, I wish for a speedy resolution.

Despite the daunting tasks and issues facing us, I look forward to the coming year with some optimism. Bolton has proven that it can stand comparison with the best Trusts in the UK. Our staff have been truly magnificent during the past year and I am confident that over the next twelve months we will continue to shine brightly.



David Wakefield

Chairman

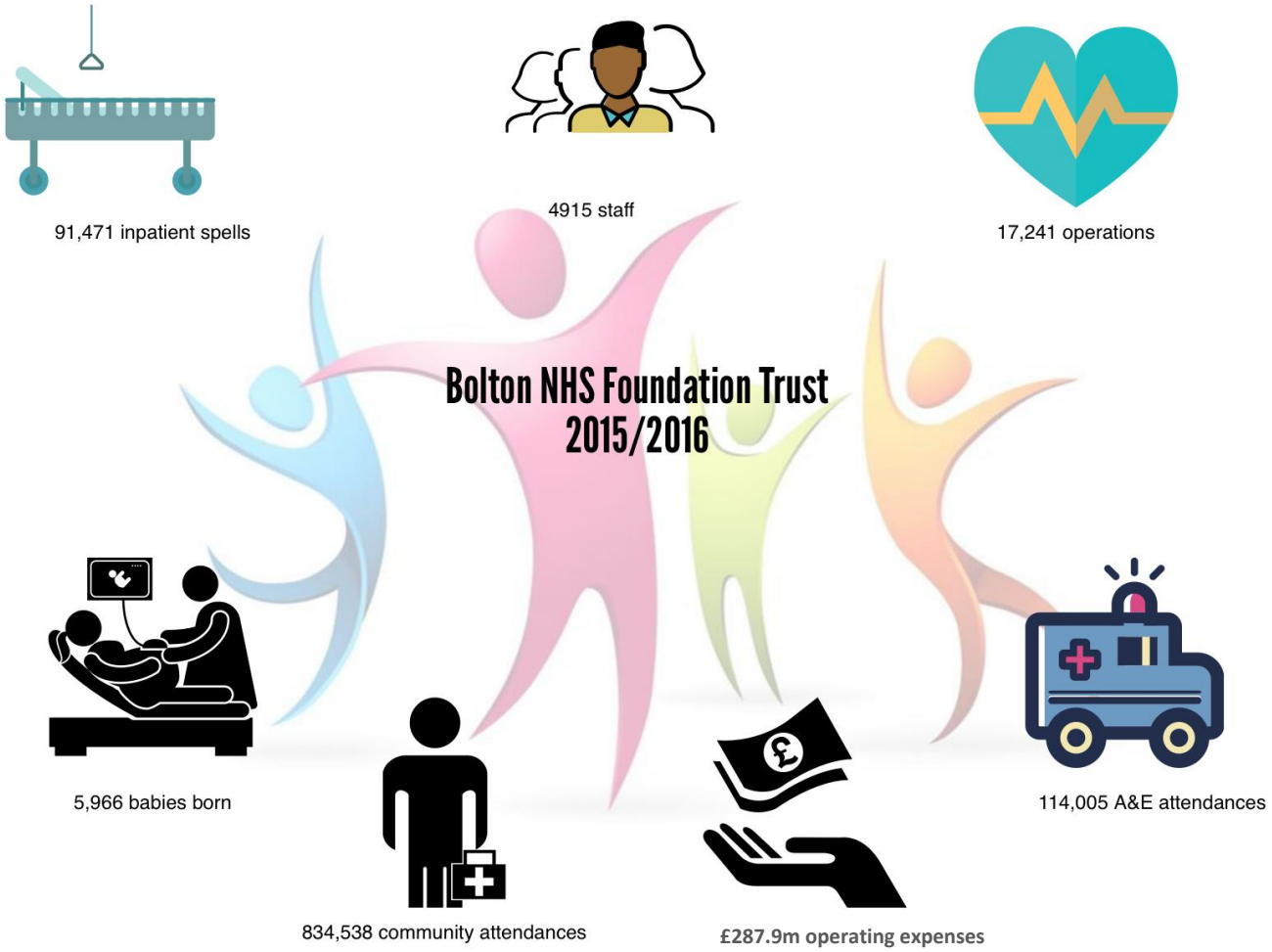
April 2016

History and Statutory Background

Bolton NHS Foundation Trust is an integrated care organisation providing care and support in the community at over 20 health centres and clinics as well as services such as district nursing and health visiting. We also provide intermediate care in the community and a wide range of services at the Royal Bolton Hospital.

The Trust was authorised as a foundation trust in October 2008 and became an integrated care organisation in July 2011 following the transfer of services from the provider arm of NHS Bolton.

Review of 2015/16



Performance Report

Chief Executive Statement



As I reflect upon our performance over 2015/16 I feel there is much about which we should feel justifiably proud. There is, of course, always more we can do to improve our performance but in the increasingly challenging environment that all NHS organisations now find themselves in some of our achievements are quite remarkable. I'm very pleased that we have continued to deliver on our commitment to drive down hospital mortality supported not least by continued improvements in infection control, and reduced harm in our care, particularly from falls and reduced medication incidents. The drive to increase incident reporting and transparency has been recognised nationally as good as has the learning from mistakes thus developing further the culture of openness we strive for.

I'm also very pleased that we have been able to honour our commitment to patients for timely access to our services, most notably in cancer pathways where our performance has been one of the best nationally. We have struggled however, to maintain timely access via our Accident and Emergency pathway during the last six months after a good start in 2015. There are a number of contributory factors to this but we have developed a robust plan to mitigate continued under performance. I am especially pleased that we have seen significant growth and improved performance in our community services. As we move forward I believe these services will be pivotal in supporting primary care to better manage urgent care, complex and chronic diseases and end of life care out of hospital where it is often more appropriate to do so.

None of this improved performance would have been possible without the commitment and determination of our staff of whom I am very proud and eternally grateful. I was very pleased therefore to see further improvement in some key metrics this year in the national Staff Survey and especially delighted that the most improved indicator was the number of staff who would recommend our Trust as a place to work or receive treatment. It is also significant that we continue to make strides in reducing staff sickness and I look forward to more of this as we attempt to further improve our productivity and efficiency in the forthcoming year.

Finally our financial performance through 2015/16 has been exemplary. The continued effort and discipline around good financial stewardship has meant that despite significant demand pressures and efficiency/savings targets we have been able to end the year with a small surplus. This has proved crucial in securing investment in our infrastructure and will be a key enabler in delivering an even better performance in the year to come.



Jackie Bene

Chief Executive Bolton NHS FT

May 2016

Performance Report

Purpose and activities

The Trust's operational plan for 2016/17 sets out our priorities for the year and builds on the remarkable progress made by the Trust over the last few years.

The challenges in 2016/17 are not to be underestimated:

- Continuing to deliver safe staffing levels to provide excellent care.
- Building on our strength as a provider of integrated hospital and community services.
- Working with our commissioners to make the right decisions to achieve consistent high quality care.

And doing all the above within our financial means.

We believe in:

High quality care centred on individual needs rather than the needs of professionals and organisations.

- Integration across health and social care.
- Accessible, convenient and responsive services 24/7.
- Local wherever possible, centralised where necessary.
- Empowering clients and patients to manage their own care and self-care with information.

Values

The Bolton VOICE represents the values that we expect each of our staff to demonstrate. As an organisation we aim to live these values and provide "better care together" to our local population.

VISION	OPENNESS	INTEGRITY	COMPASSION	EXCELLENCE
We have a plan that will deliver excellent health and care for future generations, working with partners to ensure our services are sustainable	We communicate clearly to our patients, families and our staff, with transparency and honesty	We demonstrate fairness, respect and empathy in our interactions with people	We take a person-centred approach in all our interactions with patients, families and our staff	We put quality and safety at the heart of all our services and processes
We make decisions that are best for long-term health and social care outcomes for our communities	We encourage feedback from everyone to help drive innovation and improvements	We take responsibility for our actions, speaking out and learning from any mistakes	We provide compassionate care and demonstrate understanding to everyone	We continuously improve our standards of healthcare with the patient in mind

Principal Risks

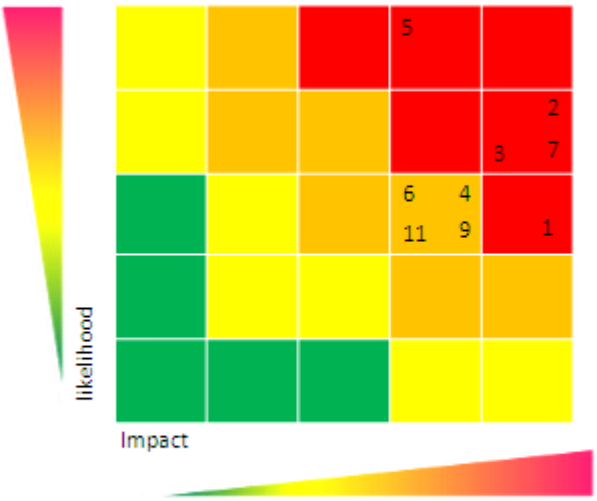
The Board has ultimate responsibility for the effective risk management of the Trust's strategic objectives. We have an established risk management process to identify the principal risks that we face. This process relies on our judgement of the risk likelihood and impact and also developing and monitoring appropriate controls. The Board Assurance Framework is used to monitor the key strategic and operational risks, and ensure appropriate mitigating actions are implemented.

The Board has considered and approved the Risk Management Strategy. The Audit Committee receives regular reports from management and internal and external auditors, detailing the risks that are relevant to our activity, the effectiveness of our internal controls in dealing with these risks and any required remedial actions along with an update on their implementation.

The Audit Committee reports to the Board on the effectiveness of the risk management process, ensuring any issues raised in internal audit reports are escalated for action and if necessary further assurance. The day-to-day risk management is the responsibility of senior management as part of their everyday business processes.

Further detail on the governance processes supporting our risk management can be found in our Annual Governance Statement on page 62 of this report.

The tables below and on the following page sets out our key risks, the risk score at year end and movement on the score during the year with examples of relevant controls and mitigating factors. The Board considers these to be the most significant risks that may impact the achievement of our objective. They do not comprise all of the risks associated with the Trust and are not set out in priority order.



Risk Scores March 2016

	Risk	score
1	Failure to reduce healthcare acquired infections	15
2	failure to provide appropriate skill mix for "safe and suitable" staffing	20
3	failure to provide an adequate timely response to the deteriorating patient	20
4	Evolving clinical governance processes	12
5	failure to meet the A&E target	20
6	Low levels of staff engagement	12
7	To fail to deliver financial plan and maintain a continuity of service rating of 2 or higher	20
9	Failure to influence commissioners in shaping future scope of services	12
11	Estates and IT investment	12

Principal Risks 2015/16

Risk	Controls and mitigation
Failure to reduce the number of hospital acquired infections as a result of poor compliance with policies and/or poor operational control.	The Trust infection prevention and control team under the leadership of the Director of Nursing in her role as Director of Infection Control oversee the management of infection control. Regular reports and assurance is provided to the infection control committee. (further information within the quality report section page 74)
Failure to meet minimum staffing levels because of vacancies and sickness could compromise patient safety and experience	Staffing levels have been agreed with recruitment plans aiming to reach the required level. Action is taken on a daily basis to address gaps caused by sickness.
A failure to provide a timely and appropriate response to the deteriorating patient may lead to an adverse impact on mortality and length of stay	Divisional action plans to improve response to early warning scores are overseen by the Mortality Reduction Group. The Trust now has an operationally closed critical care unit.
Failure to embed risk management and clinical governance processes could lead to poor patient care and experience	Progress made in 2015/16 with increase incident reporting and enhanced risk registers however three further never events occurred during the course of 2015/16 indicating that this is still a risk.
Failure to meet the A&E target as a result of increased attendance, failure to deflect patients and insufficient operational control may lead to poor patient experience and potential regulatory intervention	Performance overseen though daily flow meetings. Additional measures taken during the year On gong programme of improvement events
Low levels of staff engagement could lead to reduced job satisfaction, higher absence levels, increased turnover and reduced discretionary effort	The People Strategy was refreshed in December 2015. Staff survey results (page 36) show an improvement in the staff engagement score.
Failure to deliver the financial plan could lead to further regulatory action	The Trust's system of financial governance with an agreed financial plan including ICIPS is overseen by the Finance and Improvement Committee. (full detail on financial performance in 15/16 is included on page 13)
There is a risk that commissioner and local authority led reconfiguration may reduce control of the Trust's future scope of services	The Trust is working with partner providers and commissioners to develop new models of care.

Performance analysis

Last year was a particularly challenging one for the NHS with all Trusts expected to provide the highest standards of care while achieving demanding efficiency savings. Despite a significant rise in demand for our services, the continued tough financial climate and one of the worst winters in terms of pressure on the NHS, we are very pleased to report that Bolton NHS Foundation Trust has continued to perform well.

We continued to provide safe, high quality care to our patients and with the exception of the four hour A&E target continued to achieve all our access targets. Alongside this, in a climate where many other acute providers have struggled to achieve their financial plan, we were commended nationally for our financial performance.

Measurement of performance

The Trust has introduced an integrated performance dash board which the Board uses to monitor the performance of the organisation. The dash board contains contextual information and promotes a service line view of the organisation with equal visibility of key services.

There is a monthly integrated performance meeting (IPM) between the Executive and the Division, chaired by the Deputy Chief Executive. At the meeting the Division present for each performance dimension

- Progress against any previously agreed actions
- Proposed mitigations against any newly identified performance risks or issues
- Other assurances as required by the Executive

Information from the IPM informs the assurance the Executive team provide to the Board.

In 2015/16, the Trust continued to work towards the goals agreed in the 2013 – 2018 strategy



Performance Report

Goal 1 – quality, safety, and patient experience

A detailed review of performance against our quality priorities is included with our Quality Report starting on page 74 of this document.

Goal 2 – to be a valued provider

In our Operational Plan for 2015/16 we set ourselves a series of objectives to build on the advantages of being an integrated provider of local hospital and community-based health services. We undertook to work with our partners to provide the best care for patients throughout their healthcare journeys, developing a focus on prevention, early intervention and keeping people healthy, as well as continuing to provide excellent care for people who need treatment.

In 2015/16 we delivered against all our access targets other than the target for Accident and Emergency Department waiting time. We continued to perform strongly against all cancer targets and achieved the target for ensuring patients do not wait longer than 18 weeks to be treated.

Meeting the national four hour standard for A&E however, remains a challenge. A combination of factors, including staffing challenges and increased attendances within a department that is no longer big enough for the volume of patients who attend resulted in us failing to achieve this target.

We are working with our commissioner on interventions to support accident and emergency performance. Actions planned for 2016/17, include estates investment of £4 million in the Accident and Emergency department to improve the environment for patients and staff, overseas recruitment to manage the shortfall in nursing and redesign of the medical workforce to mitigate the staffing challenge.

We have also continued to deploy best practice as recommended by the Emergency Care Intensive Support Team to support urgent care.

Goal 3 – to be a great place to work

Our ambition is clear: engaged, recognised and rewarded people deliver excellent integrated care. In 2015/16 the Trust has achieved good performance on a wide range of people indicators.

Our overall Staff Engagement Score as calculated by NHS England in the annual staff survey has increased from 3.81 in 2014 to **3.89** in 2015. This overall indicator of staff engagement measures staff members' perceived ability to contribute to improvements at work; their willingness to recommend the trust as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

The 2015 survey was also consistent with quarterly family and friends testing and show that staff satisfaction is increasing. The year end results showing that 81% of our staff would recommend the Trust for treatment and 66% would recommend us as a place to work see us locally second only to Wrightington Wigan and Leigh NHS FT on these measures. Some of the reasons for this are clear:

- We have a higher percentage of people than ever before having a regular and timely appraisal.

- The percentage of staff reporting good communication between management and staff is up.
- Compliance with training requirements is much better and again is at an all-time high.

Rates of sickness absence (measured on a 12 month rolling average basis) have reduced from 4.8% to 4.6% over the year. This has been equivalent to recruiting an additional 11 staff at a total cost of over £300k.

Across the Trust we have seen fewer vacancies - down to 5.26% - by the end of March 2016, although they are far from equally distributed, and there are undoubtedly difficulties in some areas, for example A&E medical staff.

We have complied with NHS Improvement's cap in respect of our total aggregated expenditure on agency staff, we have however breached the caps on rates of pay in the areas of A&E and operating theatres. This has been reported in accordance with the guidance set by NHS Improvement.

Further information can be found in the section headed Staff Report please see page 36.

In 2016/17 we have signalled a sharper focus on workforce planning to ensure the efficient use of our workforce, and that we are fit for the future in terms of new job roles.

Goal 4 – to be well governed

In our plan for 2015/16, we agreed a series of objectives to embed our improved governance arrangements. The actions we agreed included:

- Improved management of risks
- To ensure timely and demonstrable learning from incidents, claims, complaints, inquests, risks and alerts
- A programme of Board and Governor development
- To undertake a review using the Monitor Well Led Framework – the Board agreed part way through 2015/16 to defer this action to 2016/17 as the planned timing would have clashed with our CQC review

With the exception of undertaking a "Well Led review", we continued to make good progress against all these objectives. We have established weekly meetings to review and share learning from incidents, claims, complaints and inquests. We have continued to improve the management and oversight of our risk registers, both through our Risk Management Committee and through divisional governance meetings.

We have had great success in increasing risk reporting, the last report issued by the National Reporting and Learning System (NRLS) places us in the top 25% of acute non specialist NHS Trusts for this measure. This is a significant improvement on our position two years ago when we were in the lowest 25%.

In a recent review of learning from mistakes published by Monitor and the TDA in March 2016, we were rated as "good" for the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust.

Goal 5 - to be financially viable and sustainable

Income and expenditure overview

The Trust planned to improve its financial position by increasing its surplus to £1.6m in the 2015/16 financial year. As can be seen from the summary statement of comprehensive income below this target has been slightly overachieved.

This second year of surplus since the Trust's significant deficits in the period 2010/11 to 2013/14 marks a sustained financial recovery which is regarded by NHS Improvement as the best example of a single NHS organisation financial turnaround in the last decade.

The Trust Board agreed the 2016/17 financial plan at its 30th March 2016 meeting. This plan identifies how the Trust can further to improve its financial position to deliver a surplus of £11.9m in 2016/17.

Statement of Comprehensive Income	**Actual 2013/14**	**Actual 2014/15**	**Actual 2015/16**	**Plan 2016/17**
Revenue	**£,000**	**£,000**	**£,000**	**£,000**
Operating revenue from continuing operations (patient care)	261,228	266,791	271,537	281,018
Other operating revenue	23,013	24,771	21,004	21,304
Operating expenses	-288,872	-309,474	-287,918	-286,893
Operating surplus (deficit)	**-4,631**	**-17,912**	**4,623**	**15,429**
Finance costs:				
Finance Income	32	41	35	41
Finance costs	-777	-849	-642	-860
Finance expense - unwinding of discount on provisions	-8	-122	-12	0
Public dividend capital dividends payable	-2,746	-2,535	-2,152	-2,708
Net Finance Costs	**-3,499**	**-3,465**	**-2,771**	**-3,527**
Surplus/(Deficit)	**-8,130**	**-21,377**	**1,852**	**11,902**
Impairment of fixed assets	-352	-21,937	0	0
Underlying Trading Surplus/(Deficit)	**-7,778**	**560**	**1,852**	**11,902**

Income analysis

The table below sets out the income trend in the period:

Income	**Actual 2013/14**	**Actual 2014/15**	**Actual 2015/16**	**Plan 2016/17**
	£,000	**£,000**	**£,000**	**£,000**
CCG's and NHS England	250,832	255,611	254,672	258,420
Local Authorities	7,257	8,538	10,450	11,675
Other	3,139	2,642	6,415	10,923
Sub total Total Income from activities	**261,228**	**266,791**	**271,537**	**281,018**
Other operating revenue	23,013	24,771	21,004	21,304
Total Revenue	**284,241**	**291,562**	**292,541**	**302,322**

There has been an increase of income between 2014/15 and 2015/16 of £1m, there is a further planned increase in income of £10m in 2016/17.

The net increase of £1m in income between 2014/15 and 2015/16 can be explained by the following factors:

- NHS Tariff deflation of 1.9%
- Increase in the marginal rate for non-elective admissions from 30% to 70% under the enhanced tariff option
- Income improvements as part of the Trust's income and cost improvement programme
- Reduced CQUIN income
- Hospital activity reductions
- Non recurrent capital to revenue transfer of £4.1m
- Investment in community services as part of the Better Care Fund
- Income loss due to the transfer of the community 5 -19 service to another NHS body
-

The planned increase in income of 2016/17 of £10m results from the following factors:

- £9.2m Forecast payment from the NHS Sustainability and Transformation fund. This national fund is designed to incentivise improved financial performance in the provider sector. The trust will only receive this income if it achieves the required improvements as determined by NHS Improvement
- Tariff inflation of 1.9%
- Quality and performance investments funded by Bolton CCG
- Full year effects of service changes and investments in 2015/16
- The planned transfer of the inpatient vascular service to another NHS Provider

Expenditure analysis

The table below sets out the expenditure trend in the period:

Expenditure trend

	Actual 2013/14 £,000	Actual 2014/15 £,000	Actual 2015/16 £,000	Plan 2016/17 £,000
Employee expenses	200,574	203,002	205,073	201,417
Drugs	17,216	18,823	20,556	19,996
Clinical Supplies	20,140	19,975	20,588	20,488
Non Clinical Supplies	35,322	33,248	32,258	34,870
Depreciation and amortisation	5,547	5,536	5,539	7,562
Impairments of property, plant and equipment	352	25,255	0	0
Redundancy	2,130	97	0	0
Misc other operating Expenses	7,591	3,538	3,904	2,560
Total	**288,872**	**309,474**	**287,918**	**286,893**
Less impairments	(352)	(25,255)	0	0
Underlying expenditure trend	**288,520**	**284,219**	**287,918**	**286,893**

Impairments are excluded from this analysis as they do not count against the Financial Sustainability Risk Rating that is used by NHS Improvement to assess NHS Foundation Trusts financial performance.

There has been an increase in expenditure of £3.7m between 2014/15 and 2015/16. There is a planned reduction in expenditure of £1m in 2016/17.

The net increase of £3.7m in expenditure between 2014/15 and 2015/16 can be explained by the following factors:

- Pay awards, increments and non-pay inflation
- Savings delivered as part of the Trust's income and cost improvement programme
- Investments in staffing to ensure quality and safety
- Revenue consequences of capital investments in Estates and IT
- Revenue impact of investments in community services under the Better Care Fund

The planned reduction in expenditure between in 2016/17 can be explained by similar factors, although there is planned to be a greater level of cost improvement relative to investments and other cost pressures.

Expenditure on Consultancy related spend has reduced from £1.1m in 2014/15 to £0.3m in 2015/16

Income and cost improvements

	Actual 2013/14 £,000	Actual 2014/15 £,000	Actual 2015/16 £,000	Plan 2016/17 £,000
Income and cost improvements	18,300	21,200	14,400	15,300
As % of income	6.4%	7.3%	5.0%	5.3%

Over the last three years the Trust has delivered £53.9m of income and cost improvements, much higher than the national average. This has enabled the Trust's sustained financial recovery at a time when the vast majority of other similar Trusts have moved into a significant deficit position.

Delivery in 2015/16 was slightly below the plan of £15.3m but still significantly higher than has been delivered in other similar Trusts.

Capital spending

As part of its financial recovery the Trust was able to secure funding of £30m (£7.8m in public dividend capital, £22.2m in long term non-commercial loans) to make necessary improvements in its Estate and IT infrastructure. This funding was formally agreed in quarter three of the 2015/16 year. This explains the increased expenditure over the normal level of operational capital spend in 2015/16 and the relatively high levels forecast in 2016/17.

Capital	Actual 2013/14 £,000	Actual 2014/15 £,000	Actual 2015/16 £,000	Plan 2016/17 £,000
Ongoing replacements	6,216	6,473	6,815	8,893
Estates Strategy	0	0	108	9,777
IT Strategy	0	0	2,390	2,295
Total	**6,216**	**6,473**	**9,313**	**20,965**

Cash

Due to its deficit position in previous years the Trust relied on cash support from the Department of Health in order to continue to operate in 2012/13 and 2013/14. Due to the Trust's financial recovery no such support has been required since then, although the Trust's cash balance remains very low compared to what would normally expected for a Foundation Trust of its size. The cash balance is expected to increase in 2016/17 due to the large surplus forecast as a result of the national sustainability and transformation fund.

Cash	Actual 2013/14 £,000	Actual 2014/15 £,000	Actual 2015/16 £,000	Plan 2016/17 £,000
Total	**408**	**5,265**	**1,470**	**7,800**

Financial Sustainability Risk Rating

NHS Improvement uses a risk rating for assessing the financial performance of NHS Foundation Trusts. Worst possible score is one the best four.

The Trust was required to achieve a sustainable risk rating of two in order for NHS Improvement to lift its regulatory action on the Trust which it did in quarter three of 2015/16.

It is expected that the Trust's risk rating will improve to a four in 2016/17 due to the large surplus and improved cash balance planned

	Actual 2013/14	Actual 2014/15	Actual 2015/16	Plan 2016/17
FSRR	1	2	2	4

Goal 6 - to be fit for the future

Being fit for the future starts with maintaining our current services. As reported elsewhere in this report, during 2015/16 we were successful in our bid for £30 million to support development of our Estates and IT. Work is already underway to invest this funding including the expansion of our Accident and Emergency Department and the expansion of our Endoscopy department. IT investment will support a significant upgrade in both our hardware and software, although there remains much to be done.

We have continued to develop our role as an integrated provider of local hospital and community based health services, playing a full part in Bolton's locality plan. The plan sets out the health challenges facing the people of Bolton and how we (all the health and care agencies in the borough) will work more closely together to meet them.

For some of our services, being fit for the future is about working with our neighbouring trusts, particularly in Salford and Wigan. For example, we are creating a 'single service partnership' for general surgery that will see some of the highest risk surgery concentrated at Salford Royal site delivered by consultants working across more than one hospital site.

In February 2015, the Government announced plans to devolve health and social care budgets and decision making powers to the NHS and Local Authorities within Greater Manchester, thus creating the Greater Manchester Health and Social Care Partnership. Since then, health and social care organisations within each of the 10 boroughs of Greater Manchester have been working together on the overall vision ie to make the biggest, fastest possible improvement to the health and wellbeing of the 2.8m people of Greater Manchester. Representatives from the Trust are also linked in to various work streams including finance, workforce, estates and pathology.

It is too soon to say how devolution will impact on NHS providers and what changes it could mean to the future workforce across Greater Manchester, we will ensure that staff and key stakeholders are provided with regular updates as the programme progresses.

Part of remaining fit for the future is to understand how others see us. In 2015 we surveyed the attitudes of stakeholders towards the trust. We received universal recognition and praise for the Trust coming out of breach and the effort and sacrifices involved; there was also a recognition of the growing need to collaborate with commissioners and providers.

Environmental impact

Sustainability

The Trust is committed to reducing the use of primary sources of energy and reducing the effect this has on the environment.

In line with this commitment the Trust is embarking on a major infrastructure programme to address the estate's ageing infrastructure and reducing our current carbon footprint.

Each year we recycle:

- 90 tonnes of mixed cardboard waste
- 160 tonnes of mixed metals
- 50 tonnes of confidential/office paper waste
- 98% of waste electrical and electronic equipment.

This programme will deliver

- The replacement of our coal boilers which produce a significant proportion of our CO^2 emissions with a Gas Combined Heat and Power Plant. This plant will generate electricity for the Hospital and heat buildings and hot water with its waste heat output.
- Use of water from the on-site water borehole for use in all on-site water use after treatment approved by the Environment Agency standards.
- Utilisation of existing on site electrical generation to support peak electrical demands.
- Looking at opportunities to install energy-efficient heating services.

Waste/Recycling

All our clinical waste is treated on site, cutting down our transport costs and associated carbon footprint. This waste is incinerated and as a by-product steam is produced which in turn heats our buildings, domestic hot water, catering production and sterile services. This steam supply is economical to produce and satisfies around one third of the site steam demand.

Utility cost and consumption

	2015/16		2014/15	
Utility	**Cost £**	**Consumption**	**Cost £**	**Consumption**
Gas	262k	9,142,919 KWh	402k	10,652,673 KWh
Electric	1,835K	15,729,462 KWh	1,900k	14,727,395 KWh
Water	254K	107,163 m^3	490k	198,276m^3
Coal	252K	2067 tonnes	460k	2315 tonnes

Social, community and human rights issues

We recognise the need to forge strong links with the communities we serves so that we are responsive to feedback and can develop our services to meet current healthcare needs.

We are committed to meeting our obligations in respect of the human rights of our staff and patients, which is closely aligned both to the NHS constitution and our values. NHS trusts are public bodies, and so it is unlawful to act in any way incompatible with the European Convention on Human Rights unless required by primary legislation.

Trust policies are reviewed on a regular basis and all are subject to an equality impact assessment.

Modern Slavery Act 2015 – Statutory Statement

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, the Trust is currently reviewing its supply chains with a view to confirming that such behaviour is not taking place.

This performance report was approved by the Board of Directors on 26th May 2016

Signed on behalf of the Board



Jackie Bene
26th May 2016

Directors' Report

Our Board of Directors

Our Directors



David Wakefield – Chairman appointed 8th August 2012 (by Monitor) Reappointed in July 2015 for a second three year term.

David is a qualified accountant and, in addition to his finance roles, has held senior posts in sales, operations and project management. He worked in the furniture trade for 12 years and with Royal Mail for 27 years. He joined the NHS as a non-executive director in Milton Keynes and later became non-executive Chairman of Milton Keynes Community Health Services and, subsequently, Chairman of Milton Keynes Hospital NHS Foundation Trust.

During 2014, David was appointed as a Non-Executive Director of Crown Commercial Services; this appointment was undertaken with the approval of the Council of Governors.

Executive Directors



Dr Jackie Bene - Chief Executive

Jackie was appointed to the Board as Medical Director in 2008 having worked at the Trust as a Consultant Physician as well as holding a number of clinical lead roles since 1998. She took up the role of Acting CEO in June 2013 and was appointed substantively to the role in January 2014. Her priorities throughout her career have been quality improvement and patient safety but she has recently led on the governance and strategic agendas for the Trust. Jackie still undertakes clinical practice for one session per week in Acute Medicine which she values enormously in keeping her close to our patient and staff experience.

Simon Worthington (ACCA) – Director of Finance and Deputy CEO



Simon has worked in financial management in the NHS since 1988. Simon was appointed in February 2013. Prior to this, from June 2011, he was Deputy Director of Finance at South London Healthcare NHS Trust, a post he had taken up in order to gain experience of working in extremely financially challenged organisations. From July 2006 Simon was Finance Director and Deputy Chief Executive of the Yorkshire Ambulance Service. During his time at the Yorkshire Ambulance Service, Simon was Acting Chief Executive for eight months. Preceding this Simon was Finance Director of the Tees East and North Yorkshire Ambulance Service for two years and was Acting Finance Director at South Huddersfield Primary Care Trust for a year.

Directors' Report



Trish Armstrong-Child - Director of Nursing appointed May 2013

Trish is a Registered General Nurse who has worked within the NHS since 1989. She has a vast wealth of experience within both nursing and operational management roles and has Executive leadership and professional responsibility for quality and patient safety. Her focus and primary aim is to ensure that excellent standards of care are received by patients and their carers and that they have a positive experience of care both within hospital and community settings, including care at home.



Andy Ennis - Chief Operating Officer

Andy started his working life as a nurse, specialising in paediatrics and specifically intensive care. After various roles in nursing including Charge Nurse of B1 Children's Ward at Bolton Royal he moved into operational management of services gaining experience in several other North West Trusts before returning to Bolton as Chief Operating Officer in January 2014.

Andy's primary role on the Board is to ensure the Trust delivers operational targets such as waiting times and that the infrastructure (Estates and IT) is fit for purpose.

Steve Hodgson - Medical Director



Steve was appointed Medical Director in March 2014. He has been a consultant orthopaedic surgeon with an upper limb interest in Bolton since 1993. He has previously held a number of leadership roles in the trust including clinical lead, associate medical director and Head of Elective Care Division. He was acting Medical Director for seven months before being appointed to the substantive post. He is a member of the British Society for Surgery of the Hand Council, for whom he leads their overseas aid project. Steve's priorities are the delivery of high quality care for our population and leading the medical workforce



Mark Wilkinson - Director of Strategic and Organisational Development

Mark joined the Trust in July 2014 from Barnsley CCG where he was Chief Officer. He joined the NHS in 1985, starting out in the finance profession before moving into general management as a PCT Chief Executive in East Lancashire. He has been a member of several provider and commissioner boards and has also worked at a national level promoting innovation, and in the pharmaceutical industry. His focus is on the strategic and organisational development of the Trust including responsibility for workforce, communications and engagement. He is passionate about the contribution motivated and well led teams can make to the delivery of high quality and seamless care.

Non-Executive Directors



Dr Mark Harrison – Senior Independent Director initially appointed 1st April 2012 for three years and reappointed in 2015 for a second three year term.

Mark Harrison, was appointed as a Non-Executive Director in April 2012. He has extensive board level experience and has delivered large scale change, technology and efficiency programmes, negotiated and managed major contracts and partnerships, overseen strategic planning and delivery, and shaped and delivered output services to the public.

Mark is a member of the Finance Committee and the Audit Committee and is the nominated NED for whistle blowing.

Carol Davies - Chair of Audit Committee initially appointed in September 2010 and appointed September 1st 2013 for a second three year term.



Carol is currently Director of Finance and Resources at Mount St Joseph Business and Enterprise College. She has held senior finance positions in a number of other organisations, including Bolton Council and Trafford Health Authority. She is a qualified accountant with the Chartered Institute of Management Accountants.

Carol is Chair of the Trust's Audit Committee and a member of the Quality Assurance Committee.

Neal Chamberlain



Neal Chamberlain was appointed a Non-Executive Director in October 2014. Neal has 28 years' experience as an HR professional, having held senior roles in companies including ICI, AstraZeneca, Unilever, Tata and Costain. Neal is a Fellow of the Chartered Institute of Personnel and Development (CIPD), a Member of its Manchester Branch Committee, and a Member of the International Coaching Federation. In addition to his Trust activities, Neal is also a Non-Executive Director for the Manchester Camerata chamber orchestra, and has recently established his own HR consulting business, A1 Performance Consulting Ltd.

Neal is Chair of the Charitable Funds Committee

Directors' Report



Allan Duckworth – Non Executive Director re-appointed 1st January 2016 for a second three year term

A Chartered Management Accountant, Allan brings 24 years board level experience in high profile, consumer facing businesses, including fourteen years as Chief Executive of Burnden Leisure PLC, the parent company of Bolton Wanderers FC and De Vere Whites Hotel. Prior to this role he spent ten years as a finance director at Umbro International Ltd, Lo-Cost Stores Ltd (Safeway Group PLC) and Vernons Organisation Ltd (Ladbroke Group PLC).

Allan is Chair of the Finance and Investment Committee and a member of the Charitable Funds Committee.

Ann Gavin-Daley



Ann has a clinical background in nursing and quality and a passion for high quality patient focused care gained over 30 years nursing in acute and integrated community and mental health trusts in the North West.

Her previous experience includes significant strategic management as an NHS Executive Director and Trust Board member with involvement in developing and managing innovative acute and community services at operational and strategic level in teaching and non-teaching NHS organisations.

Ann has valuable Governor and public and private sector consultancy experience providing a broad, objective perspective and understanding of the NHS and the role of the Non-Executive Director.

Ann is a member of the Quality Assurance Committee and the Audit Committee

Andrew Thornton



Andrew joined the Board as an interim Non-Executive in August 2014 and was subsequently appointed substantively in March 2015. Andrew Initially started his career in the health service as a podiatrist and has remained within health and social care serving in a variety of senior leadership posts within both the public and private sector.

Andrew has a strong ethos of quality in all aspects of service delivery and brings his experience of developing clinical and operational improvements to the Trust.

Andrew is a member of the Quality Assurance Committee and from May 2016 took over the position of Chair of the QA Committee.

Disclosures

Statement of register of interests

The Trust Secretary maintains a register of other significant interests held by Directors and Governors which may conflict with their responsibilities. Access to the register can be obtained by submitting a written request to the Trust Secretary.

Pension disclosure

The accounting policies for pensions and other retirement benefits are set out in note 1.9 to the accounts and details of senior employees' remuneration can be found in the remuneration report on page 28.

Statement of accounts preparation

The accounts have been prepared under direction issued by Monitor, the independent regulator for Foundation Trusts, as required by paragraphs 24 and 25 of Schedule 7 to the National Health Service Act and in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Better payment practice code

The Trust is expected to pay 95% of all creditor invoices within 30 days of goods being received or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier. The table below shows performance against this target in 2013/14 and 2014/15.

	Year ended 31 March 2016		Year ended 31 March 2015	
	Number	£'000	Number	£'000
Total non-NHS trade invoices paid within the target	52,890	65,147	48,775	47,331
Total non-NHS trade invoices paid in the period	64,573	84,083	68,841	70,339
Percentage of non-NHS trade invoices paid within the target	81.9%	77.5%	70.9%	67.3%
Total NHS trade invoices paid within the target	1,655	17,033	1,663	14,781
Total NHS trade invoices paid in the period	2,279	26,160	2,269	21,027
Percentage of NHS trade invoices paid within the target	72.6%	65.1%	73.3%	70.3%

Income disclosure required by section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

The Trust meets the requirement for income from the provision of goods and services for the purposes of the Health Service in England to be greater than its income from the provision of goods and services for any other purposes.

The small amount of other income received by the Trust helps support the provision of NHS care. The Trust will continue to meet the requirement for its prime business to be the provision of goods and services for the purpose of the health service in England

Statement as to disclosure to Auditors

Each of the Directors at the date of approval of this report confirms that:

So far as the Director is aware, there is no relevant audit information of which the NHS Foundation Trust's Auditor is unaware; and

The Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

Quality Governance

In March 2013 the Trust commissioned an external, independent review of its arrangements for quality governance against the criteria described in Monitor's Quality Governance Strategy (Deloitte QGAF report 2013).

The Deloitte Quality Governance report reviewed the Trust against the criteria as described in the Monitor Quality Governance Framework including strategy, capabilities and culture, processes and structures and measurement. Deloitte found several areas of good practice including the engagement of staff and support for staff. There were however areas where improvement was required including the management of risks, the production of information and the need for an overarching quality strategy.

Since the publication of the Deloitte report, the Board has overseen a programme of actions to address issues identified in this report and in other associated reports into governance and quality. The actions undertaken include:

- The development of a new integrated performance report
- The publication of a quality strategy
- The publication of a new Patient Experience Strategy
- The publication of a new People (workforce) Strategy
- Development of a new complaints process
- Review of the Board Assurance Framework (BAF)
- A programme of Board and Governor development.

The Trust have been able to provide Monitor with assurance that the recommendations in the Governance report have been addressed and in September 2015, Monitor issued the Trust with a certificate of compliance with all discretionary requirements and enforcement undertakings.

A review using Monitor's "Well Led Framework" which incorporates aspects of the Quality Governance Framework is planned for quarter 3 or 2016/17.

Further information on governance including quality governance can be found in the annual governance statement on page 62.

Patient Care

Further information on the quality of services provided by the Trust can be found in our quality report which is included in this report from page 74.

Stakeholder Relations

Significant partnerships and alliances

Devolution – Taking Charge in Greater Manchester

In February 2015 the 37 NHS organisations and local authorities in Greater Manchester signed a landmark devolution agreement with the Government to take charge of health and social care spending and decisions in our region.

We will work in collaboration with our partner Foundation Trusts to deliver best care for our most sick patients, and with commissioners and providers within Bolton to deliver place based care tailored to the needs of the Bolton population

Acute Services Collaboration

As part of the North West Sector of Greater Manchester our organisation is working in collaboration with Wigan, Wrightington and Leigh Foundation Trust and Salford Royal NHS Foundation Trust to develop single shared services for the benefit of the sector population. Discussions are currently underway around the foundation membership of a Hospital Group.

Pre-implementation plans for a single service provision of high risk emergency general surgery, urgent, acute and emergency medicine and radiology are already well underway.

Involvement in local initiatives

The Bolton Health and Care 5 Year Locality Plan was developed and agreed by all Bolton commissioning and provider organisations in December 2015 this transformation plan will inform the future strategic direction of the Trust.

Consultation with local groups and organisations

We attend regular meetings with our local HealthWatch and Overview and Scrutiny Committee to share our plans for future services and to provide updates on challenges facing the Trust and the wider health economy.

Public and patient involvement activities

As a Foundation Trust with public members, the majority of our public and patient involvement is through our membership. We recognise the importance of involving our patients and the wider public in the development of services. During the course of the year we used our membership newsletter to provide updates on developments at the Trust and to invite members to participate in events and activities. These events included our Medicine for Members talks, participation in PLACE inspections and the Cancer Peer review process.

In Quarter 3 of 2015, we commissioned Deloitte LLP to undertake a stakeholder review to enable us to better understand the perceptions of our stakeholders. Responses from external stakeholders were provided by other NHS providers, commissioners and GPs, the Local Authority and the FT regulator Monitor. Although there were many positive elements within the feedback there is a perception held by some of our stakeholders that we do not collaborate to the extent that others would wish for. An action plan has been developed in response to this feedback.

Remuneration Report

The remuneration report has been prepared in compliance with the relevant elements of sections 420 to 422 of the Companies Act 2006, Regulation 11 and Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2001, parts 2 and 4 of Schedule 8 of the Regulations as adopted by Monitor for the purposes of the Annual Report Manual and elements of the NHS Foundation Trust Code of Governance.

Annual Statement on Remuneration

I am pleased to present the remuneration report for 2015/16. As Chair of the Trust, I chair the two Committees charged with responsibility for Nomination and Remuneration:

- a Board Nomination and Remuneration Committee with formal delegated responsibility for the nomination and remuneration of Executive Directors and
- a Governor Nomination and Remuneration Committee for the appointment and remuneration of the Chair and Non-Executive Directors - this second committee acts in an advisory and supporting capacity for the full Council of Governors but does not have formally delegated powers**.**

The exception to this arrangement is when my own performance or remuneration is being discussed. In these circumstances the Vice-Chair of the Trust will chair the Governor Nomination and Remuneration Committee.

In 2015/16 the Committee reflected on the financial context of both the local and national health economy, decisions on remuneration reflected the current financial climate and the competitive market.

Having made significant changes to the Board between 2012 and 2014, 2015/16 provided an opportunity for consolidation and team development. No changes were made to the Executive team and as a Committee; we feel the current team provide strong and stable operational leadership to the Trust.

Unfortunately, at the start of the financial year one of our Non-Executive Directors resigned from her position on the Board due to ill health. The Governor Nomination and Remuneration Committee took the opportunity to review the composition of the Board and agreed to create an additional Non-Executive position bringing the total number of Non Executives to seven. Mr Andrew Thornton who had previously served as an interim NED was appointed substantively for a three year term. In consultation with our governors we used an open advert to attract potential Non Executives with strong clinical background. Shortlisted candidates were invited to attend for interview and assessment and, as a result of this process, Mrs Ann Gavin Daley was appointed as a new NED in August 2015. Ann and Andrew both join the Board with a strong background of senior clinical leadership.

In 2013/14 benchmarking was used to agree and establish salary scales for Executive Directors and Very Senior Managers; these scales are described within the remuneration policy section of this report. On an annual basis we review national benchmarking data for both Executive and Non-Executive Director's salaries to ensure the remuneration paid to our Board is within the range paid by other similar NHS organisations. We have not used other external advice when setting Non-Executive Director salaries

In all debates and discussions pertaining to salaries for senior managers the Nomination and Remuneration Committee have ensured that the policies applied reflect those applicable to our staff on Agenda for Change contracts. As with Agenda for Change salary scales, staff not yet at the

top of their salary band had the chance to progress as described in the next section but the bands were not increased.

In 2016, our Chair of Audit will come to the end of her six year tenure, the Governor Nomination and Remuneration Committee has begun the process to appoint an appropriately qualified and experienced Non-Executive Director to Chair our Audit Committee. The Committee recognise the benefits of being able to draw from a wider pool of talent as possible and having staff that can relate to our diverse communities and will work with our appointed recruitment agency to ensure the candidate is selected from a diverse shortlist.

The Committee has a duty to ensure the Trust can recruit and retain and motivate the senior managers with the appropriate skills and values to lead the organisation. At the same time, the Committee recognises that this must be within the confines of public acceptability and affordability.

The Chief Executive and Finance Director/Deputy Chief Executive are both paid more than £142,500 per anum. In both cases, the Committee reflected on benchmark salary information for comparative jobs within the NHS and concluded that the remuneration agreed was appropriate and reasonable for the current post holders.



Chairman

Remuneration Report

Future policy table

Element	Link to strategy	Operation	Maximum	Changes
Base salary	To set a level of reward for performing the core role	The aim is to offer benchmarked salary which the committee consider appropriate for experience and performance.	For each role there is an agreed salary scale. When reviewing salaries, the Committee take account of personal and organisational performance and any national award offered to the wider employee population	No
Taxable benefits	The current remuneration policy of the Trust does not make provision for taxable benefits or performance related bonuses			
Annual performance related bonuses				
Long term performance bonuses				
Pension related benefits	To provide pensions in line with NHS policy	Directors are automatically enrolled in the NHS final salary pension scheme on the same basis as all other colleagues within the NHS	Pension arrangements for the Chief Executive and all Executive Directors are in accordance with the NHS Pension Scheme. The accounting policies for pensions and other relevant benefits are set out in Note 1.9 to the accounts.	No

For the purpose of the accounts and remuneration report the Chief Executive has agreed the definition of a "senior manager" to be Directors only.

Senior manager pay progression

At appointment, a Director is placed at the appropriate point on the salary scale as determined by the Remuneration Committee having considered previous experience.

The Remuneration Committee is firm in the view that progression through the salary ranges should not be automatic or linked to length of service but should be a true reflection of performance in the role as assessed through an effective appraisal system.

For Directors other than the Chief Executive, the Chief Executive provides the Remuneration Committee with a report on each Director summarising the achievement of specific objectives within the wider frame of the performance for the whole organisation. The award may also be constrained by affordability.

The senior pay policy makes provision for sums paid to be withheld or recovered if required.

NED remuneration policy

The fees payable to the Chair and Non Executives are determined by the Council of Governors. These fees were unchanged in 2015/16.

Non-Executive Directors are appointed for a three year term of office. They must be considered independent at the time of appointment. A Non Executive Director's term of office may be terminated by the Council of Governors if the NED no longer meets the criteria for appointment as a NED.

Service Contract obligations

Senior managers' service contracts do not include obligations on the Foundation Trust which could give rise to or impact on remuneration payments or payments for loss of office.

Policy on payment for loss of office

Senior managers' service contracts include a six month notice period. In the event of a contract being terminated the payment for loss of office will be determined by the Nomination and Remuneration Committee. Payment will be based on contractual obligations. Payment for loss of office will not be made in cases where the dismissal was for one of the five "fair" reasons for dismissal.

Statement of consideration of employment conditions elsewhere in the Trust

In setting the remuneration policy for senior managers, consideration was given to the pay and conditions of employees on Agenda for Change. The 2015 salary scales for Executive Directors were agreed following a review of salary data provided by the NHS Providers.

Remuneration Report

Annual report on remuneration

Nomination and Remuneration committee

The Nomination and Remuneration Committee met three times during the reporting period to consider the appointment, performance and remuneration of the Executive Directors. The Chief Executive, the Director of Strategic and Organisational Development and the Trust Secretary attended meetings other than when matters being discussed would have meant a conflict of interest. Minutes of meetings were recorded by the Trust Secretary. Attendance is shown in the table below.

Nomination and Remuneration Committee Attendance	
David Wakefield	3/3
Neal Chamberlain	3/3
Carol Davies	1/3
Allan Duckworth	2/3
Ann Gavin-Daley	2/2
Mark Harrison	3/3
Andrew Thornton	3/3
Dr Jackie Bene	3/3
Mr Mark Wilkinson	3/3
Esther Steel	3/3

Governor Nomination and Remuneration Committee

The Governor Nomination and Remuneration Committee met three times during 2015/16:

- to discuss the appointment of a new NED to replace G Ashworth
- to consider a proposal to increase the number of Non-Executive Directors to seven
- To consider and recommend the reappointment of Mr D Wakefield for a second period of office.
- To receive the outcomes of NED appraisals.
- To consider Non-Executive Director remuneration – The Committee approved a recommendation to maintain the current level of remuneration

During 2015/16, the Trust did not receive services or advice from any external parties other than legal advice on compliance with regulation.

Remuneration Report

Expenses paid to governors and directors

The majority of the expenses claimed by Directors and Governors were for travel costs

	Directors		Governors	
	14/15	15/16	14/15	15/16
Total number of Directors in office	16	13	42	41
Number of Directors receiving expenses	10	8	5	6
Aggregate sum of expenses	£6930	£5451	940	£668

Remuneration

The following tables provide information which is subject to audit review about the salaries, allowances and pension and pension entitlements of employees and appointees.



Jackie Bene

Chief Executive, 26th May 2016.

Remuneration Report

		2015/16						2014/15					
Name	Tenure	A	B	C	D	E	Total - bands of £5,000	A	B	C	D	E	Total - bands of £5,000
Mr D Wakefield **Chairman**	From 08/08/12	60 - 65	No additional taxable benefits, annual performance bonuses or long term performance bonuses were paid to any member of the board.				60 - 65	60 - 65	-	-	-		60 - 65
Dr J Bene* **Chief Executive**	From 22/06/13	195 - 200				532.5 - 535	725 - 730	195 - 200	-	-	-	45 - 47.5	240 - 245
Mr S Worthington **Director of Finance**	From 18/02/13	155 - 160				217.5 – 220	375 - 380	135 - 140	-	-	-	62.5 - 65	195 - 200
Mr S Hodgson* **Medical Director**	19/12/12 - 25/03/13 From 01/09/13	185 - 190				57.5 - 58.0	245 - 250	170 - 175	-	-	-	72.5 - 75	245 - 250
Mr A Ennis **Chief Operating Officer**	From 01/01/14	110 - 115				75.0 – 77.5	185 - 190	100 - 105	-	-	-	47.5 - 50	150 - 155
Mrs S Woolridge **Acting Director of Workforce & OD**	13/05/13 – 04/08/14	-				-	-	20 - 25	-	-	-	-	20 - 25
Mrs T Armstrong-Child **Director of Nursing**	From 13/05/13	110 - 115				27.5 – 30.0	135 - 140	105 - 110	-	-	-	-57.5 - -55	45 - 50
Mr M Wilkinson **Dir Strategic & Org Development**	From 4/8/14	120 - 125				-35 - -27.5	85 - 90	80 - 85	-	-	-	-17.5 - -15	65 - 70
Mrs B Tabernacle **Acting Director of Nursing**	From 19/1/15	50 - 55				137.5 - 140	190 - 195	15 - 20	-	-	-	-	15 - 20
Non-Executive Directors													
Dr E Adia	01/12/11 - 31.07/14	-	-	-	-	-	-	5 - 10	-	-	-	-	5 - 10
Mrs G Ashworth	01/01/13 - 31/03/15	-	-	-	-	-	-	10 - 15	-	-	-	-	10 - 15
Mrs C A Davis	01/09/11	10 - 15		-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Mr N Chamberlain	From 1/10/14	10 - 15	-	-	-	-	10 - 15	5 - 10	-	-	-	-	5 -10
Mrs A Gavin Daley	From 01/08/15	5 - 10	-	-	-	-	5 -10	-	-	-	-	-	-
Dr M Harrison	From 01/04/12	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Mr A Duckworth	From 01/01/13	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Mr A Thornton	From 1/10/14	10 - 15	-	-	-	-	10 - 15	5 - 10	-	-	-	-	5 -10

Increases shown in pension related benefits reflect the changes to the pension accrual used for pension assessments upon retirement in accordance with the NHS Pension Scheme. For some Board members these have changed significantly in year following changes in contractual arrangements.

A	Salary and Fees	D	Long term performance bonuses
B	Taxable benefits	E	Pension related benefits
C	Annual performance related bonuses		

The salary and fees for Bene and Hodgson include elements which are not part of their senior manager role including 0.1 wte consultant role and Clinical Excellence Allowance (CEA) in the case of Bene and the CEA in the case of Hodgson. This is as per guidance released in May 2016 stating that this should be all remuneration including that which is not for the performance of their senior manager role. Bene has an additional £11,951 (£9,586 consultant 0.10 wte salary and £2,365 CEA level 7 relating to this role) and Hodgson £28,253 (£23656 relating to 15/16 CEA and £4,435 relating to 14/15 arrears for CEA)..

Remuneration Report

Total Pension Entitlement

Name and title	Real increase in pension sum at age 60	Real increase in lump sum at age 60 at 31 March 2016	Total accrued pension at age 60 at 31 March 2016	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 1 April 2015	Real Increase in Cash Equivalent Transfer Value funded by Employer	Cash Equivalent Transfer Value at 31 March 2016	Employers Contribution to Stakeholder Pension
	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	
Dr Jacqueline Bene	22.5 - 25.0	67.5 - 70.0	65.0 - 70.0	195.0 - 200.0	756	429	1,194	
Stephen Hodgson	2.5 - 5.0	7.5 - 10.0	50.0 - 55.0	155.0 - 160.0	1,056	66	1,135	
Simon Worthington	9.0 - 9.5	27.5 - 30.0	50.0 - 55.0	155.0 - 160.0	738	167	913	
Patricia Armstrong-Child	0 - 2.5	2.5 - 5.0	35.0 - 40.0	105.0 - 110.0	521	23	551	
Andrew Ennis	2.5 - 5.0	10.0 - 12.5	40.0 - 45.0	125.0 - 130.0	726	67	801	
Mark Wilkinson	minus	minus	40.0 - 45.0	130.0 - 135.0	754	(21)	742	
Beverley Tabernacle	32.5 - 35.0	97.5 - 100.0	30.0 - 35.0	95.0 - 100.0	425	101	531	

Pension arrangements for the Chief Executive and all Executive Directors are in accordance with the NHS Pension Scheme. The accounting policies for pensions and other relevant benefits are set out in note 1.8 to the accounts.

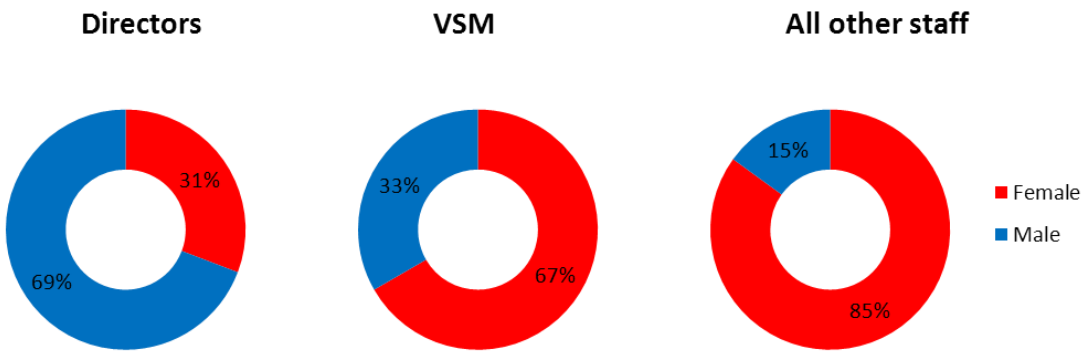
Introduction

Our organisation can only ever be as good as the people who work in it. Our goal for Bolton people is therefore simple: the team should feel fully engaged in their work, well recognised and fairly rewarded. Only as we achieve this can the Trust achieve its goals.

Staff numbers – by professional group

	average full time equivalent	
Staff Group	permanent	temporary/fixed term
Add Prof Scientific and Technic	126	9
Additional Clinical Services	851	25
Administrative and Clerical	855	36
Allied Health Professionals	351	6
Estates and Ancillary	194	13
Healthcare Scientists	95	0
Medical and Dental	229	108
Nursing and Midwifery Registered	1657	20

Staff numbers – by gender

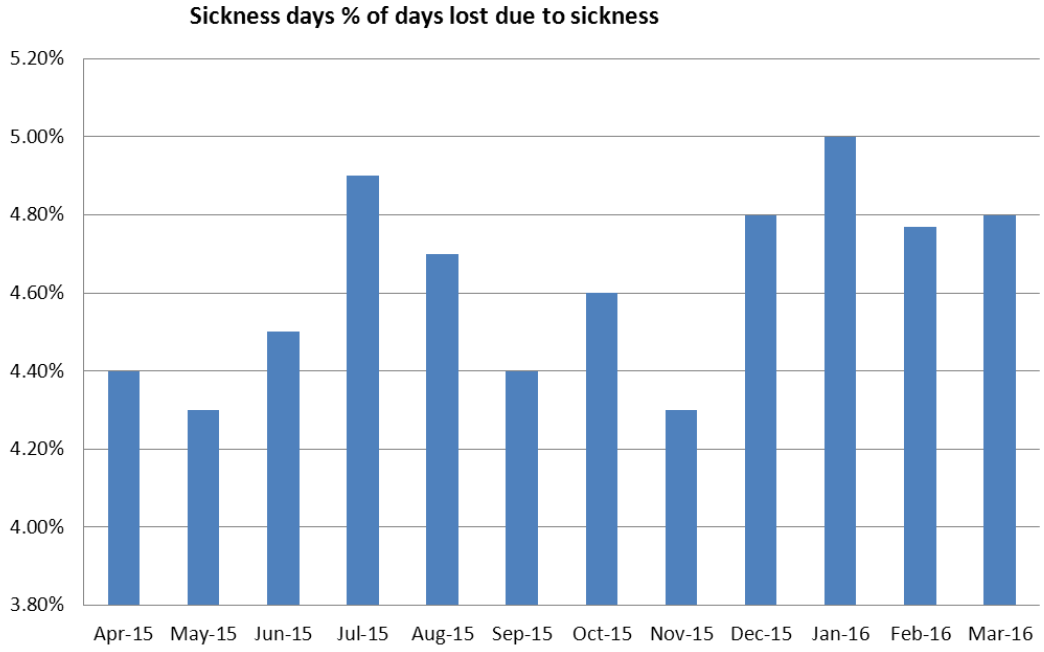


Sickness absence data

We work hard to ensure our staff are healthy and enjoy work and to see a year-on-year improvement in attendance. We have a comprehensive attendance management policy and encourage staff to seek professional medical support through our extensive occupational health and well-being services if needed.

Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff).

The chart below shows the percentage of days lost to sickness during 2015/16.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sickness days % of days lost	4.40%	4.30%	4.50%	4.90%	4.70%	4.40%	4.60%	4.30%	4.80%	5.00%	4.77%	4.80%

The data in the table below is provided by the Department of Health through the Health and Social Care Information Centre1 (HSCIC) for the calendar year 2015 (with 2014 data for comparison)

	Average FTE	**Adjusted FTE days lost to Cabinet Office definitions**	**FTE-Days Available**	**FTE-Days Lost to Sickness Absence**	**Average Sick Days per FTE**
2015	4,516	47,532	1,648,236	77,107	10.5
2014	4,546	Not provided in 2014	1,022,903	51,887	11.4

Staff policies and actions

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities

It is our policy to give full and fair consideration to applications for employment received from disabled persons, having regard to their particular aptitudes and abilities, and wherever possible to continue the employment of, and to arrange appropriate training for, employees who have become disabled persons during the period of their employment. Bolton NHS FT provides the same opportunities for training, career development and promotion for disabled people as for other employees.

The Trust's Recruitment and Selection policy was revised in January 2015. The policy ensures that all recruitment undertaken by the Trust is done in a consistent manner, whilst also ensuring the elimination of discrimination and the provision of equality of opportunity.

Section 6.4.1 of the Recruitment and Selection policy specifically outlines the Trusts commitment to the employment and career development of disabled people.

Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period

The Trust has recently revised the Attendance Management process to ensure clarity in supporting staff with long term conditions. The policy amendments have been made to ensure managers have the flexibility to make adjustments to working patterns and duties for staff who may suffer from a long term condition which may not, at this point in time, be classed as a disability. This policy was developed following a specific case that brought this matter to the attention of the HR team and staff side, and this element of the Attendance Management policy was developed with a view to ensuring adequate support to such staff.

Policies applied during the financial year for the training, career development and promotion of disabled employees

All policies are subject to an Equality Impact Assessment. In relation to disabled employees the HR team give expert advice on the need for reasonable adjustments to be made to ensure that there is equal access to training and development and promotion opportunities.

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees

Communication with our staff takes many forms: we have a weekly bulletin and a monthly face to face team brief, alongside team meetings that cover a variety of practice-based topics. If we are considering a change that will impact on an individual or a team then we would always discuss our proposals within a consultation framework with the staff affected. The Trust also has a monthly meeting with the staff side organisations where information is shared on the Trust's quality, finances, performance and workforce matters. To complement this the Chief Executive and Executive Directors undertake regular visits to different wards and departments across hospital and community teams to gain feedback from staff working at the front line.

Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests

During 2015/16, we held Staff focus groups to update our staff on a variety of issues, including Healthier Together and Greater Manchester Health and Social Care Devolution. The sessions have updated on the latest decision making and focussed on the possible impact on service delivery and workforce implications locally.

Other forums for consultation with staff have included

- Local staff focus groups to gain more granular level feedback on themes addressed in the annual staff survey and quarterly staff friends and family test.
- Local consultation sessions with staff affected by transformational change.
- Local action planning sessions around the 2015 Staff Survey results commenced in February 2016, with the view to publishing and implementing a comprehensive Trust-wide Action Plan at the end of April 2016

Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance

As a Trust, we actively encourage the involvement of our employees at all levels in all aspects of performance. Activities during 2015/16 include:

- Involvement of clinical & non-clinical staff in 'Perfect Week' events in acute and community settings
- A staff consultation event was held in November 2015 to explore the theme of Innovation & Improvement, leading to the appointment of a Continuous Improvement Co-ordinator in the PMO.
- Involvement of clinical staff and partners from Bolton Council and Bolton CCG in a one day accelerated discharge event in March 2016
- Use of our Staff friends and family survey data in local sessions with teams to strengthen engagement and improve team performance

Occupational Health

We are part of joint venture commercial collaborative Occupational Health service, set up in 2014. The service is hosted by Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) and is managed jointly between WWL, Bolton and Lancashire Teaching Hospitals NHS Foundation Trust (LTH). The service is called Wellbeing Partners and provides Occupational Health services to a number of public and private sector organisations across Lancashire, including large service provision contracts with Edge Hill University, Bridgewater Community NHS Foundation Trust and Lancashire Care NHS Foundation Trust.

The service vision is to develop a sustainable, clinician-led occupational health service for both public sector and private sector organisations in North Manchester and Lancashire that delivers excellent results and value for money for NHS organisations and for a broad client base.

The service provided by Wellbeing Partners provides all our occupational health requirements, including, support on pre-employment health checks, health referrals, flu inoculations and

proactive health interventions such as fast track physiotherapy referrals and mental health drop in sessions.

Health and Safety Performance

There have been no prosecutions or enforcement notices issued to the Trust by the Health and Safety Executive (HSE) during the reporting period. Similarly, the Trust has maintained its excellent accident/incident record of very low numbers of staff accidents requiring over seven days' absence from work

Information on policies and procedures with respect to countering fraud and corruption

The Trust has a Counter Fraud and Corruption Policy in place. A counter fraud work plan is agreed with the Director of Finance and approved by the Audit Committee. The local counter fraud specialist is a regular attendee at Audit Committee meetings to report on any investigatory work into reported and suspected incidents of fraud and to provide an update on the on-going programme of proactive work to prevent potential fraud.

Staff Survey

Commentary

Our approach to Staff Engagement has been informed by our new People Strategy which outlines a number of key priorities around culture, leadership & HR processes.

In August 2015, the Trust appointed a Staff Engagement Lead. In the last 6 months, we have focused on the following initiatives:

- Creation of a Staff Engagement Steering Group, chaired by our CEO and with representation from Executive Directors, Divisional leaders, HR and staff side; this meets bi-monthly to guide our progress
- Implementation of a Leadership Visibility Plan to improve access to Executive Directors and senior leaders within each Division, including monthly listening lunches with our CEO
- Greater use of Staff friend and family test data to determine areas of good practice and 'hotspots' within the Trust; and work with local teams on improvement actions to strengthen engagement
- Analysis work to explore the relationship between Staff FFT and Patient FFT/Complaints, with a view to developing integrated metrics around the staff/patient experience
- Refresh of the Trust Values, involving staff consultation between November 2015 and January 2016, to reflect our positive performance and ambitions within the Greater Manchester Health & Social Care Devolution context
- Greater use of local action planning within our Divisions to build a comprehensive Trust Action plan in response to the 2015 Staff Survey results

Staff Report

We continue to monitor our improving Staff Engagement scores through the Staff FFT, local staff surveys and the NHS Staff Survey. Our Listening Lunches with the CEO have been established since October 2015 and are covering all staff groups.

Summary of Performance – NHS 2015 Staff Survey

Our response rates in the most recent Staff Surveys are shown below:

	2014/15 (2014 Survey)		**2015/16** (2015 Survey)		Trust improvement / deterioration
Response Rate	Trust	National Average	Trust	National Average	
	46.6%	**42.3%**	**44.7%**	**41.0%**	A reduction of 1.9% in Bolton response rate, but still above national average.

Our main areas of improvement from 2014 to 2015 have been as follows:

- Our overall Staff Engagement Score has increased from 3.80 (2014) to 3.88 (2015)
- Our most improved Key Factor is KF1 (Staff Recommendation of the organisation as a place to work or receive treatment, moving from 3.68 to 3.83; this mirrors an upward trajectory in our Staff FFT results over the last few quarters
- We have seen a statistically significant improvement in 10 Survey Questions, a number of which relate to improvements in the quality of line management within the Trust

	2014/15 (2014 Survey)		**2015/16** (2015 Survey)		Trust improvement / deterioration
Top 4 ranking Key Factors	Trust	National Average *	Trust	National Average +	
KF9 Effective Team Working	**3.86**	**3.75**	**3.92**	**3.77**	An increase of 0.06, well ahead of the national average
KF10 Support from Immediate Managers	**3.74**	**3.75**	**3.88**	**3.66**	An increase of 0.14, we are above the national average
KF8 Staff satisfaction with level of responsibility and involvement	-	-	**4.03**	**3.93**	A new factor in 2015, we are ahead of the national average
KF19 Organisation interest in and action on health & wellbeing	-	-	**3.76**	**3.59**	A new factor in 2015, we are ahead of the national average

* All Acute Trusts
+ All Combined Acute & Community Trusts

The areas where our performance has declined are:

- We have seen a statistically significant decline in three Survey Questions, two of which relate to reporting of physical abuse/harassment/bullying/verbal abuse and one which concerns confidence in the organisation addressing unsafe clinical practice
- In comparison to other Acute Trusts, we are significantly worse on two items; 14a (Physical violence from patients/service users, their relatives or other members of the public) and 15d+ (Last experience of harassment/bullying/abuse not reported)

The following table shows our bottom four scores

	2014/15 (2014 Survey)		**2015/16** (2015 Survey)		Trust improvement / deterioration
Bottom 4 ranking Key Factors	Trust	National Average*	Trust	National Average+	
KF27 % of staff / colleagues reporting most recent experience of harassment, bullying or abuse	-	-	**15%**	**37%**	A new factor in 2015, we are behind the national average; more work required to spread awareness of the need to record such incidents.
KF22 % of staff experiencing physical violence from patients, relatives or the public in the last 12 months	**17%**	**14%**	**19%**	**14%**	An increase of 2% from last year, we are above the national average; this is a priority area within our new Trust Action Plan.
KF28 % of staff witnessing potentially harmful errors, near misses or incidents in the last month	**33%**	**32%**	**32%**	**27%**	A decrease of 1% from last year, but we remain above the national average.
KF25 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**28%**	**27%**	**29%**	**27%**	An increase of 1% from last year, we remain just above the national average; this is a priority area within our new Trust Action Plan.

* All Acute Trusts
\+ All Combined Acute & Community Trusts

Future Priorities and targets

- Our focus on strengthening Staff Engagement will continue during 2016-17, prioritised around embedding our new Trust Values model and using integrated staff/patient metrics to inform supportive interventions
- We are confident that our comprehensive Trust Action Plan will address the areas where our Survey scores have decreased.

- In particular, local actions identified within our Acute Adult Division will address both the perceived threat of violence from patients towards staff and the need to report such concerns; the increase in dementia patients with challenging behaviours will be an area of focus for us
- Staff feedback is actively encouraged within our Trust and we are looking at harnessing Intranet & Smartphone technology to enhance the available feedback channels in 2016-17
- Our Staff Engagement activity will be formalised into a strategic engagement framework during 2016 to demonstrate clearly aligned support for our People Strategy and our continued journey towards a high-performance healthcare organisation,

Expenditure on consultancy

Expenditure on Consultancy related spend has reduced from £1.1m in 2014/15 to £0.3m in 2015/16

Off payroll engagements

Statement on off payroll arrangements

Our policy for off payroll arrangements is in line with the guidance provided by Monitor and based on HM Treasury guidance that:

- board members and senior officials with significant financial responsibility should be on the organisation's payroll, unless there are exceptional circumstances – in which case the Accounting Officer should approve the arrangements – and such exceptions should exist for no longer than six months;
- engagements of more than six months in duration, for more than a daily rate of £220, should include contractual provisions that allow the department to seek assurance regarding the income tax and NICS obligations of the engagee – and to terminate the contract if that assurance is not provided;

We have established processes in place by which the need for employees can be assessed and the appropriate individuals recruited. While our preference is to employ our own staff,

The need may arise from time to time to cover areas of work which are specialist and outside our current areas of expertise and/or; particular circumstances dictate that someone outside the Trust should be engaged (e.g. certain investigations).

In such cases a determination is made as to which method of resourcing is most appropriate

Our preferred order of consideration would generally be

- Employment
- Agency
- Self-Employed Contractor (off-payroll)

The following tables provide detail of off-payroll engagements of more than £220 per day lasting for longer than six months

Existing off-payroll engagements as of 31 March 2016

No. of existing engagements as of 31 March 2016.	2
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

All existing off-payroll engagements, outlined above, have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

New off-payroll engagements and those that reached six months in duration between 1 April 2015 and 31 March 2016

No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	1
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	1
No. for whom assurance has been requested	1
Of which...	
No. for whom assurance has been received	0
No. for whom assurance has not been received	1
No. that have been terminated as a result of assurance not being received.	0

The request for assurance has been acknowledged by the individual however this is their first year of trading and their accounts are currently being prepared by their accountant, so they have not yet been able to provide the proof of assurance.

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements.	13

Fair Pay multiple

	2015/16	2014/15
Highest paid director salary - (J Bene) Dr Bene salary includes her 0.1wte consultant role and accompanying CEA	£195,046	£195,748
Median Salary	£27,090.00	£27,901
Median Salary Ratio	7.20	7.02
Employees receiving remuneration in excess of the highest paid director.	none	none
Remuneration range	£6,000 - £195,000	£6,000 - £196,000

Total remuneration does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions."

Exit Packages

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages		Total cost £000	
	15/16	14/15	15/16	14/15	15/16	14/15	15/16	14/15
<£10,000			26	7	26	7	88	42
£10,001 - £25,000			3	3	3	3	40	55
£25,001 - 50,000			1		1		38	
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Total	**0**	**0**	**30**	**10**	**30**	**10**	**166**	**97**

Exit packages: non-compulsory departure payments

Exit packages: other (non-compulsory) departure payments - 2015/16	Number of Payments agreed		Total value of agreements £000	
	15/16	**14/15**	**15/16**	**14/15**
Voluntary redundancies including early retirement contractual costs		10		97
Mutually agreed resignations (MARS) contractual costs	1		38	
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	29		129	
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval				
Total	**30**	**10**	**166**	**97**
of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary				

Payments for loss of office and to past senior managers

No payments have been made for loss of office or to past senior managers during the reporting year 2015/16.

Code of Governance Disclosures

Statement of Compliance with the Code

Bolton NHS Foundation Trust has applied the principles of the NHS foundation Code of Governance on a comply or explain basis. The NHS foundation Trust code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012

The Trust Secretary reviews our compliance with the NHS Foundation Trust Code of Governance and prepares a report for the Audit Committee. The Audit Committee considered this report at its meeting on February 23rd 2016 and agreed that Bolton NHS Foundation Trust complied with the main and supporting principles of the Code of Governance.

The Code is implemented through key governance documents, policies and procedures of the Trust, including but not limited to:

- The Constitution
- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- Schedule of Matters Reserved for the Board
- Code of Conduct (for Directors, for Governors and for Senior Managers)
- Staff Handbook
- Governor Handbook.

Summary Schedule of Matters Reserved for the Board

The Schedule of Matters reserved for the Board details the decisions and responsibilities reserved to the Council of Governors, the Board of Directors and those delegated to the agreed committees of the Board of Directors.

In the event of any unresolved dispute between the Council of Governors and the Board of Directors, the Chair or the Secretary may arrange for independent professional advice to be obtained for the Foundation Trust. The Chair may also initiate an independent review to investigate and make recommendations in respect of how the dispute may be resolved.

The overall responsibility for running an NHS foundation trust lies with the board of directors. The Council of Governors is the collective body through which the directors explain and justify their actions; the council should not seek to become involved in the running of the trust.

Directors are responsible and accountable for the performance of the foundation trust; governors do not take on this responsibility or accountability. This is reflected in the fact that directors are paid while governors are volunteers.

The Council of Governors

As set out in the constitution, the Council of Governors consists of 23 publicly elected Governors, six staff Governors and nine appointed partner Governors.

The Council of Governors meets formally in public every two months

The role of the governor is to:

- hold the Non-Executive Directors individually and collectively to account for the performance of the board of directors
- to represent the interests of NHS foundation trust members and of the public
- Set the terms and conditions of Non-Executive Directors
- Approve the appointment of future Chief Executives
- Appoint or remove the Trust's external auditor
- Consider the annual accounts, annual report and auditor's report
- Be consulted by the Board of Directors on the forward plans for the Trust.
- Approve changes to the constitution of the Trust
- Take decisions on significant transactions
- Take decisions on non NHS income.

The Board of Directors and the Council of Governors enjoy a strong working relationship. The Trust Chairman chairs both and acts as a link between the two. Each is kept advised of the other's progress through a number of systems, including informal updates via the Chairman, ad hoc briefings, exchange of meeting minutes and attendance of the Board of Directors at the Council of Governors and by individual Directors at Council of Governors sub-committees.

The Governors have not had cause to exercise their power to require one or more of the directors to attend a governors' meeting. The Executive and Non-Executive Directors attend the majority of Governor meetings to provide information about the performance of the Trust and to develop the relationship between the two bodies. In 2015/16 an additional briefings between Executive Directors and Governors were introduced. A rolling bi-monthly programme is now in place for Governors to meet with each Executive for informal discussions on areas relevant to individual portfolios.

Governors have a responsibility to canvass the opinions of the Trust's members and the wider public with regard to their views on the forward plans of the Trust. Governors are able to attend local area forums to meet with members within their own areas of the public constituency. Governors also took the opportunity to network informally with members prior to the Annual Members' Meeting and prior to Medicine for Members events.

The Membership and Member Communication subgroup have agreed to focus on member engagement during 2016/17

Code of Governance Disclosures

Public Governors

Name	Area	Date Elected	End of period of office	Meeting attendance
Ann Bain	Breightmet	Oct13	Sept 16	5/5
Derek Burrows	Kearsley	Oct 13	Sept 16	4/5
Michael Connolly	Westhoughton South	Oct 13	Sept 16	5/5
Kate Cowpe	Out of Area	Oct 14	Sept 17	2/5
Ken Hahlo	Heaton and Lostock	Oct 15	Sept 18	4/5
Eric Hyde	Little Lever and Darcy Lever	Oct 14	Sept 17	4/5
Pauline Lee	Westhoughton and Chew Moor	Oct 15	Sept 17	3/5
Carol McBride	Horwich and Blackrod	Oct 13	Sept 16	1/5
Martin McLaughlin	Halliwell	Oct 13	Sept 16	4/5
Jeffrey Mangnall	Rumworth	Oct 13		1/3
Geoffrey Minshull	Bromley Cross	Oct 14	Sept 17	4/5
Champak Mistry	Harper Green	Oct 13	Sept 16	1/5
Meena Patel	Hulton	Oct 14	March 16	0/5
Jack Ramsay★	**Bradshaw**	**Oct 14**	**Sept 17**	**3/5**
Bill Riley	Astley Bridge	Oct 13	Sept 16	2/5
Barbara Ronson	Horwich NE	Oct 14	Sept 17	3/5
Sorie Sesay	Great Lever	Oct 13	Sept 16	2/5
Jim Sherrington★	**Tonge with the Haulgh**	**Oct 13**	**Sept 16**	**5/5**
Janet Whitehouse	Smithills	Oct 14	Sept 17	3/5

Staff Governors

Name	Area	Date Elected	End of Period of Office	
Dipak Fatania	All other staff	Oct 13	Sept 16	3/5
Tracey Halliday	Nurses and Midwives	Oct 14	Sept 17	4/5
Sarah Hulme	All other staff	Oct 15	Sept 18	3/3
Dan Hindley	Doctors and Dentists	Oct 14	Sept 17	3/5
Janet Roberts★	**Nurses and Midwives**	**Oct 13**	**Sept 16**	**3/5**
Sarah Rutherford	AHPs and Scientists	Oct 14	Sept 17	3/5

★ Chair of a sub-committee and one of the three lead governors.

Code of Governance Disclosures

Appointed Governors

Name	Representing	Date Appointed	Meetings
Jack Firth	Bolton HealthWatch	Dec 10	1/5
Jane Haworth	Bolton University	July 14	0/5
Dawn Hennefer	Salford University	Sept 14	5/5
Susan Howarth	Bolton Metropolitan Borough Council	April 2014	2/5
Samir Naseef	Bolton Local Medical Committee	Nov 12	2/5
Thaira Qureshi	Bolton Council For Voluntary Services	Oct 08	1/5
Leigh Vallance	Bolton CVS	July 14	4/5
Anna Maria Watters	Bolton Metropolitan Borough Council	Nov 12	

Elections to the Council of Governors

Elections to the Council of Governors were held according to the constitution in September 2015. Results were as reported below.

Seat	Turnout	Governor elected
Heaton	44.2%	Ken Hahlo
All other staff	14/7%	Sarah Hulme

There were no uncontested elections in the year 2015/16

Code of Governance Disclosures

Lead Governor

In consultation with the Chairman and the Trust Secretary, the Council of Governors decided to nominate the three chairs of the sub-committees to jointly act as lead governor. The lead governor role is undertaken in accordance with Monitor guidance as the point of contact between Monitor and the Council of Governors with no additional responsibilities. In 2015/16, the three Governors fulfilling these roles were Janet Roberts, Jack Ramsay and Jim Sherrington.

Directors' and Governors' Register of Interests

A register is kept of Directors' and Governors' interests. Access to the register can be gained either by contacting the Trust Secretary or from the Trust website.

In accordance with the disclosure requirements the Chairman advised the Council of Governors of his appointment to serve as a Non-Executive Director and Chair of Audit Committee for Crown Commercial Services.

Developing understanding

The Board of Directors has taken steps to ensure that members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about their NHS Foundation Trust.

David Wakefield chairs both the Board of Directors and the Council of Governors and with the assistance of the Trust Secretary is the link between the two bodies. The full Council of Governors meets a minimum of six times a year and these meetings are attended by representatives of the Executive Directors, the Senior Independent Director and the Non-Executive Directors. The Governors' meetings provide the opportunity for the Governors to express their views and raise any issues so that the Executive Directors can respond. Minutes of the meeting are shared with the Board of Directors so they can pick up and respond to any issues raised. In 2014 at the request of the Governors, the part two section of the Board of Directors was opened up for Governors to attend and observe. Governors have provided feedback in support of this change which has allowed them to gain a greater degree of the understanding of the work of the Board.

The Governors have two formal sub-committees dealing with Auditor appointment, and nomination and remuneration. These are attended by the Chair of Audit and Director of Finance (Auditor appointment) and by the Senior Independent Director (nomination and remuneration).

The Governors also have three sub-groups, each chaired by a Governor nominated by the group. The chairs of the sub-groups meet with the Chairman on a regular basis, these groups are also attended by the Trust Secretary and other members of Trust staff as required.

The Trust recognises the importance of being accessible to members. Council of Governors meetings are held in public and publicised on the Trust website, member newsletters and notices around the Trust. The Governors representing the electoral wards of Bolton are able to attend the local area forums run by Bolton Council to meet individual FT members and members of the public and hear their views.

Code of Governance Disclosures

Board of Directors

The Board of Directors comprises the Chairman, Chief Executive, Senior Independent Director, five other independent Non-Executive Directors and five Executive Directors. The Board meet monthly in public. Papers for the meeting including the minutes of the previous meeting are available on the Trust website.

The Directors have collective responsibility for setting strategic direction and providing leadership and governance.

The Scheme of Delegation which is included in the Trust's standing orders, sets out the decisions which are the responsibility of the Board of Directors and those which have been delegated to a sub-committee of the Board.

The Executive Directors of the Trust meet weekly to consider the operational management and the day to day business of the Trust. These meetings are supported by monthly integrated performance meetings with the divisions and bi-monthly Divisional Executive meetings attended by Executive Directors and the senior management team. The primary purpose of these meetings is to contribute to the forward strategy and review performance against the annual objectives agreed in accordance with the strategy.

Balance, Completeness and Appropriateness

There is a clear separation of the roles of the Chairman and the Chief Executive, which has been set out in writing and agreed by the Board. The Chairman has responsibility for the running of the Board, setting the agenda for the Trust and for ensuring that all Directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day to day business of the Trust.

The Board of Directors has continued to assess the independence of its Non-Executive Directors further to the requirements of the Code of Governance, and considers that each Non-Executive Director is independent in character and judgement.

The Board considers that the Non-Executive Directors bring a wide range of business, commercial, financial and other knowledge required for the successful direction of the Trust.

All Directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust.

A review of Board governance was commissioned from KPMG in June 2012, the implementation of the recommendations was completed during 2014/15. A further review under the Monitor Well Led Framework will be conducted in 2016/17.

The external advisors used during 2015/16 have no other connections to the Trust.

Code of Governance Disclosures

Attendance at Board of Director meetings	
David Wakefield	11/11
Trish Armstrong Child*	7/11
Jackie Bene	11/11
Neal Chamberlain	11/11
Carol Davies	9/11
Allan Duckworth	11/11
Andy Ennis	10/11
Ann Gavin Daley	8/8
Mark Harrison	8/11
Steve Hodgson	10/11
Bev Tabernacle	4/4
Andrew Thornton	11/11
Mark Wilkinson	11/11
Simon Worthington	11/11
Esther Steel	11/11

* Attendance limited due to long term sickness

Code of Governance Disclosures

Audit Committee

The Audit Committee met on six occasions during the period April 1st 2015 and March 31st 2016.

The purpose of the Audit Committee is to provide independent assurance to the Board that there are effective systems of governance, risk management and internal control for all matters relating to corporate and financial governance and risk management.

A key aspect of the Audit Committee's work is to consider significant issues in relation to financial statements and compliance. As part of the preparation for the audit of financial statements, our external auditor KPMG undertook a risk assessment and identified risks as laid out in the table below:

Issues	**Mitigation**
Valuation of land and buildings	Review of revaluation basis Work to understand the basis upon which impairments to land and buildings have been calculated Assessment of the independence and objectivity of the surveyors and their terms of engagement
Recognition of NHS and Non NHS income and associated fraud risk	Testing of the completeness, existence and accuracy of the balances recorded within the financial statements Investigation of a sample of contract variations Participation in the Agreement of Balances exercise with other NHS organisations
Fraud risk from management override of controls	Testing of entries that are outside the Trust's normal course of business or are otherwise unusual Audit testing of controls External Audit review of register of interests and disclosure of any related party transactions Local Counter Fraud support

In addition to the review of financial statements, other key activities during the period April 1st 2015 and March 31st 2016 were:

- Consideration of the Going Concern report prior to approval by the Board of Directors.

- Providing oversight of the financial governance improvement plan - the Audit Committee provided regular oversight of the financial governance improvement plan developed to address weaknesses identified in external and internal reviews of financial governance.
- Reviewing the Board Assurance Framework and Risk Register - in addition to receiving the Board Assurance Framework the committee workplan scheduled a detailed focus on specific areas of the BAF, with the lead director required to attend the meeting to provide additional assurance that the risks to the Trust's strategic objectives are managed with mitigations in place.
- Receiving reports from the internal and external auditors and providing oversight to ensure agreed recommendations are addressed.
- Receiving regular reports from the local counter fraud specialist to provide assurance of the on-going development of an anti-fraud culture and specific actions taken in relation to concerns raised both internally and through national fraud awareness initiatives.
- Reviewing compliance with the Code of Governance.
- Receiving and providing oversight of regular reports on losses, waivers and variations.

Audit Committee Attendance	
Members	
Carol Davies (Chair)	6/6
Ann Gavin Daley	3/4
Mark Harrison	4/6
Neal Chamberlain	5/6
Attendee	
Simon Worthington	5/6
Esther Steel	6/6

Auditor Appointment

In 2015, a review of the Audit Committee, including both the Internal and External Audit functions was conducted using HFMA guidance. This review included consideration of value for money and the overall effectiveness of the committee. The Chair of the Audit Committee presented an overview of the Committee's work to the Council of Governors in January 2016. The Chair of the Audit Committee presented the Annual Report of the Audit Committee to the Board of Directors in November 2015.

External Auditor

The Trust is in the third year of a three year contract for External Audit services from KPMG. The appointment of KPMG as auditors was made by the Council of Governors in accordance with Monitor guidance. The value of external audit services (excluding the review of the charitable funds accounts) is £57,874 excluding VAT.

On occasion the Trust may decide to request additional services from the external auditor. The Council of Governors delegated specific authority for commissioning additional services to the Trust's Audit Committee, subject to an overall policy cap on directly attributable fees which

should not exceed 50% in aggregate of the approved annual statutory audit fee in any twelve month period. This would be on the understanding that the Audit Committee takes responsibility for agreeing any specific areas of additional work to be undertaken and, in doing so, considers whether the external auditor or any other organisation is best placed to provide the service i.e. based on relevant experience, expertise in that particular area and value for money. The Trust did not commission any non-audit services from its external auditor during 2015/16.

Internal Audit

Internal Audit services are provided by Price Waterhouse Cooper (PwC)

The Audit committee receive and approve the internal audit plan and through the course of the financial year receive regular reports on progress against the plan, accompanied by detailed reports providing the findings, recommendations and actions agreed following the audits agreed in the plan. The plan provides evidence to support the Head of Internal Audit's opinion which in turn informs the Annual Governance Statement (page 62)

Membership

Any member of the public over the age of 14 can become an FT member of Bolton NHS Foundation Trust and give their views on how they think we should develop our services. Through our members, we can really get to know what the public wants and, more importantly, act on that as our services evolve.

Membership strategy

We are committed to building a membership that is representative of and reflects the local communities we serve in terms of disability, age, gender, socio-economics, sexuality, ethnic background and faith.

Public members

Membership of the Trust is open to anyone who resides in England although we would expect the majority of our members to reside in Bolton and the surrounding areas of Salford, Wigan, Bury and South Lancashire. There is a lower age limit of 14 but no upper age limit. There are no limits on the number of people who can register as members.

Public members are placed in constituencies based on where they live. There are 20 constituencies representing the electoral wards of Bolton and one to represent "out of area" members.

Staff members

We have an opt out arrangement in respect of staff membership. Under this arrangement, staff will automatically be registered as a member of the Trust unless they have completed the opt out form which was circulated with payslips prior to authorisation as a Foundation Trust. New members of eligible staff are provided with information and a form at induction.

Staff membership is open to everyone who is employed by the Trust full or part time on a contract with no fixed term or those staff on fixed term contracts of 12 months or more. Membership is also available to those bank staff who have an agreement to work for the Trust and have done for 12 months or more. Staff working for the Trust's contractor for portering and domestic services are also eligible for staff membership if they meet the above criteria.

Staff membership ceases at the point that the member leaves the service of the Trust, but individuals can then choose to become a public member.

Benefits of membership

Although there are no financial benefits to FT membership, there are also no costs. There is, however, much satisfaction in being in a position which can help local people and local services. There are no benefits to members in terms of access to services.

We will use our members as a valuable resource calling on those who have expressed a willingness to participate in surveys and focus groups to gain a snapshot view of the user's perspective.

Membership recruitment

We aim to continue recruiting new members and are using a variety of methods to ensure we reach as many people as possible. People wishing to join can do so by registering online at www.boltonft.nhs.uk or by calling 01204 390654. Alternatively application forms are available throughout the hospital.

Code of Governance Disclosures

Contact procedures for members that wish to communicate with Governors and/or Directors

Members who wish to communicate with Governors may do so by email to Governor@boltonft.nhs.uk or by post c/o the Trust Secretary. To communicate with Directors contact angela.barber@boltonft.nhs.uk

Membership Statistics

Public Constituency	
At year start (1 April 2015)	4354
At year end (31 March 2016)	4487
Staff Constituency	
At year start (1 April 2015)	5244
At year end (31 March 2016)	4955

Analysis of current public membership

Public Constituency	Number of members	Eligible membership
Age		
0 - 16	4	3,646
17- 22	56	155,597
22+	4185	252,135
Not known	242	
Ethnicity		
White	3347	222,105
Mixed	34	4,750
Asian or Asian British	584	38,309
Black or Black British	84	4,457
Other	108	1,757
Not known	213	
Socio-economic groupings		
ABC1	395	38,240
C2	2032	55,395
D	1082	31,522
E	919	74,159
Not known	59	
Gender		
Male	1752	134,865
Female	2673	136,513
Not known	62	

Regulatory Ratings

The continuity of services risk rating

There are four rating categories ranging from one, which represents the most serious risk, to four, representing the least risk. A low rating reflects the degree of financial concern Monitor may have about a provider.

Governance rating

Monitor use a specified set of national metrics as proxies for overall standards of governance, including A&E waiting times, referral-to-treatment targets and rates of C. difficile infection. In addition, when the Care Quality Commission has serious concerns about a trust, Monitor will consider whether it is in breach of its licence and what action is needed.

There are three categories to the governance rating applicable to all NHS foundation trusts:

- A green rating is assigned where there are no grounds for concern at a trust.
- Where Monitor have identified a concern at a trust but not yet taken action, they will provide a written description stating the issue at hand and the action being considered.
- A red rating will be assigned when regulatory action has been taken.

The regulatory ratings are based on self-certification received from trusts in their annual plan, in-year quarterly submissions and any exception reports, including any reports from third parties such as the Care Quality Commission (CQC).

Monitor intervention

April 2012	The Trust was found to be in significant breach of two of the terms of its authorisation: its governance duty, and its healthcare targets and other standards duty. The decision was triggered by the failure of the Trust to meet healthcare targets (specifically A&E waiting times and the Referral to Treatment (RTT) 18 week target) and failings in Board governance.
August 2012	Monitor exercised their formal powers of intervention after finding the Trust had failed to comply with its terms of authorisation.
April 2013	The Trust became licensed with conditions which included discretionary requirements and enforcement undertakings
December 2014	The Trust was issued with a certificate of compliance with all enforcement undertakings and a statement of compliance in respect of the discretionary requirements relating to target breaches, board effectiveness and governance
September 2015	Monitor confirmed that the Trust was no longer in breach of the provider licence and had returned to a green governance rating

Regulatory Ratings

The ratings for Bolton NHS Foundation Trust over the last two years are summarised in the tables below.

The ratings awarded at the start of the year are based on the expected performance at the time of the annual risk assessment in our annual plan. The quarterly ratings are based on actual performance reported to Monitor, via quarterly in-year submissions.

	Annual Plan	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
Continuity of Service rating	2	1	2	2	2
Governance risk rating	green	red	red	green	green

	Annual Plan	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
Continuity of Service rating	2	1	2	2	2
Governance risk rating	red	red	red	red	red

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Bolton NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Bolton NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Bolton NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed



Jackie Bene

Chief Executive

Date 28th May 2016

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Bolton NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Bolton NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

As Accounting Officer I Chair the Risk Management Committee and have overall accountability for internal control. To support this role there are clear systems of accountability within the organisation with each Executive Director having specific areas of responsibility

The **Risk Management Strategy** sets out details of the risk management structure and key risk manager roles. The role of the Board and Standing Committees is detailed, together with the individual responsibilities of the Chief Executive, Executive Directors and all staff in managing risk. In particular, the Risk Management Committee, the Quality Assurance Committee, the Informatics Committee, the Finance and Investment Committee, the Clinical Governance Committee and the Divisional Governance Boards provide the mechanisms for managing and monitoring clinical, operational, financial and information governance risks throughout the Trust. The Audit Committee oversees the systems of internal control and overall assurance process associated with managing risk.

The Board of Directors routinely receives reports from its Standing Committees and also receives reports on all serious incidents. The Clinical Governance Committee receives detailed reports on the management of actions agreed following investigations into serious incidents (SIs).

The executive team is supported by a divisional management structure consisting of four clinical divisions and an Estates and Facilities Division. Each division has a clinical Head of Division and a Divisional Director of Operations who are jointly responsible for the delivery of key objectives in their areas. Each division is supported by a Divisional Director of Nursing with specific responsibility for delivering on patient safety, quality and the governance agenda. Each

of the Clinical Divisions provides a detailed quarterly report to the Quality Assurance Committee.

Performance monitoring

The integrated performance report provides comprehensive information to the Board and its sub-committees and to the divisions. The report includes a ward to board heat map to provide ward level information. Operational focus on the performance report is conducted through the monthly integrated performance meetings between the Divisions and the Executive team

The Quality Assurance Committee monitors the performance dashboard to provide assurance to the Board. Where concerns are identified using the heat map the QA Committee may seek further assurance that the issues are being managed and may at the discretion of the Chair escalate any concerns to the Board to ensure that the Board as a whole are appraised of and have the opportunity to challenge the planned actions.

Training

To ensure the successful achievement of the Risk Management Strategy and implementation of the Risk Management Policy, staff at all levels are provided with appropriate training in carrying out risk assessments and the reporting of incidents. The on-going programme of training within the Trust includes: managing safely, risk register training, fire safety training, manual handling, safeguarding training, major incident training and conflict resolution training.

Medicine management training is delivered at doctors' induction programmes and during educational and developmental sessions. Support and advice on medicine management is also provided at ward and departmental level by the Chief Pharmacist and link pharmacists.

Risks and safety in respect of clinical equipment and devices are discussed and disseminated by the Medical Devices and Equipment Management Committee. All divisions are represented on this committee which also has a training sub group and each ward has a link nurse.

General awareness raising on risk management issues is achieved through staff briefings, team brief, safety bulletins, induction and the intranet.

The Executive Team and the Board of Directors monitors management capability, (leadership, knowledgeable and skilled staff, adequate financial and physical resources), to ensure the processes and internal controls work effectively.

The risk and control framework

Risk management in the trust

Risk management is recognised as a fundamental part of the Trust's culture, and an integral part of good practice. It is integrated into the Trust's philosophy, practices and business plans. Risk management is the business of everyone in the organisation.

The Trust's **Risk Assessment** process, investigating incidents, complaints and claims procedures are the principal sources of risk identification. The Risk Assessment process identifies the criteria for risk scoring both likelihood and consequence on a scale of 1 to 5, with the highest risk being accorded a score of 25 (5x5). The risk assessment process also requires an appropriate risk management plan.

The Risk Assessment process clearly states the escalation of management seniority to monitor management and mitigation of the risk according to its overall likelihood and consequence.

The Risk Assessment process is applied to all types of risk, clinical, financial, operational, capital, and strategic.

The Trust **Risk Register** procedure requires Divisions to maintain and monitor their own Risk Registers. All risks with a score rating of 15 or above are reviewed by the Risk Management Committee.

All "business cases" have to be supported with a risk assessment. The scored risk rating strongly influences priorities within the Trust Capital Programme.

The **Board Assurance Framework** helps provide assurance to internal and external stakeholders in relation to meeting the Trust objectives. Assurance of the system is also supported by independent assurance processes – internal and external, and achievement of satisfactory outcomes or results.

The Assurance Framework identifies Bolton NHS Foundation Trust's principal objectives and their associated principal risks and is developed in consultation with the Executive Team. The control systems which are used to manage these risks are identified together with the evidence for assurance that these are effective. Lead managers and Directors are identified to deal with gaps in control and assurance and are responsible for developing action plans to address the gaps.

The Board ensures effective communication and consultation at all levels within the organisation and with external stakeholders. We engage with our main commissioner (Bolton CCG) in contract review meetings and through Joint Leadership meetings. A representative of Bolton CCG Group also has a seat on our Quality Assurance Committee. We engage with other key stakeholders at various forums including but not limited to, Council of Governor Meetings, Overview and Scrutiny Committee and Healthwatch. These meetings provide an opportunity for risk related issues to be raised and discussed.

A Board approved assurance framework (BAF) was in place for the period 1st April 2015 – 31st March 2016

In 2015/16, the BAF was revised to include a description of risk appetite for each risk and additional background information including tracking the score of the risk over time.

The Board receive a monthly update on the BAF within the Chief Executive's report. This update highlights any changes to risks and ensures a continued focus on the risks to the achievement of the overall strategy.

Risk Appetite

When approving the Board Assurance Framework the Board agree their risk appetite for each of the strategic goals of the organisation

- Risk averse to risks that affect the quality of care and the experience of every person accessing our services
- We will not knowingly take decisions to reduce safety or ignore safety issues
- We will not tolerate failure in basic standards of compliance which could compromise licence conditions
- We have an appetite for developing partnerships but will not enter into partnerships that convene our statutory duty as an NHS Foundation Trust.

Quality Governance Arrangements

The Quality Governance Framework has been developed by Monitor as an assessment tool for Trusts to use to benchmark their arrangements for effective quality governance in four categories:

- Strategy
- Capabilities and culture
- Process and structure
- Measurement

Strategy - Quality is embedded in the Trust's overall strategy, the safety and effectiveness of care and the experience of patients are at the heart of all that we do. In 2013, the Trust approved and adopted a new five year Quality Strategy and strategies to reduce the rate of falls and pressure ulcers

Capabilities and Culture - The Board is assured that quality governance is subject to rigorous challenge with full NED engagement in the Audit Committee and NED involvement in the assurance providing committees.

Process and Structure - The Corporate Governance Structure was reviewed in 2013 to ensure clarity of reporting between wards and departments and the Board and between the Board and its supporting committees. A new Risk Management Committee was formed in September 2013 and the remit of the Clinical Governance Committee and the Quality Assurance Committee was clarified. Integrated Performance Meetings ensure clear routes of escalation to the Executive team.

The Trust has clear process in place for:

- Clinical incident and accident policy
- Raising concerns (Whistle blowing)
- Complaints
- Management of SIs

Action plans are put in place to address issues arising from these processes.

Performance information - A new integrated performance report was developed during 2014. This report provides a clear dashboard and high level apex report for the Board of Directors and Council of Governors with full reports reviewed in the Board sub committees and at the Integrated Performance Meeting. We recognise the importance of regularly reviewing the information provided to the Board and have started the process to review the format and content of this report in readiness for the launch of a new report in May 2016.

The foundation trust is fully compliant with the registration requirements of the **Care Quality Commission.** Assurance is obtained on compliance with CQC registration requirements and the fundamental standards to provide care that is safe, effective, caring, responsive and well led through the following mechanisms:

- Divisional reports to the Quality Assurance Committee have been framed around the domains and standards set by the CQC. Divisions have undertaken self assessment

using the CQC KLOEs to evaluate the services they provide. Action plans are in place to address any areas identified as requiring improvement. These action plans are monitored through the quarterly reports to the Quality Assurance Committee.

- A series of internal Quality Reviews has been implemented using the CQC format to undertake unannounced inspection visits to all areas of the hospital and the community. Findings from these inspection visits are reported to the Quality Assurance Committee and triangulated with the Divisional self assessments.
- A "Better Care Together" group has been established to co-ordinate the programme of assessments. This group is chaired by the Director of Nursing with membership including senior leadership from each clinical division.
- The CQC conducted a full inspection in March 2016, the results of this inspection will not be available until quarter two of 2016/17. Initial feedback from the CQC was positive with no immediate regulatory action.

Compliance with the NHS foundation trust condition 4 (FT governance)

To assure itself of the validity of its annual governance statement required under NHS FT Condition 4 (8) b the Board of Directors receives an annual assurance statement and associated evidence. In addition, the Board of Directors has received quarterly reports which it has submitted to the sector regulator - Monitor regarding its principal risks to compliance with its Governance and Continuity of Service ratings.

A review of the effectiveness of the Board of Directors and Board Committee was undertaken as part of the enforcement undertakings accepted by the Trust in 2013. A further review using Monitor's Well Led Governance Framework is planned for 2016.

Compliance with NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

In 2016, the Trust received assurance from its internal auditors that effective processes and procedures for the NHS Pension scheme process are well established and operate in a consistent manner.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust regularly reviews the economic, efficient and effective use of resources with robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include:

- Ensuring the financial strategy is affordable
- Scrutiny of cost savings plans
- Co-ordination of individual and departmental objectives with corporate objectives.

In addition to the above, in 2015/16, the Trust was an early adopter of recommendations from the Carter review and was one of the 32 trusts that worked with Lord Carter of Cole to inform his report on operational productivity.

Performance against objectives is monitored and actions identified through a number of channels:

- Approval of the annual budgets by the Board of Directors
- At Executive Director meetings
- Bi-monthly reporting to the council of Governors
- Monthly reporting to the Board of Directors and the Executive Board on key performance indicators
- Integrated Performance Monitoring meetings to hold divisions to account for performance against quality, operational and financial objectives.
- Monthly review of financial targets by the Finance and Investment Committee
- Quarterly reporting to Monitor.

Finance

The Trust achieved its financial plan in 2015/16 however a significant element of this delivery was from non-recurrent initiatives including a £4.1m capital to revenue transfer and over £3m of technical balance sheet measures.

Assurance is provided by:

Internal audit - PwC were appointed as the internal auditor in June 2013. At the time of appointment a three year audit plan was agreed. This plan has been formulated based on PwC's risk assessment of the inherent risk and the control environment. The Head of Internal Audit meets regularly with the Director of Finance and the Chair of the Audit Committee to review progress against the plan and to ensure the plan remains tailored to the needs of the Trust.

The Head of Internal Audit opinion is that the Trust has a "Generally satisfactory" system of internal controls

During 2015/16 the Trust received the following internal audit reports.

Report	Risk rated

Capital assets and accounting	Medium risk
Key financial controls	Medium risk
Serious incidents and complaints	Low risk
Service integration – risk management	Low risk
Cost improvement programme – idea generation	Low risk
Quality Assurance Committee effectiveness	Low risk
IT project assurance – PAS convergence	High risk
Discharging and outpatients	Low risk
Clinical coding	Low risk
Quality governance – pressure ulcer reporting	Low risk
Pensions charter	Low risk
Assurance Framework and risk management	Low risk

The one high risk internal audit report focused on the implementation of the programme to converge the two patient administration systems used by the Trust. The high risk recommendations relate to the programme management of the project and do not have an impact on the wider system of internal control.

Procurement of goods and services is undertaken thorough professional procurement staff and through working with neighbouring organisations within a procurement hub.

In year cost pressures are rigorously reviewed and challenged, and alternatives for avoiding cost pressures are always considered.

Information governance and Data Security

During 2015/16, there were no serious incidents relating to information governance including data loss or confidentiality breach.

The Trust Information Risk Management Policy sets out key principles, the legislative and good practice framework, revised information governance structures, and roles and responsibilities, including the concept of Information Asset Owners.

The Trust has encrypted all laptops and desktop PCs. Centralised storage has been rolled out across the Trust to ensure that all critical and sensitive data is held securely, not on local equipment. All portable devices such as memory sticks that are plugged into PCs and laptops have enforced encryption.

Email encryption software has been procured which allows the encryption of emails containing sensitive information. An Email and Internet Access Policy has been approved to reflect the capabilities that new security applications now give the Trust. Staff have been reminded that email must not be used to send personally identifiable data, unless it is encrypted or NHSmail is used and messages remain within the NHS.

The Trust recognises the information governance risks relating to the use of tablet devices and “cloud sharing” and has purchased the software to support and protect information processed on these devices.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

Governance and Leadership

In producing the Quality Account 2015, the Trust identified key areas for improvement of patient safety, clinical effectiveness and experience. To ensure a balanced view, the Board worked with Governors and other internal and external stakeholders to select the priorities on which the Trust would be reporting in 2016/17.

In developing the report, consideration has been given to the comments made by internal and external stakeholders including our partner organisations and the External Auditors on previous reports.

Policies and plans

In 2014 the Board approved a new overarching quality strategy with supporting strategies for the reduction of harm from falls and pressure ulcers. The launch of these policies provided an opportunity to re-engage with staff across the organisation on the importance of zero tolerance of harm. Results reported in our quality account provide evidence that these strategies have been effective with significant reductions in patient harm reported.

Data use and reporting

We have used existing performance management arrangements to track progress throughout the year on the targets selected and have reported at year end on these to the Board. An external audit report on our 2014/15 Quality Account and a review of data accuracy have provided some assurance that the Trust has arrangements to ensure the accuracy of data. Data accuracy is however still a key priority for the Trust, until the Trust is in a position to implement a full electronic patient record this will remain a risk.

Assurance of 18 week Elective waiting time data

The operational teams and Business Intelligence work collaboratively to ensure 18 week data is accurate and of a high quality

In order to do this the following are in place:

- Specific data quality suite of reports are run by Business Intelligence and circulated to specialties to review on a weekly basis.
- Patient Tracking List (PTL) data on Info Flow is updated daily and this is used by the teams to review the patients within their specialties
- PTL meeting takes place on a weekly basis chaired by Elective Care Division where all departments report back on patients on their PTL, discrepancies that have been corrected and action that is being taken where delays have been identified within the pathway
- Validation of patients is carried out on a weekly basis by teams

- At the end of the month further validation is carried out by all departments
- Business Intelligence circulate month end report which is reviewed by departments and where appropriate corrections are made prior to signoff and upload

Testing of the 18 week RTT indicator by the external auditor for the 2015/16 quality report, identified a number of instances where pathways were incorrectly reported as a breach of the 18 week target – that is to say the Trust was underreporting on performance against this target.

Assurance of cancer data

Teams in Cancer Services and Business Intelligence work collaboratively to ensure cancer data is accurate and of a high quality.

In order to do this the following is in place:

- Discrepancy reports are generated by the staff in Business intelligence and shared across the trust to highlight any issues. These are actioned in a timely manner by both the centralised and devolved booking teams. LE2.2 / Somerset are corrected as appropriate, or justification provided for any genuine date anomalies.
- In April 2015, a cancer workshop was created to focus on the five most challenging pathways. This included clinical and managerial teams working in collaboration to improve pathways.
- All Cancer treatments are validated by Business Intelligence and signed off prior to uploading
- All data uploaded for the various national cancer audits is validated by Business Intelligence staff prior to upload
- A monthly Somerset report highlighting clock re-starts is produced and patients cross checked to ensure clocks are only restarted following DNAs.
- All patient breaches for 2 week wait and breast symptomatic 14 day standard are validated
- All 62 day, 31 day, screening, subsequent and upgrade breaches are validated
- The Trust is part of the Greater Manchester Cancer Network and actively collaborates with the network to drive improvement work.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Maintaining and reviewing the system of internal control

The Board

The Chief Executive and Board of Directors have overall responsibility for the Trust's Risk Management programme.

The Audit Committee

This Committee acts independently from the Executive, to provide assurance to the Board, based on a challenge of evidence and assurance obtained, that the interests of the Trust are properly protected in relation to financial reporting and internal control. It keeps under review the effectiveness of the system of internal control; that is the systems established to identify, assess, manage and monitor risks both financial and otherwise, and to ensure the Trust complies with all aspects of the law, relevant regulation and good practice.

This Committee reports to the Board any matters in respect of which the Committee considers that action or improvement is needed, and makes recommendations as to the steps to be taken.

The Risk Management Committee

This Committee provides the Board with an objective review of, in relation to: -

- Risk governance, the risk management frameworks and the promotion of behaviours and cultures that drive approaches to risk management.
- The systems of internal control in relation to governance and risk management, in that these are fit for purpose, adequately resourced and underpin the Trusts performance and reputation
- The overall risk governance process in that it gives clear, explicit and dedicated focus to current and forward-looking aspects of risk exposure

The Quality Assurance Committee

This Committee provides the Board with an independent and objective review in relation to:

- All aspects of quality, specifically: clinical effectiveness, patient experience and patient safety; monitoring compliance against the essential standards of quality and safety set out in the registration requirements of the Care Quality Commission
- Governance processes for driving and monitoring the delivery of high quality, clinically safe, patient-centred care
- Performance against internal and external quality and clinical improvement targets, and directing management on actions to be taken on sub-standard performance
- The overarching Quality Strategy
- Assurance on safeguarding quality and to provide appropriate scrutiny to clinical effectiveness, patient safety and patient experience
- Assurance (positive and negative) derived from clinical audits is reported through the Clinical Governance committee to the Quality Assurance Committee.

The Finance and Investment Committee

This Committee provides the Board with an objective review of, and assurances, in relation to: -

- Finance, contracting and commissioning issues; presenting reports and recommendations in relation to ensuring we maintain cash liquidity and are an effective going concern

- Financial governance processes
- Business cases referred to it by the Capital and Revenue Investment Group requiring major capital investment
- Reviewing and challenging budgets
- Compliance with legislative, mandatory and regulatory requirements in terms of the Committee's scope

The Executive Team has responsibility for the development and maintenance of the system of internal control and the outputs from its work provide me with assurance.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

Significant Internal Control Issues

The Trust identified the following internal control issues during 2015/16. These have been or are being addressed through the mechanisms described in this statement.

A & E Performance

Meeting the national four hour standard for A & E remains a challenge. Constraints on medical and nursing staffing resulted in the Trust concentrating on Ambulatory care, which although showing significant signs of success, were not enough to prevent continued failure to meet the standard through quarters three and four.

The Trust is working with partners in the locality to support accident and emergency performance, has commenced overseas recruitment to manage the shortfall in nursing and is redesigning the medical workforce to mitigate the staffing challenge.

The Trust has also continued to deploy best practice recommended by the Emergency Care Intensive Support Team to support urgent care and is investing £4 million in the Accident and Emergency department to improve the environment for patients and staff

Never Events

In 2015/16, the Trust reported three never events relating to surgery

Our three Never Events for 2015/16 are as follows:

- Retained foreign object post procedure (retained sling – identified during other investigation and had not resulted in harm to the patient)
- Retained foreign object post procedure (a throat pack was briefly left in situ but was removed before the patient was aware)
- Wrong site surgery – an anaesthetic block was given to the wrong side prior to an eye procedure – the error was identified and rectified prior to surgery.

Investigations have been undertaken/initiated for each incident, although each of these incidents is a never event, it is important to note that there was no lasting harm to the patient in any of the cases

In August 2015, The Royal College of Surgeons were commissioned to undertake an external review of surgery. An Action plan developed in response to this review was agreed and has been overseen by the Quality Assurance Committee.

Conclusion

Despite the significant control issues identified above the Trust have made significant improvements to the system of internal control. Actions are in place to address the issues leading to the control issues and the Board are confident that there is a robust system in place to oversee the implementation of these actions.



Signed

Chief Executive Date: 26th May 2016

Statement on Quality from the Chief Executive

This last year was a particularly busy one for Bolton Foundation NHS Trust; however, our main priority and focus has been to ensure that our services are Safe, Effective, Caring, Well-led, and Responsive.

Since the last publication of our Quality Accounts a key achievement for the organisation was to be taken out of breach of our Foundation Trust licence. This was achieved against a backdrop of strong performance on some of our key quality and safety indicators such as cancer targets, diagnostic tests, stroke targets, hospital acquired infections, falls and many others. I recognise that it is only through the hard work, commitment and support of all our staff that we have achieved this and it is of huge importance to me and the organization that we do everything we can to support our staff in their work. We were delighted therefore, that our staff satisfaction scores continued to rise this year, with the majority now in the top 20% of the UK, and our patient feedback has also improved, highlighting the effects of improved care throughout the Trust.

For the period April 2015 – October 2015 the National Reporting and Learning System reported that the Trust was in the top 25% of acute non specialist NHS organisations for incident reporting – indicating that a healthy incident reporting culture thrives in the organisation, thereby enabling the Trust to learn from errors and reduce the risk of further errors. Data drawn from the 2015 NHS Staff Survey further confirms this via the NHS England March 2016 publication; 'Learning from Mistakes League' which positions the Trust 34th out of 230 NHS organisations and categorising the Trust as 'Good: levels of openness and transparency'. Instilling a culture of openness and transparency is key to robust debate, challenge and decision-making giving us confidence that we provide well-led and responsive services. These achievements are also testimony to the commitment and engagement of everyone in the Trust; working together to drive quality improvements forward for the benefits of our patients. There is, however, room for improvement and as a Chief Executive and clinician I know from personal contact with patients and carers that we can always do better. I also know that the Board, Governors and every member of staff are fully committed to providing the very best services we can and that where gaps are identified they are quickly addressed.

The Care Quality Commission (CQC) review of our Trust took place in March; the formal report will be available later in the year, but I am pleased to report initial feedback was very positive, with no serious concerns escalated by the CQC to the Trust either during or immediately after the inspection.

So as we look to 2016/17 I am clear that our emphasis and focus will remain on delivering consistently high quality, efficient and effective care for all our patients. Devolution Manchester and Healthier Together also provides us with an opportunity to review how we work in collaboration with other healthcare providers in the region; in addition to working closely with our local commissioners to ensure we continue to meet the needs of patients local to Bolton.

In terms of our key quality improvement priorities for the coming year, we have worked with our staff, our Foundation Trust members and our Council of Governors to select priorities which we feel will have the greatest impact on improving the quality of care for our patients. These are:

- Recognising and responding to deteriorating patients
- Stroke
- End of Life Care

Finally, I would like to extend a warm thank you to all of the staff at Bolton NHS Foundation Trust who work tirelessly every day to better the lives of patients and the community we serve. To the best of my knowledge, the information we have provided in this Quality Report is accurate and I hope it provides you with a clear picture of how important continuous quality improvement, patient safety and experience are to us at Bolton NHS Foundation Trust.



Dr Jackie Bene, Chief Executive

26th May 2016

Quality Report

Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

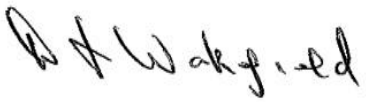
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2015 to April 2016
    - papers relating to Quality reported to the Board over the period April 2015 to April 2016
    - feedback from the commissioners dated
    - feedback from governors
    - feedback from local HealthWatch
    - feedback from local Health Overview and Scrutiny Committee.
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
    - the 2015 national patient survey
    - the 2015 national staff survey
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 05/2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



Chairman

26th May 2016



Chief Executive

26th May 2016

How Quality Initiatives are prioritised in the Trust

This Quality account identifies the progress made against the Quality and Safety strategies this year and identifies the Quality Improvement aims for 2016/17.

The Safety and Quality programme will enable the Trust to maintain a focus on the Quality and Safety agenda, whilst delivering our clinical strategy to improve the health and outcomes of our local population based on the values and principles set by the Board and in line with the NHS outcomes framework.

Following extensive consultation with our Commissioners, Patient Experience Committee and Foundation Trust Governors, the following key improvement priorities for 2016/2017 have been chosen:

Key Improvement Priorities for 2016/2017:

- Recognising and responding to deteriorating patients
- Stroke
- End of Life Care

Continuous improvement of clinical quality is further incentivised through the contracting mechanisms that include quality schedules, penalties and CQUIN payments. The Trust hosted a workshop and ensured a comprehensive consultation with our Commissioners and our Clinicians to set-up our CQUINs for 2016/2017 and agree a workplan for the delivery of these.

Quality Performance in 2015/16:

In our Quality Report for 2014/15 we set ourselves a series of key priorities for improvement, these were:

- Reducing Mortality
- Infection Prevention and Control
- Reduction in medication errors
- Reduction in falls that result in harm to our patients
- Reduction in staff Sickness

The following pages of our report provide an update on the priorities we agreed for 2015/16

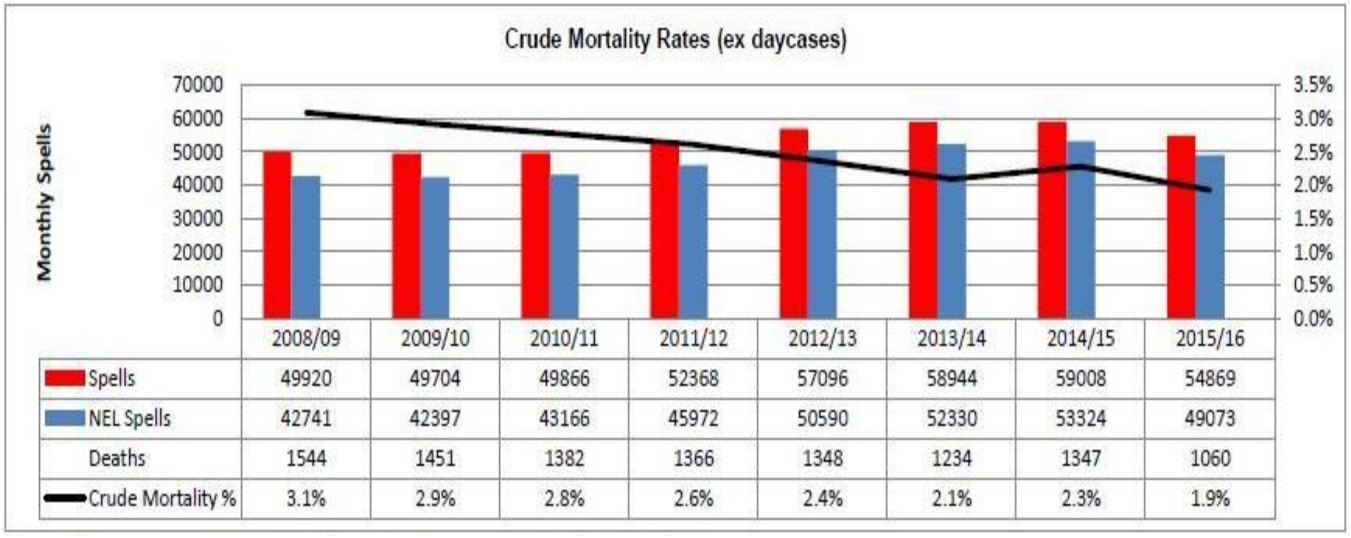
Priority one: Reducing Mortality

We set ourselves the objective of continuing to reduce mortality towards our ultimate aim of being in the top 10% for risk adjusted mortality across the NHS

Achieved a reduction in crude mortality from 2.3% to 1.9%*

*(2015/16 to February 2016 compared with 2014/15)

Outcome:
There has been good progress in crude mortality with reduction in the overall number of deaths in Royal Bolton Hospital. Our risk adjusted mortality remains in the 'as expected range'; with our Standardised Hospital Mortality Index (SHMI) at **104.0** (10/14 – 09/15) compared to **106.9** (2014/15)



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Spells	49920	49704	49866	52368	57096	58944	59008	54869
NEL Spells	42741	42397	43166	45972	50590	52330	53324	49073
Deaths	1544	1451	1382	1366	1348	1234	1347	1060
Crude Mortality %	3.1%	2.9%	2.8%	2.6%	2.4%	2.1%	2.3%	1.9%

Further improvements for 2016/17:

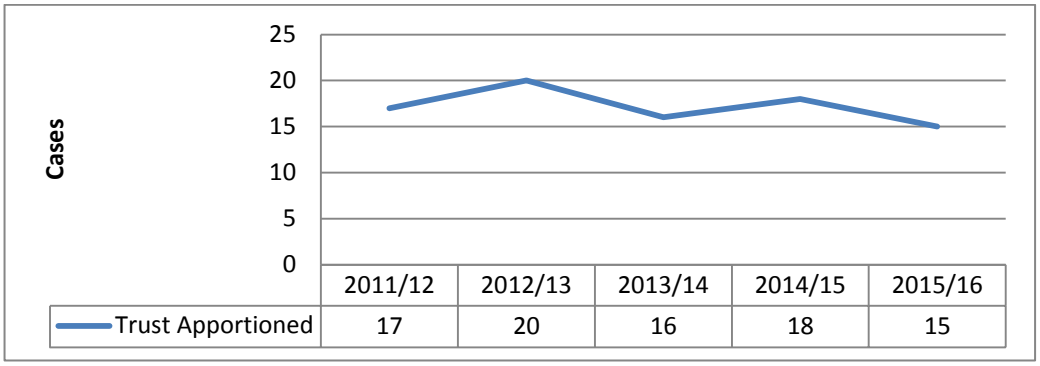
- Mortality rates will continue to be tracked at the monthly Mortality Reduction Group chaired by the Medical Director.
- The priorities for 2016/17 will focus on recognising and responding to the deteriorating patient and delivering high quality end of life care.
- We have a programme of staff training and robust audit of performance, supported by introduction of an electronic observation recording system.
- Continue our reduction in crude mortality and to be in the top 10% for risk adjusted mortality across the NHS.

Priority two: Infection prevention and control

We set ourselves an overall objective of preventing infection and harm to patients and identified that a key step in achieving this would be to achieve a 10% reduction in antibiotic prescribing through improved antibiotic stewardship

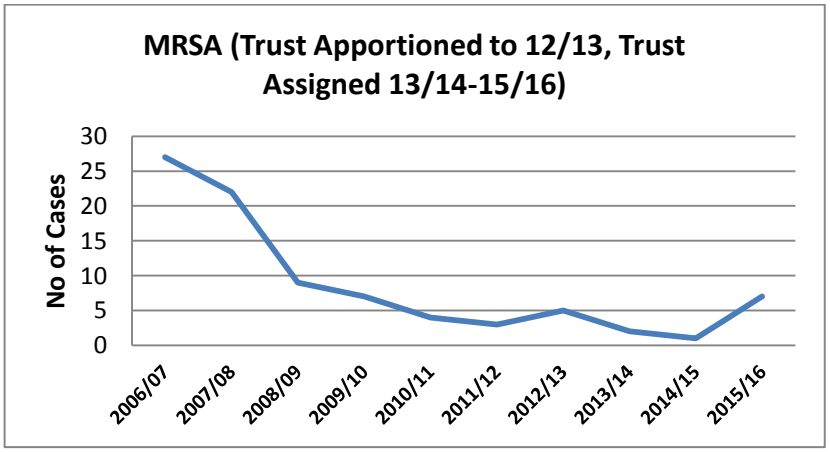
Outcome:

MSSA:
There has been a 10% reduction in Trust apportioned MSSA cases in 2015/16 compared with 2014/15.

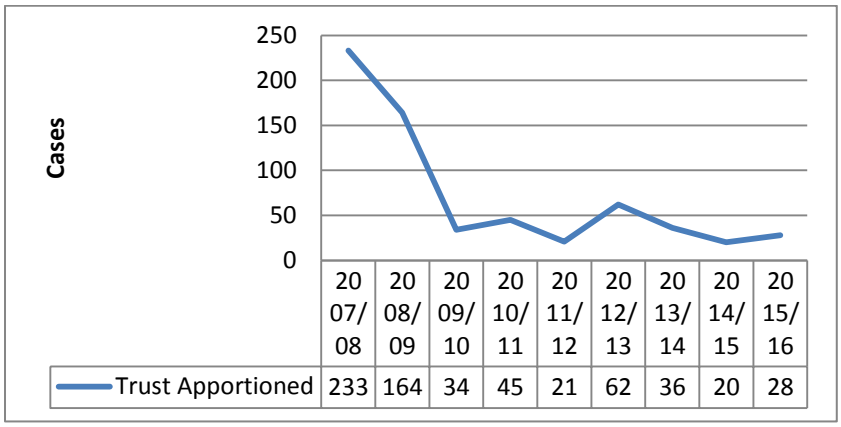


Antibiotic Prescribing:
Based on the quarterly antibiotic prescribing audits, there has been no significant change in antibiotic consumption in 2015/16 compared with 2014/15

MRSA
There were seven Trust assigned MRSA bacteraemias in 2015/16. Four were "true" bloodstream infections, three were blood culture contaminants. Of the four infections, two related to line care, one was a recurrent infection from an earlier MRSA episode and one had no clear root cause.



CDT:
Of the 28 cases in 2015/16, three have been successfully appealed; with a further four due for appeal in May 2016. We are hoping to be successful in our appeal bringing our year end position to 21 cases, an increase of 1 (5%) on 2014/15.



Further improvement identified for 2016/17:

MRSA and MSSA:

- Establish a blood culture contaminant working group to focus on improvement of the blood collection process. By reducing the overall contaminant rate, the likelihood of MRSA cases related to contaminants is reduced
- Revise Trust peripheral intravenous line care policy and peripheral line care plan; with training and audit plan to support implementation
- Revise plans for a dedicated nurse led IV access service

CDT:

- Trustwide roll-out of SIGHT (**S**uspect infection, **I**solate, **G**loves and aprons, **H**and washing, **T**est for toxin), supported by a revised protocol for the management of patients with diarrhoea with no alternative cause and a new Diarrhoea Management Tool
- Continued promotion to improve antibiotic prescribing standards led by our lead Consultant Microbiologist and supported by our junior doctor forum

Priority three: Reduction in medication errors

We set ourselves a target of reducing incidents relating to missed doses of medication by 10%

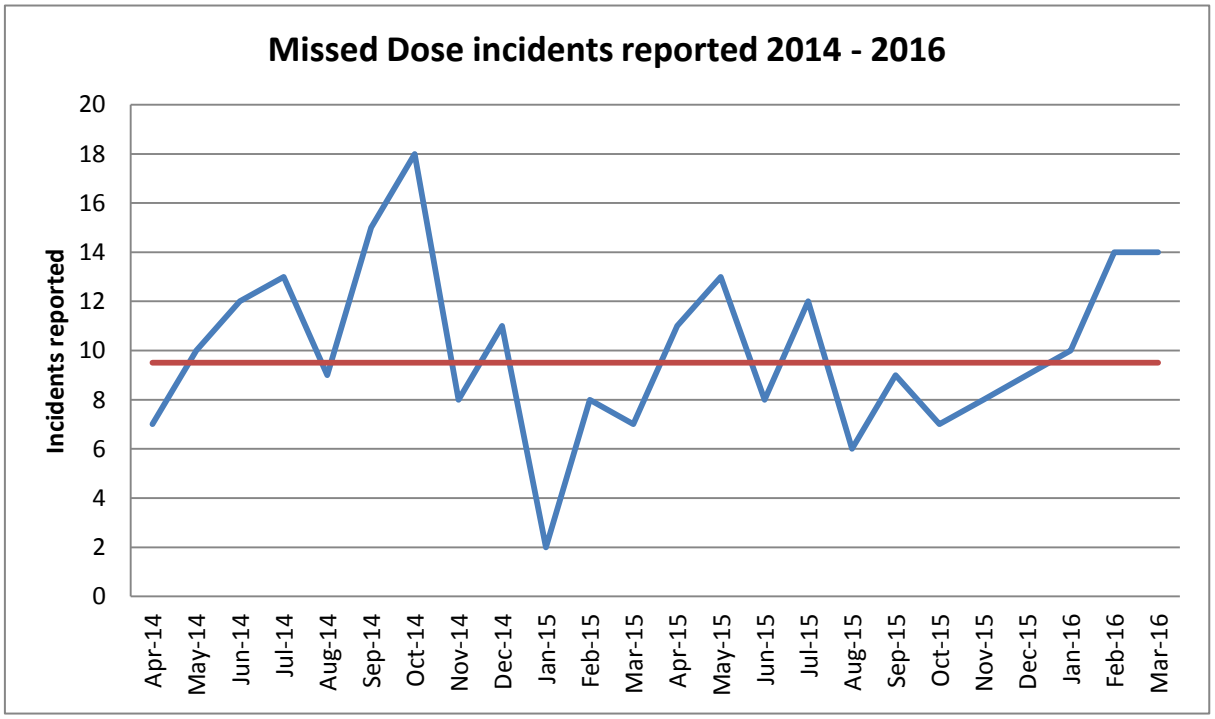
Achieved a 2% reduction in incidents relating to missed doses*

* *within a sub category of preparation and administration related incidents*

Outcome:

The number of reported medicines incidents (2014/15= 1146, 2015/16= 1143) and missed doses (2014/15= 120, 2015/16=118) remains constant – see chart below.

However, missed doses fall within a sub category of preparation and administration related incidents and within this category missed doses have reduced by 2% since 2014/15



Further improvement identified for 2016/17:

We will continue to focus on the reduction of medication incidents related to the omission of medication and will do this by:

- Developing an audit process for measuring the reduction for this group of incidents in quarter 1 to establish the baseline on which to measure the 10% improvement.
- Monthly data regarding incidents will be monitored through the Medications Management Committee, clinical teams will produce actions plans based on the themes and trends identified
- The medicines safety nurse will roll out a programme of education and audit.

Priority four: Reduction in falls with harm

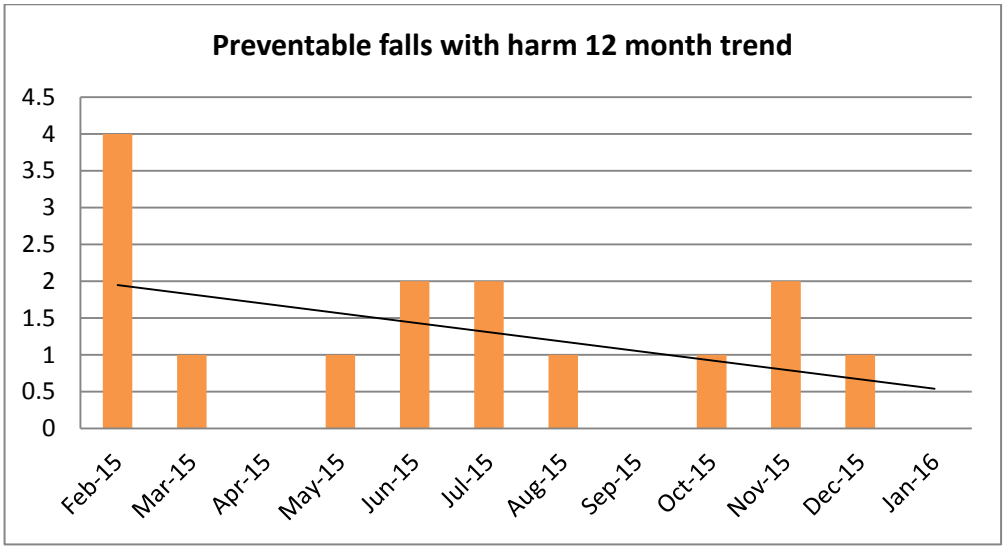
We set ourselves the objective of achieving a 10% reduction in falls where patient experience severe harm

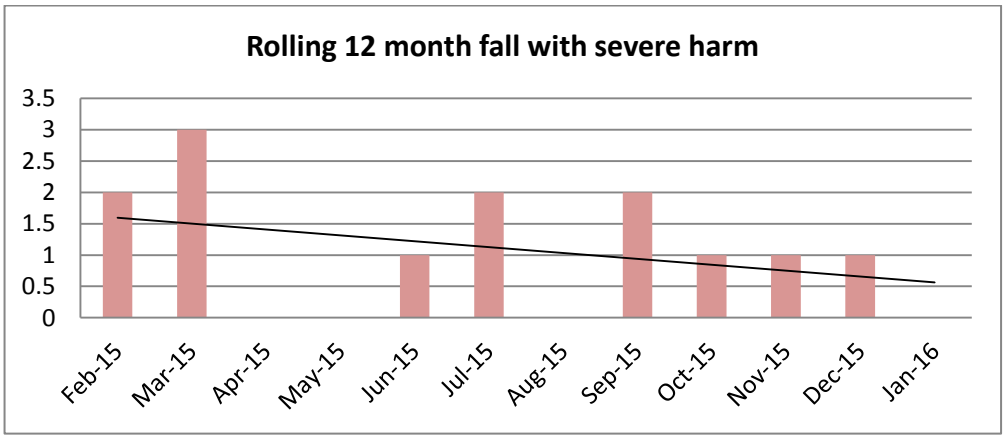
Achieved a 40% reduction in preventable falls with harm*

Achieved a 47% reduction in falls where patients experience severe harm *

**Comparing data from April 2014-March 2015 with April 2015-March 2016*

Outcome:
The 12 month rolling picture continues to show a downward trend as indicated in the graphs below





Further improvements achieved:

- Improvements in most aspects of the 2015 National Audit of Inpatient falls (compared with 2014) in which Bolton performed better than the national average but with focus on the areas for improvement we can be better still.
- Falls management plan embedded Trust-wide
- Falls specific data at a divisional level for trend analysis and opportunities for improvement

- Themes from Falls Harm Free Panel shared trust-wide
- Staff training programme with 1225 staff now trained in fall prevention.
- Establishment of trust-wide “Arms reach commode tagging”
- A Harm Free intranet page providing all staff with access to falls related resources

Further improvement identified for 2016/17:

Reduction in falls remains a key priority for the Trust; due to the changing demographics of the patients now under our care, for example a rise in average age, complexity, frailty and frailty. Increasingly more of our patients are considered to be high risk of falls and therefore needing more care and attention from all staff than before. In 2015, the Trust contributed to the National falls and fracture audit, which highlighted areas for improvement. Actions for 2016/17 include:

- Falls Steering Group re-launch - feeding into the harm free committee
- Further roll out of frame label to ensure safe patient mobility.
- Improved compliance with completion of accurate lying and standing blood pressure to identify possible falls risk due to postural drop in blood pressure.
- Review of the falls management plan to ensure optimum documentation of individual falls risks.
- Better identification and treatment of delirium in collaboration with the dementia steering group to facilitate further reduce falls risks.
- Medicine reviews to include assessment for medication likely to increase falls risk and adjustments made where appropriate.
- Improved access to walking equipment for patients admitted out of core therapy hours.
- Individualised continence assessments leading to appropriate continence care plans with falls risk taken into account.
- Optimisation of staff distribution across bed based areas to ensure high visibility and regular contact with all high risk patients.
- To capture and understand the patient experience following a fall and use any learning to further improve fall prevention strategies.

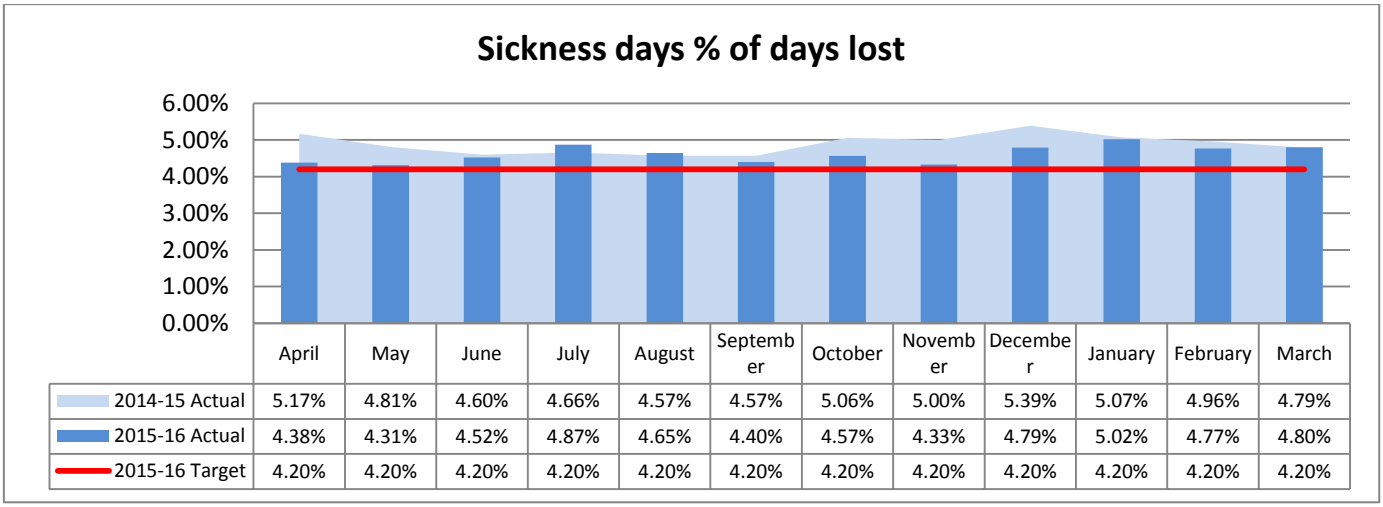
Priority five: Reduction in staff sickness

We set an objective of reducing staff sickness to 4.2%

Achieved a reduction in sickness levels from 4.99% to 4.64%*

*(Year to date rolling sickness January 2015 compared with January 2016)

Outcome:



	April	May	June	July	August	September	October	November	December	January	February	March
2014-15 Actual	5.17%	4.81%	4.60%	4.66%	4.57%	4.57%	5.06%	5.00%	5.39%	5.07%	4.96%	4.79%
2015-16 Actual	4.38%	4.31%	4.52%	4.87%	4.65%	4.40%	4.57%	4.33%	4.79%	5.02%	4.77%	4.80%
2015-16 Target	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%

Further improvement identified for 2016/17:

- Development of a health and wellbeing strategy going beyond the focus on reducing sickness absence by addressing the common causes of poor health and helping people to improve their lifestyles.
- Increased full time release of staff side representatives in order to improve the timeliness of sickness case management.
- Ongoing training and coaching for our managers and supervisors on the Attendance Management Policy.
- Monthly audits to ensure consistent application of the Policy amongst managers, with focused feedback and coaching provided to each manager.
- Continuing fast track mental wellbeing sessions and physiotherapy treatment for staff.
- Delivering interventions on staff engagement and leadership development in teams as required to improve team working, cohesion and leadership.

Key Quality Priorities for 2016/17

Our Quality Improvement Strategy (2014-2017) outlines a number of quality improvement projects that we believe will lead to demonstrable improvements in outcomes, safety and patient experience; and we have been working on these projects for a number of years. We would, however, like to highlight the following projects as Bolton Foundation NHS Trust's key improvement priorities for 2016/17:

Priority one: Recognising and responding to deteriorating patients

Background:

Earlier recognition of acutely unwell patients improves their chance of survival and management may prevent critical care admission and means that a patient's deteriorating condition is much less likely to result in a cardiac arrest.

We also know that a number of factors can lead to patients not receiving the highest standard of care. Our audits of cardiac arrests, critical care escalation and end of life care demonstrate continued opportunities for improvement.

Aim:
The overall aim of this workstream is to reduce the number of avoidable cardiac arrests within ward areas by 50% within one year. However, the work has a much wider remit and aims to ensure that the Trust has sustainable systems in place to prevent and respond to deteriorating patient and escalate.

What we will do
In 2016/17 we aim to test, and if successful, implement a range of interventions that will:

- Provide early recognition and treatment of patients with deteriorating but reversible conditions
- Identify patients whose care requires escalation and action in a timely manner
- Identify patients in whom deterioration indicates+ the approaching end of life and make appropriate resuscitation status decisions to facilitate a dignified and peaceful death

Our interventions can be grouped into the following categories:

Culture, teamwork, accountability & sustainability

- Clearly defined protocols and policies
- Root cause analysis and learning
- Simulation
- Performance monitoring
- Staff competencies

Assessment & observation

- High risk patients identified
- Standardised processes for essential observations
- 90% compliance with observation policy
- Care of the dying

Response

- Immediate appropriate response to deterioration
- Increased ward level capability
- Optimal patient management – step up/ down
- Escalation policy

Patient flow & communication

- Ensure efficient and standardised handovers and transfers
- Increased understanding of systems
- Cascade of command
- Quality improvement initiatives

Measurement:
Outcome measure - 50% reduction in the number of avoidable cardiac arrests (33 in 2015/16)

Other measures we will monitor include:

- Recording of National Early Warning Scores (NEWS) to Gold Standard. - *National Sepsis CQUIN (72.7% in 2014, 71.4% in 2015
- Standardised Hospital Mortality (SHMI) (104 in 2015/16)
- Risk Adjusted Mortality – rebased each year and therefore not used as a baseline for this report.

Reporting our progress:

- All our improvement projects follow an established governance structure which monitors and measures performance and progress.
- The forum which will provide progress, oversight and accountability for this workstream is the Mortality Reduction Group, which is chaired by the Medical Director.

Priority two: Stroke

Background:

Stroke affects a wide range of individuals and has a variety of impacts upon their quality of life and on-going long term care needs. Bolton aims to provide fast, effective and evidence based care to meet the complex needs of the stroke population and their carers. Improving the care and outcomes for stroke patients involves a wide range of individuals and organisations, across the health and social care, professional and public, and statutory and voluntary and over the next year, Bolton NHS Foundation Trust will work with these organisations to maintain and improve Stroke care.

Aim:

Every patient diagnosed as having suffered a stroke will receive best available, evidence based stroke care in line with the Greater Manchester stroke pathway delivered seamlessly and efficiently across partner organisations. This will include timely and effective communication with patients, families and carers to enable inclusive and informed decision making at all stages of the pathway.

What we will do:
In 2016/17 we aim to implement a range of interventions that will:

- Ensure sufficient capacity to deliver the appropriate levels of care in location best suited to the patients' needs.
- Ensure that the service is structured to comprise the staff with the skills, competency and knowledge to lead, adapt, develop and deliver the stroke service to ensure that all patients experience safe, responsive and effective care.
- Ensure the timely collection, analysis and sharing of national audit data (SSNAP) to support the identification of areas of good practice and areas requiring improvement. This data will inform the stroke service action plan, detailing the objective, action, out-come and progress of any area identified for improvement.
- Ensure participation in and compliance with the existing comprehensive network of forums and systems in place for the delivery of education and training, information sharing and two way reporting for all stakeholders, including service users.

Our interventions can be grouped into the following categories:

Responsive Care (across pathway)

- Defined protocols and procedures for transfer of patients across the pathway
- Root cause analysis and learning
- Rapid identification of delayed discharges and escalation
- Flexible capacity to meet surges in demand
- Consideration of sector working for rehabilitation provision

Effective and Timely Intervention

- Standardised assessment and diagnosis protocols for clinical staff
- Internal professional standards (health and social care)
- Recruitment and retention initiatives for highly skilled staff

Transforming the Workforce

- Workforce review and restructure
- Shared learning and problem solving events
- Staff competencies
- Deliver of education and training programme

Information Intelligence

- Access to and utilisation of newly implemented electronic systems.
- Timely and consistent inputting of validated data into the SSNAP database
- Performance monitoring

Measurement:
We will use following the national key performance indicators from the Stroke Sentinel National Audit Programme (SSNAP) to track progress against our aims:

Indicator	Q1 14/15	Q2 14/15		Q4 15/16	Q1 15/16	Q2 15/16	Q3 15/16
Admission to a stroke unit within 4 hours of presentation at an urgent care facility	73%	68.50%	Scores not available for Q3 2014/15	41.40%	65.00%	65.80%	76.90%
90% of stroke patient's stay in hospital is on a stroke unit once confirmed diagnosis of stroke	97.70%	87.10%		75%	83.70%	87.30%	92.90%
Opportunity to receive thrombolysis at Comprehensive Stroke Centre for those patient who are eligible / compliance with the Greater Manchester Stroke pathway	9%	6.80%		2%	4.90%	1.40%	4.50%
All appropriate stroke patients have a urinary continence plan drawn up by discharge from inpatient care	100%	95.20%		95.50%	98.00%	98.10%	97.4%
All stroke patients whose nutritional screening identifies a high risk of malnutrition are seen by a dietician prior to discharge	89%	92%		80%	79%	66.70%	77.8%

All applicable stroke patients receive occupational therapy equivalent to 45 minutes on 5 days per week.	99.6%	86.8%		99.7%	94.1%	93.70%	90.6%
All applicable stroke patients receive physiotherapy equivalent to 45 minutes on 5 days per week.	69.10%	66.30%		83.30%	84.70%	60.60%	75.0%
All applicable stroke patients receive speech and language therapy equivalent to 45 minutes on 5 days per week.	24.10%	16.40%		20.40%	23.80%	19.80%	22.6%
All stroke patients presenting with new or previously diagnosed atrial fibrillation are anti-coagulated on discharge, or with a plan to start, or with a documented rationale for not anti-coagulating	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%
All stroke patients are discharged with a joint health and social care plan and a named contact.	100.0%	100.0%		98.3%	98.6%	100.0%	100.0%
All applicable Stroke patients are discharged to an Early Supported Discharge Team	66.70%	67.30%		79.70%	75.70%	66.20%	73.5%

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Reporting our progress:

- All our improvement projects follow an established governance structure which monitors and measures performance and progress.
- The forum which will provide progress, oversight and accountability for this work stream is the Stroke Service Governance Meeting, chaired by Business Manager and Stroke Service Clinical Lead and the Better Care Together Meeting, chaired by the Director of Nursing
- Externally Bolton reports to the Greater Manchester Stroke Operational Delivery Network via the following meetings:
- Board
- Clinical Effectiveness Group
- Rehabilitation Group
- Training and Education Group

Priority three: End of Life Care

Background:

Improving End of life care involves a wide range of individuals and organisations, across the health and social care, professional and public, and statutory and voluntary spectrum. In 2016/17 Bolton NHS Foundation Trust will work with colleagues and individuals across our health economy to implement and improve end of life care for patients in the last year of life.

We recognise the increasing needs of patients and their families during the final year of life and the importance of anticipating their needs and forward planning of care. We also recognise that exemplary care in the final year of life requires commitment from all health and social care; it is everyone's responsibility.

Aim:

We aim to ensure every patient will receive optimal holistic patient centred end of life care, encompassing their physical, spiritual and emotional needs, taking into account their wishes and preferences. Patients, families and carers will be treated with dignity and respect, and be communicated with in an open, honest and compassionate manner; and this care will be provided during the final 12 months of life and extend into bereavement.

What we will do

Our interventions can be grouped into the following categories:

Patient and Carer experience

- Implementation of Bereavement and Care questionnaire
- Monitoring of complaints and compliments, review of action logs and learning
- Implementation of the Bereavement and Donor Alliance
- Reduction of DNA rates for clinic
- All patient to be asked about preferred place of care

Education and Training

- Staff to attend Sage and Thyme.
- Ward managers/team leaders /clinical leads to have attended enhanced communication training
- Establishment of Palliative and End of life education group
- Development of End of Life Care link/leads group, supported by End of Life university module
- Attendance report on training monthly report

Documentation and Communication

- Trust-wide roll out of "Record of care"

Agree and implement work plan and Measurements of KPIs

- Development of End of Life Care Action plan with associated key performance indicators to track progress

- Non-executive/lay person representative to form part of End of Life Care Steering Group
- Review and approval of all end of life care polices

Measurement:
Outcome measures:

- All patients and families report good or outstanding care
- 90 % of patients on *Record of care* for the dying person
- 95% of patients on *Record of care* to be asked about their preferred place of care.

Other measures we will monitor include:

Patient and Referrals to Specialist Palliative care team:

- Hospital referrals -100% referral to the specialist palliative care team for pain and symptom control within hospital setting are seen within 24 hours
- Community referral -100% referral for pain and symptom control have first contact within 72 hours

Record of care of the dying person:

- 80% of expected deaths in hospital identified to be in the last few days of life are placed on the Record of care of the person document

Bereavement Questionnaire

- 100% of bereaved families are sent a questionnaire two weeks after hospital death

Specialist palliative care MDT

- Attendance of Core members at the weekly specialist MDT is greater the 66%

Education and Training of end of life care

- 100% of eligible nursing staff are trained to carry out nurses verification of expected death
- 25% of clinical staff in the trust has received 5 priorities of care of the dying person (this training is for all clinical staff and now part of the induction for all new clinical starters)

Reporting our progress:

The "Record of Care for the dying person" was introduced in 2015/16, in 16/17 we are aiming to establish a baseline with the above metrics agreed as targets to be monitored and reported as below:

- All our improvement projects follow an established governance structure which monitors and measures performance and progress.
- The forum which will provide progress, oversight and accountability for this workstream is the End of Life Steering Group and the Better Care Together Meeting, chaired by the Director of Nursing; and is also accountable to the Clinical Governance and Quality Committee

Statement of assurance from the board

Review of services

During 2015/16 Bolton NHS Foundation Trust provided and/or sub-contracted seven regulated activities (as defined by the CQC) across 38 specialities.

Bolton NHS Foundation Trust has reviewed all the data available to it on the quality of care in these NHS services.

The income generated by the relevant services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Bolton NHS Foundation Trust in 2015/16

Participation in Clinical Audits and Research Activity

During 2015/16 41 national clinical audits and 4 national confidential enquiries covered relevant health services that Bolton NHS Foundation Trust provides.

During that period Bolton NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries Bolton NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

Audit	Participation 2015/16
Heart Failure National Audit Project	Yes
MINAP	Yes
National Diabetes Foot care Audit - Diabetes (Adult)	Yes
Diabetes (Paediatric) (NPDA)	Yes
Emergency Use of Oxygen	Yes
National Comparative Audit of Blood Transfusion programme	Yes
NCA Patient Blood Management/Blood Use in Elective Surgery	Yes
Transfusion sample labelling Re-audit (errors detected at the pre-testing stage)	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes
National Audit of Intermediate Care	Yes
UK Parkinson's Audit (previously known as National Parkinson's Audit)	Yes
Procedural Sedation	Yes

VTE risk in lower limb immobilisation in plaster cast	Yes
Vital signs in Children	Yes
MBRACE Maternal, new-born & infant Clinical outcome review programme	Yes
WHO Baby Friendly Initiative	Yes
National Diabetes In-patient Audit - Diabetes (Adult)	Yes
National Diabetes Audit - Diabetes (Adult) Secondary Care	Yes
Pregnancy in Diabetes (NPID) NCAPOP	Yes
Paediatric Asthma BTS 2015	Yes
Neonatal Intensive and Special Care (NNAP)	Yes
Pulmonary rehabilitation Audit - National COPD Audit Programme, BTS	Yes
Downs Syndrome Screening + amino / cvs	Yes
Lower limb amputation	Yes
Diabetic foot ulcer	Yes
Management of Diabetic Ketoacidosis (DKA) in adults	Yes
National Joint Registry (NJR)	Yes
Falls and Fragility Fractures Audit Programme (FFFAP) 3 Work streams include: **1. Nation Hip Fracture Database** **2. Fracture liaison service database** **3. National Audit of Inpatient Falls**	Yes
2015 National Comparative Audit of Lower Gastrointestinal Bleeding and the use of blood (RCS BDRF ACPGBI)	Yes
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes
National Emergency Laparotomy Audit (NELA)	Yes
Rheumatoid and Early Inflammatory Arthritis	Yes
ICNARC Case Mix Programme (CMP)	Yes
Bowel cancer (NBOCAP)	Yes
Lung cancer (NLCA)	Yes

National Prostate Cancer Audit	Yes
Oesophageal- gastric cancer (NAOGC)	Yes
Elective surgery (National PROMs Programme)	Yes
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Yes
National Vascular Registry	Yes
Diabetes Foot Care National Audit - 2015/16	Yes

Table 1: National Clinical Audits

The reports of 9 national clinical audits were reviewed by the provider in 2015/16 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

National Comparative Audit of Blood Transfusion programme
Blood Transfusion competency assurance paper presented to Clinical Governance & Quality committee Staff lists to be data cleansed and the Blood Transfusion team updated accordingly. Medical Staff to be targeted on next induction. Blood Transfusion Link Nurses will be revisited for low performing clinical areas. Training dates for Link Nurses to be obtained from the Blood Transfusion team and Link Nurses to be booked onto training.
National Bowel Cancer Audit
Colorectal Cancer MDT upload should move to a monthly configuration allowing all consultant colorectal surgeons to actively inspect their data in real time.
Falls and Fragility Fractures Audit Programme – National Audit of In-patient Falls - September 2015
Dementia and delirium Falls teams should work closely with dementia and delirium teams to ensure team working for these high-risk patients. Work in progress. Dementia working group currently working through action plan to improve awareness of dementia and delirium. Falls representation also involved. Use of assessment tools and care plans to be audited once established. **Blood pressure** – All patients aged over 65 years have a lying and standing blood pressure performed as soon as practicable, and that actions are taken if there is a substantial drop in blood pressure on standing. This is already recommended and encouraged for all patients deemed at risk of falls but practice is poor at present (though improving). Matrons to continue to encourage this and to be checked regularly via NEWS audit. **Medication review** – All patients aged over 65 years have a medication review, looking particularly for medications that are likely to increase risks of falling. Poorly done at present. Pharmacy staff to begin to check for medication likely to increase falls risk during medicines reconciliation and advise medical staff accordingly. **Visual impairment** – We recommend that all patients aged over 65 years are assessed for visual impairment and, if present, that their care plan takes this into account. This is already in the falls management plan but not routinely completed so requires further encouragement for improvement. To be checked again in next audit of falls management plan. **Walking aids** – We recommend that trusts and health boards develop a workable policy to ensure that all

patients who need walking aids have access to the most appropriate walking aid from the time of admission.
Regular audits should be undertaken to assess whether the policy is working and whether mobility aids are within the patient's reach, if they are needed.
There is a mechanism for accessing therapy staff out of core hours when walking equipment is needed. To ensure all staff have access to contact details for this process.
To check location of mobility aids again in next audit of falls management plan.
Continence care plan – We recommend that all patients aged over 65 years have a continence care plan developed if there are continence issues, and that the care plan takes into account and mitigates against the risks of falling.
Pilot currently being done on B1 and G4 to encourage good continence assessment. If successful will be rolled out to other wards.
Call bells – We recommend that all trusts and health boards regularly audit whether the call bell is within reach of the patient and embed change in practice if needed.
Practice is generally good across the organization with this but could be further improved. This will be audited through clinical nurse walk about and intentional rounding.

MINAP National Report

Introduction of ward round to CDU to determine if any patients are for C1 or CCU care.
Implementing new minimum data standards
Expand MINAP coordinators role so that they are more involved and make the data collection exercise meaningful and patient centered, not a tick-box exercise.
Timeliness of angiography following nSTEMI - dependent on the tertiary centre accepting patients within the timeframe.

National Lung Cancer Audit

People with lung cancer have adequate tissue samples taken in a suitable form to provide a complete pathological diagnosis including tumour typing and sub-typing, and analysis of predictive markers.
Service is clinically appropriate and taking into account multiple risk factors

National Emergency Laparotomy Audit (NELA)

A sustained multidisciplinary effort is required to provide 24-hour interventional radiology, this is essential for units providing an EGS service. Available weekdays during daytime hours. Work continues to develop sector solution

Sentinel Stroke National Audit Programme (SSNAP)

Discuss partnership working with WWL
Improve planning for annual leave and sickness cover for TIA clinic though use of 'e-leave'
Recruitment to Consultant vacancy – geriatrician with stroke certificate
Work with CCG and GP to review how and what information is currently given to patients and agree new process
Seek patient feedback on satisfaction with TIA clinic booking process
Revise referral form to include potential barriers to short notice access e.g. mobility/dependency
Immediate feedback to referrers when referral indicates a delay between being seen and referral being sent

National COPD Audit Programme RCP/BTS

Patient length of stay – hospital model work in progress.
Better identification of COPD on admission.
Implementation of Admission / discharge care bundles.
Develop trust O2 training programme.
Participation in research project by BTS & Bristol University.
Medical staffing - Improve ratio of ST3+. Business plan.

National Emergency Laparotomy Audit
24-hour interventional radiology. Available weekdays during daytime hours. Work continues to develop sector solution. Financial/staffing issues need resolving to provide this service

Table 2: National Clinical Audits: Actions to Improve Quality

	Number cases Included	Local Gap Analysis Completed Outcomes of published Report
Mental Health	N=5/5 Cases 100%	**Report due mid 2016**
Awaiting report		
Acute Pancreatitis	N=5/5 Cases 100%	**Report due mid 2016**
Awaiting report		
Sepsis Draft Gap Analysis Dec 2015	N=5/5 Cases 100%	**21 recommendations – Are we compliant?** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21**
Action Plan: *6.* Nursing home trial to extend. Increase collaboration with CCG 7. As above + Liaise with NWAS 8. Ongoing discussion re vitals recorded at triage. Moving towards NEWS 10. Emphasised locally but not incorporated into guideline. Awaiting national approach. 16. Awaiting national publication of support booklet 18. Education to junior doctors completing discharge. Happens ad hoc. 19. Occurs inconsistently at departmental M&M. Plan for sepsis RCA 20. Inconsistent nationally as some coroners don't accept diagnosis. To discuss locally. 21. National approach needed. Local work being undertaken to achieve better coding.		
Gastrointestinal Haemorrhage **Gap Analysis Nov 2015**	N=2/2 Cases 100%	**1** **NA** **NA** **4** **5** **6** **7** **8** **9** **10** **NA** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21** **NA** **NA** **24** **NA** **NA**
Action Plan: 1. Formal network required through IR. 6, 12. Audit required 11, 22, 23. For professional documents 15. Business case 25, 26 For JAG		

Table 3: NCEPOD Confidential Enquiries Projects Participation

Local Audits:
297 Local Audits were registered between April 2015 and March 2016.

The reports of **40** local clinical audits were reviewed by the Trust in 2015/16 and the Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Title	Actions	Theme of change In practice
Adult IBD Organisational Audit	Regular MDT meetings on a 6-8 weekly basis. Chaired by Nurse Consultant. The IBD nursing team meets monthly. Access for relapsing patients. All patients are seen within 2 weeks; IBD named coordinator. Audit required. Specialist support for young IBD patients Transition pathway in place, QI updates in progress	Communication Process
Acute exacerbation od COPD	Determine causes of death within this audit cohort. Re-audit deceased patients.	Re-audit
Metastatic Spinal Cord compression Pathway review	Improve the current inadequate information sent with referrals to our service – forward & discuss audit results with referring agencies.	Process
In Hospital falls	Update of falls assessment tools. Increase awareness & use of falls assessment tools. Improve access to medical assessment tool – availability. Disseminate audit results & learning.	Local Guideline Update Process
Community Acquired Pneumonia	Dissemination of results to Primary Care / CCG colleagues. Work towards better are for CaP in the community. Radiographers to prioritise chest x-rays in acute areas.	Education Process
Alcohol Withdrawal Management	Improve link nurse network for cascade training. Increase awareness among junior doctors by formal / Informal training. Explore other options for withdrawal assessment. Update & implement new withdrawal care plan. Maintain relationships with departments within the Trust.	Communication Training Process
Risk assessment during antenatal, intrapartum & postnatal period	Failure to recognise risks at booking - Existing list in ANC pathway guideline. Lack of compliance with 3rd Trimester Antenatal Risk Assessment and Mental Health Risk Assessment - ensure all staff are aware of the importance of assessment and it is the responsibility of all staff to complete Assessment Improve compliance of risk assessment in ANC/ labour/ Postnatal/ community - ensure staff are aware of relevant sections	Process Standard working Training
Essure Re-audit	Reduction in pain score categorisation. Trial use of paracervical block & re-look at pain scores	Documentation Process
High Risk / Delayed Results in paediatrics	Improved documentation of negative results in the notes along with improved documentation of correspondence with colleagues and patients and families - new proforma	Documentation

	from August 2015.	
Puerperal Sepsis outlier audit – CQC 2015	Positive feedback regarding reduced SSI to all teams. (Oct 2015) Further training and awareness around diagnosis and management of sepsis with the current cohort of doctors, midwives, anaesthetic trainees, and senior doctors. (Nov 2015) Audit to be repeated on a monthly rolling basis with smaller multidisciplinary panel. Revision of audit proforma. (Nov 201	Training Re-audit
Diabetic Ketoacidosis in Paediatrics	Ensure guideline states BM should be monitored hourly whilst on IV insulin. More clarity regarding what time the insulin infusion has been started. Revision of IV fluid prescription charts Adopt NICE guidelines and change to starting insulin at 0.05 UNITS/kg/hr.	Process Training
IV fluids in children – audit of prescribing	Ensure U&E rechecked within 24 hrs. - Education , clear indication on new I/V Rx charts Replaced of old charts by the new charts - Waiting printing to chase. Guideline to better direct choice between 24/48hrs deficit replacement. Review guidelines and if necessary update.	Process Standard working Documentation
Cow's Milk Allergy – Diagnosis & Management	Clarify indications for IgE testing in new guideline - Guideline update due November 2015 Incorporate lactose intolerance and its management in new guideline (with indications for stool testing) Introduction of separate Gastro-oesophageal reflux guideline Introduce separate Cow's Milk Protein Allergy information leaflet - Incorporate into information leaflet work already on-going	Standard working Documentation
CAMHS Record Keeping 2015/16	Training of staff on good record keeping standards. All have responsibility for ensuring standards.	Training Documentation
Acute Paediatrics Record Keeping 2015/16	Display outline of recordkeeping standards poster to remind staff. Supervisors to monitor trainee's documentation. 1st staff member to see patient on F5 ward to prepare clerking document with patient details labelling on all pages.	Training Documentation
Nutrition & Fasting in Hip Fracture Patients	Emphasise fasting guidelines Nutrition assessments to be completed & risks to be highlighted to medical staff Educate staff nurses regarding proper documentation in NAT chart Encourage availability of snacks/ sociable meal times Dietician review in all patients with dementia	Training Standard working
Pre-operative Quality &	Booking 2-4weeks prior to operation	Standard

Service Improvement – Bolton One	Investigation review prior to pre-op clinic Referral documentation with specific indication Nurse pre-assessment visit prior to anaesthetist	working Training
Safety on discharge	Embed as Routine practice Document on anaesthetic chart Recovery staff to audit practice	Standard working Documentation
STOP Before You Block Audit	Ensure awareness of STOP before you block All to perform 'STOP' immediately prior to block. Re- design Audit form to capture if patient was awake or asleep at the time of block. Adapt how data collected for on- going audits.	Training Documentation
Bolton Pain Assessment Scale Staff Knowledge - Pain Management	Continue Pain Education across Trust Encourage good attendance from Link Nurse from all wards and Departments at Quarterly Pain Link Nurse meetings Organise Trust wide Study days twice a year that all staff can access Develop business case to expand Acute Pain Team	Training
Pain Clinic - Patient Satisfaction Survey	Reduce waiting times	Standard working
5 year locoregional recurrence following breast cancer surgery	Audit showed a locoregional recurrence rate of 2.9% which is lower than the published literature of 3-10%. High current level of treatment for our patients. No changes identified Re-audit.	Re-Audit
Consenting Practice within Bolton Breast Unit for Common Breast Procedures	Breast Consent form Steering group established Raise awareness amongst surgical team Develop consensus opinion/guideline on the necessary risks to be documented for each procedure Develop breast procedure specific consent forms Trial of sticky labels	Communication Training Documentation
RBH ITU Tracheostomy Checklist & Consent Audit	Consent to be fully documented - patient obviously incapacitated from clinical context Checklist use Fully complete forms including Timeout and/or Post-procedure Checks	Documentation
Emergency case operation notes	Improve legibility and completeness of operation notes Increase uptake of typed operation notes - dedicated printer installed in recovery room in theatres.	Documentation
NICE CG174 fluid prescription guidelines on Surgical Wards	Fluid management an active part of all ward rounds. Improved documentation Fluid management included into the induction booklet for new junior doctors to surgery. Re-audit in 3-6 months.	Standard working
Re-Audit of Consent & Information for Blood Transfusion	Feedback results of this audit to raise awareness Further discussion - Recording information given prior to discharge (in cases where the patient could not give consent at the time of transfusion) Re-audit	Training Documentation

Review of pregnancy outcomes in women with high βHCG MoMs	Add comments to results of high **βHCG MoMs** Abstract at FOCUS 2016	Documentation
Transfusion Sample Rejection Re-Audit 2015	Disseminate presentation via email to Divisions for consideration through quality forums for further action Contact clinical leads to evaluate practice in key service-user areas with above average error rates (Paediatrics/Neonatal) Continue to monitor NPSA transfusion competency assessment compliance and report to Trust and Divisions Continue transfusion sample zero tolerance i.e. all incorrect samples are discarded (a minority of qualifying samples may be tested under concession, as per transfusion policy) Continue to evaluate implementation of positive ID system for blood samples using barcode technology (to be managed via HTC action plan)	Training Standard working
Local Re-Audit of Transfusion Bedside Practice 2015	Competency assessment to continue to be monitored and reported to the Trust via the quarterly Transfusion Metrics report Local re-audit in 2016 Present this audit at the Hospital Transfusion Committee Meeting and add any further actions to HTC action plan Present this audit at the Trust Governance and Quality Committee Meeting and add any further actions to action plan. NPSA/Training Transfusion Competency assessment non-compliance has been escalated from HTC.	Standard working
Body Weight Dosing of Red Cells for Patients with Normovolaemic Anaemia: Phase 2 Validation Audit	Agree target Hblevels to be used for the calculation Amend code in red cell calculator program Full validation project as per Quality Management standards Implement in practice if successful validation and approved by Trust Q&G Re-audit of cases where the calculator has been implemented	Standard working
Re-Audit of Blood Transfusion Consent Documentation	Re-design blood request/prescription form to improve emphasis of consent section. Gain user opinion. Change at next re-print Training structure and content to remain same. Update induction Power-point slides with new graphics Update e-learning programmes with new graphics	Documentation Training
Suspected / Confirmed Neutropenic Sepsis	Develop a generic proforma to collect data All out of hours Haematology patients to go via A&E rather than D1/D2	Documentation Process
NICU imaging in assessing line placement	To use lower exposure factors, reduce dose creep, and use tighter collimation. Continue to attempt to correctly position the infant to allow no rotation. Radiographers to check that all arte facts are removed prior to exposure, especially those related to ECG leads. Encourage use of markers. Encourage radiographers to magnify their images on PACs	Standard working Process

	when verifying and to record which mobile machine was used as per IRMER. Audit to be performed on imaging for line insertion.	
Application of Staging System in Cancer Diagnosis	No actions Re-audit in one year time with bigger sample study to have more reliable representation of the audit result	Re-audit
Record Keeping and Consent audit Darley Court	Review archiving process and identify new procedure All staff to attend documentation up-date training sessions Review current practice in PT meeting and agree guidelines to support practice	Training Standard working
MSK Therapy Out-Patients Appointment time compliance	Endeavour to see patients as close to their appointment time as possible.	Standard working
Patient Experience Audit Therapy Out-Patients	No actions	NA
New Joint Injection pathway from GP direct to MSK Physiotherapy	Audit injection referrals. Establish if all GP's aware that injection appointments offered at RBH Discuss with injection therapists	Communication
Effectiveness of the Hydrotherapy Group Sessions	Admin staff to fill all slots each week. Strict D/C policy for DNA's. Give out exercise sheets at Hydro sessions Give referral letters to all patients on completion of their sessions. Liaise with management staff and IT to establish pathways.	Standard working Documentation

Participation in Clinical Research

The total number of patients receiving relevant health services provided by Bolton NHS Foundation Trust that were recruited to participate in research in 2015/16 was 798. 671 of these patients were recruited into 45 open NIHR Portfolio Trials, an increase of 102 (17.9%) patients recruited from 2014/15.

Goals agreed with Commissioners: use of the CQUIN payment framework

A proportion of Bolton NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between Bolton Foundation NHS Trust and any person or body they entered into a contract agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. (CQUIN)

Further details of the agreed goals for 2015/16 and for the following 12 month period are available on request via joanne.bolger@boltonft.nhs.uk

In 2015/16 Bolton NHS Foundation Trust achieved 85% of the £4.9m CQUIN target agreed with commissioners.

In 2014/15 Bolton NHS Foundation Trust achieved 92% of its CQUIN target, and received £5.4m of its £5.9m target

Care Quality Commission Registration

Bolton NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions". The Care Quality Commission has not taken enforcement action against the Bolton NHS Foundation Trust during 2015/16.

Bolton NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Bolton NHS Foundation Trust was inspected by CQC in March 2016 and at the time of reporting we have not yet received our inspection report. In preparation for our CQC inspection we undertook self-assessments across our services and while we identified many areas of outstanding care we did identify some areas where we felt improvement was required.

At the end of our inspection week we received some high level feedback from the CQC inspection team, this was in line with our own assessment with recognition that actions are planned to address estates and IT issues and further action is required to improve flow through our A&E department.

The CQC team provided welcome feedback on the overall care provided in the Trust praising us for our excellent, passionate and caring staff.

We look forward to receiving the full report from the CQC inspection and will ensure the report and our response to it is made publically available.

Data Quality

The Trust submitted records during 2015/16 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records relating to admitted patient care which include the patient's valid NHS number

	Admitted Patient Care		Outpatient Care		Accident and Emergency	
	Apr 14 - Jan 15	Apr 15 - Jan 16	Apr 14 - Jan 15	Apr 15 - Jan 16	Apr 14 - Jan 15	Apr 15 - Jan 16
Bolton	99.80%	99.80%	99.90%	99.90%	99.20%	99.10%
National	99.20%	99.20%	99.30%	99.40%	95.20%	95.30%

The percentage of records relating to admitted patient care which include the patient's General Medical Practice Code

	Admitted Patient Care		Outpatient Care		Accident and Emergency	
	Apr 14 - Jan 15	Apr 15 - Jan 16	Apr 14 - Jan 15	Apr 15 - Jan 16	Apr 14 - Jan 15	Apr 15 - Jan 16
Bolton	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
National	99.90%	99.90%	99.90%	99.80%	99.20%	99.10%

Apr 15 - Jan 16 data is taken from the SUS data quality dashboard based on the provisional April 2015 to January 2016 SUS data at month 10 inclusion date

Information Governance

Bolton Foundation NHS Trust Information Governance Assessment Report overall score for 2015/16 was 79% and was graded green

Clinical Coding Audit

Bolton Foundation NHS Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Action to Improve Data Quality

Bolton Foundation NHS Trust will be taking the following actions to improve data quality:

A Data Quality Group has been established, with senior representation from each Division, in order to co-ordinate action to improve data quality. A set of metrics has been developed against which improvements in data quality can be measured.

Routine daily checks identify common data quality errors which are investigated and fixed. Where appropriate, further training is provided to staff.

We receive assurance on the accuracy of our data quality through an annual report on non-financial data from our internal auditors with a review of the metrics included in this report being performed by our external auditors.

Data is benchmarked nationally using the CHKS system and a number of additional external audit reports are also used where appropriate.

Never Event

In 2015/16, the Bolton NHS Foundation Trust has focused on embedding learning from Never Events, and invited the Royal College of Surgeons to conduct a review of surgery as part of this, and PWC were asked to review the process around Serious Incidents. The Serious Incident process was found to be robust, and the Royal College of Surgeons made some valuable suggestions on team-working and culture.

In 2015/16 there were 3 Never Events:

- Retained surgical sling (this was an error from 2014 which came to light in 2015)
- Retained throat swab (removed in Theatre Recovery)
- Wrong site anaesthetic block

None of the three Never Events in 2015/16 resulted in significant harm for those involved; however, the Trust took these events very seriously. In particular, we have reviewed the training development for staff, and strengthened the protocol for throat packs. There is also work underway on Human Factors training. In addition, a Never Event Assurance Framework has been produced to look at all potential never events, and the strength of the controls in place to prevent those from happening.

The Trust continues to seek external opinion on the investigation report where there has been a Never Event, and as part of the monthly learning slides, is reminding staff how the different Never Events are prevented.

Duty of Candour

Whilst the Trust primarily works towards reducing harm, we endeavour to be open and honest with all incidents where a patient was harmed. Where there has been moderate harm or greater, there is a conversation with the patient or family, and a formal letter of apology sent. These incidents are investigated, and the findings sent to the patient. Over the course of 2015/16 our Quality and Assurance Scorecard demonstrates that the Trust well over the course of the year with a dip from 100% performance in August, September and October. Performance returned to 100% (number of duty of candour letters sent to patients) in November 2016. A combination of training sessions, awareness raising and an increasing confidence in staff that a duty of candour letter is an apology for harm caused (or thought to be caused). The Trust approach to the Duty of Candour is a reflection of the Trusts values (Vision, Openness, Integrity, Compassion and Excellence). Work has been undertaken across the year to ensure not only initial letters of apology have been sent, but these have been followed up with a second letter containing the findings and actions from any investigation. In 2016/17 the Trust will continue to follow up completion of both Duty of Candour letters (where the 1st has indicated only possible harm, with a continuation of monthly training. A review of complaints and claims will be undertaken to establish if the Duty of Candour process has had any impact on these processes.

Sign Up to Safety

The Trust has joined the Sign-Up-To-Safety campaign, and is committed to the goals of the campaign in terms of reducing harm, and has successfully reduced significant harm incidents this year. The Trust is committed to on-going work to learn from incidents, complaints, claims and inquests, and to explore new ways to improving the effectiveness of this process.

Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC). An overview of the indicators is provided in the table. It is important to note that whilst these indicators must be included in the Quality Accounts the most recent national data available for the reporting period is not always for the most recent financial year. Where this is the case the time period used is noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Indicator	2015/16	National Average	Best	Worst	Trust Statement	2014/2015	2013/14
			Where applicable				
Mortality: **The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for 10/14 – 09/15 latest data available**	SHMI value = 1.04 **Band 2 as expected** (10/14 – 09/15)	SHMI value = 1.056 **Band 2 as expected**	SHMI Value = 0.685 **Band 3**	SHMI Value = 1.211 **Band 1**	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Monthly mortality meeting chaired by the Medical Director Implementation of level one facilities for monitoring patients within ward areas Increase intensive care consultants within critical care External critical care outreach.	SHMI value = 1.056 **Band 2 as expected** (10/13 – 09/14)	SHMI value = 1.078 **Band 2 as expected** (10/12 – 09/13)
% patients deaths with palliative care coded at either diagnosis or specialty level for (2013/14 latest data available	20.28% (13/14)	20.45%	0.05%	43.93%	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Continually to auditing the quality of our clinically coded data for deceased patients as part of our mortality reviews to ensure it is an accurate reflection of the patient's diagnoses and procedures The Clinical Coding team receive weekly information on any patients who have had a palliative care or	18.75% (12/13)	16.83% (11/12)

					contact with the palliative care team, so that this can be reflected in the clinical coding Quality of clinical coding in relation to deceased patients is discussed, with action being taken to address any queries Our mortality review programme, which includes validation of the clinical coding for the patient's spell of care		

Indicator	2015/16	National Average	Best	Worst	Trust Statement	2014/2015	2013/14
			Where applicable				
Patient reported outcome scores							
for groin hernia surgery 04/15 – 03/16 latest data available * provisional	31.4%	51.1%	100%	12.5%	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Centralisation of pre-operative services to standardise information received.	47.4%	53.1%
for varicose vein surgery 04/15 – 03/16 latest data available * provisional	25.0%	54.1%	100%	14.3%		46.8%	41.2%
for hip replacement surgery 04/15 – 03/16 latest data available * provisional	90.0%	81.3%	100.0%	25.0%	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Work has commenced with the CCG in relation to thresholds for surgery Continue to adhere to implant best practice	89.7%	91.9%
for knee replacement surgery 04/15 – 03/16 latest data available * provisional	81.8%	74.7%	100.0%	25.0%		76.0%	75.3%

Indicator	2015/16	National Average	Best	Worst	Trust Statement	2014/2015	2013/14
			Where applicable				
28 day readmission rate for patients aged 0 – 15 2011/12 latest data available	12.82% (11/12)	9.5% (11/12)	5.1% (11/12)	13.58% (11/12)	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Establishing a clinically led readmission group Working collaboratively with the CCG to carry out a follow up audit to determine causes Further work is on-going around risk stratification of high risk patients with long term conditions.	13.78% (10/11)	14.02% (09/10)
28 day readmission rate for patients aged 16 or over 2011/12 latest data available	10.04% (11/12)	11.2% (11/12)	8.96% (11/12)	13.5% (11/12)		10.17% (10/11)	9.74% (09/10)
The latest national data for 28 day readmission rate provided above is for 2010/11. Our internally reported performance against this target for 2015/16 was 13.4%							
Responsiveness to inpatients' personal needs: national inpatient survey score 2014/15 latest data available	69.3% (14/15)	68.9% (14/15)	86.1% (14/15)	59.1% (14/15)	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The methodology follows exactly the detailed guidelines determined by the Survey Co- ordination Centre for the overall National Inpatient Survey programme. We triangulate our staff and patient survey data with that from the CQC in-patient survey, which gives a more accurate method of identifying patient concerns. Data from other surveys including the Friends and Family test can also be used to give a clearer picture of patients' concerns. Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: The development and implementation of the PATIENT, Family and Carer integrated experience strategy. Review and refining of the complaints process Implementation of the Bedside Booklet Analysis of patient stories	70.9%	68.9%

Indicator	2015/16	National Average	Best	Worst	Trust Statement	2014/2015	2013/14
			Where applicable				
Percentage of staff who would recommend the provider to friends or family needing care 2015 Staff Survey	73.3%	69.8%	N/A	N/A	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The methodology follows exactly the detailed guidelines determined by the Survey Co- ordination Centre for the overall National Staff Survey programme. Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Increased use of Friends and Family Test – available in a variety of formats Use of Staff FFT results as the basis for team development sessions Starting to correlate Staff FFT results to Patient Experience measures Communicating the process to the public Implementation of the 'you said' 'we did' process for feedback	63.5%	57%
% of admitted patients risk-assessed for Venous Thromboem bolism April 15 – Dec 15	97.33%	**95.7%**	**100%**	**18.3%**	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health & Social Care Information Centre (HSCIC) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Appointment of Nurse Champion Nurse-led DVT Clinic VTE database Staff Awareness campaign RCA of patients developing clots for continuous learning and improvement	96.76%	96.30%

Indicator	2015/16	National Average	Best	Worst	Trust Statement	2014/2015	2013/14
			Where applicable				
Rate of C.Difficile per 100,000 bed days 15/16 latest data available	11.66	15.1	0.00	21.62	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health Protection Agency (HPA) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Introduction of a deep cleaning programme. Hand washing basins and gel outside all wards. Weekly strategic meetings to discuss all cases Improved scrutiny of antibiotic management. Investment in estate Collaborative working across the health economy Investment in the infection control and prevention team Clear guidance and policy	8.78	17.22
Number/Rate of patient safety incidents per 1000 admissions latest data available Apr15 – Sep15	44.17 (count of incidents 4,229)	38.1 (count of incidents 632,050)	31.64	61.35	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the National Patient Safety Agency (NPSA) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Introduction of a new risk management strategy Risk management training for clinical risk managers New risk management committee established Introduction of "harms" meeting to review incidents and ensure appropriate actions are taken External training programme for managers to undertake RCA training Review of current electronic incident reporting system to ensure investigation conclusion can be logged	38.65 (count of incidents 3,658)	36.21 (count of incidents 3,214)
Rate of patient safety incidents per 1000 admissions that resulted in severe harm or death 04/15 – 09/15) latest data available	0.17 (count of incidents 17)	0.15 (count of incidents avg 15)	0.01	0.7		0.12 (count of incidents 11)	0.12 (count of incidents 9)

Indicator	2015/16	National Average	Best	Worst	Trust Statement	2014/2015	2013/14
			Where applicable				
Inpatient Friends and Family Test To 01/16 latest data available	96%	95.77%	100%	76.3%	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The data has been obtained from the Health and Social Care Information Centre (HSCIC) Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Increased use of Friends and Family Test – available in a variety of formats Communicating the process to the public Implementation of the 'you said' 'we did' process for feedback	95.66%	78.33%
Accident and Emergency Friends and Family Test To January 2016 –latest data available	85.7%	87.55%	99.33%	60.11%		80.00%	61.75%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months 2015 Staff Survey KF26	23%	24%	-	-	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The methodology follows exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall National Staff Survey programme. Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Our 2015 Staff Survey Action Plan will include actions to improve the quality of Incident Reporting. HR will continue to offer support for employees reporting such incidents. The Trust will shortly appoint a 'Speak Up Guardian' on a 6-month trial basis.	18%	20%

Indicator	2015/16	National Average	Best	Worst	Trust Statement	2014/2015	2013/14
			Where applicable				
Percentage of staff believing that the trust provides equal opportunities for career progression or promotion 2015 Staff Survey KF21	91%	86%	-	-	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: The methodology follows exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall National Staff Survey programme. Bolton Foundation NHS Trust has taken the following actions to improve this indicator and so the quality of its services by: Our 2015 Staff Survey Action plan includes an item to address perceived fairness & transparency around allocation & moves of Nursing staff between Wards. We are establishing a Career Academy. We are investigating the expansion of our numbers of Apprentices.	94%	91%

Performance against Trust selected metrics

This section of the report is provided to give an overview of the quality of care across a range of indicators covering patient safety, clinical effectiveness and patient experience. We have chosen to use the same indicators as previously used in 2014/15.

Where these priorities are discussed elsewhere in the report we will refer to that data to avoid repetition.

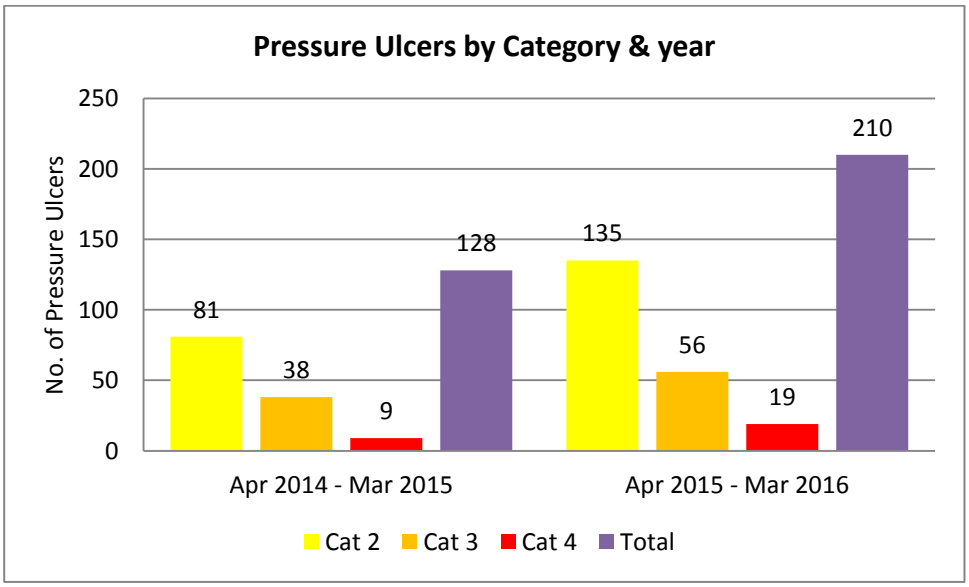
	Indicator/Measure	
Patient Safety	Mortality	Please see page 79
	Infection Control	Please see page 80
	Pressure ulcers	Please see page 114
Patient Experience	Patient Experience	Please see page 116
	Lessons Learnt	Please see page 118
	Dementia	Please see page 119
Effectiveness	Sickness Management	Please see page 85
	Appraisal rates	Please see page 121
	Mandatory Training compliance	Please see page 121

Pressure Ulcers

Pressure ulcers occur when the skin and the tissue beneath it becomes damaged due to pressure. Pressure ulcers are a widespread and often underestimated health problem. In the UK, it is estimated that between 4% and 10% of all patients admitted to hospital will develop at least one pressure ulcer. For elderly people with mobility problems, the figure can be as high as 70%. Some patients, particularly those who are frail, sick, bed ridden or have limited mobility, are more susceptible to developing ulcers whilst in hospital without corrected intervention.

Pressure ulcers are categorised following national guidance, ranging from a Category 1 pressure ulcer, which is minimal damage, to a Category 4 pressure ulcer, which would be classed as significant harm. Based on NICE guidance, Category 1 pressure ulcers are not reported in any Trust figures.

Our doctors and nursing staff are being encouraged and empowered to make pressure ulcer prevention a key priority as part of the Trust's patient safety agenda.



The number of pressure ulcers attributed to Bolton Foundation Trust has increased over the past 12 months; however, there has been a reduction in those which were unavoidable.

Following an identified discrepancy in reporting data towards the end of this year, we invited internal auditors to review our Harm Free Care process to ensure we were following a satisfactory process to determine the outcome of pressure ulcer harms. The findings from the report indicate robust documented procedures are in place. These procedures comprise of the following:

- Timely reporting of pressure ulcers
- Verification of pressure ulcers undertaken by Tissue Viability Nurses
- Outcomes of pressure ulcers determined and agreed at Harm Free Care panel
- Accurate data reporting to Trust Board on a monthly basis

Target for Pressure Ulcers 2016-2017

Category of Pressure Ulcer	Current figures 2015-2016	Percentage reduction required	Target figures 2016-2017
Category 2	135	20%	108
Category 3	56	50%	28
Category 4	19	90%	2

A pressure ulcer reduction action plan has now been developed to help in the drive to achieve the target for 2016-2017. This action plan includes the following:

- Training
- Policy review
- Review of documentation
- Evaluation and introduction of new devices to support pressure relief
- Improve collaborative working by engaging the CCG and external care agencies
- Reviewing themes and responding to lessons learned to be monitored and shared between divisions to ensure whole health economy is benefitting from this with the aim of reducing pressure ulcers.

Patient Experience

2015/16 has been an active and busy year for the patient experience team. The Friends and Family Test has been rolled out across Community Services, Outpatients and Day Care.

Envoy messaging were contracted to carry out the FFT surveys using text messages to mobile phones and voice messaging to land lines. Where these methodologies were not deemed appropriate a paper based FFT method was incorporated into the roll out plan. As a result of this expansion the Trust can report achievement of the 5% increase in volume of FFT responses through a wider range of services reporting.

A total of 86,700 responses were received and the table below demonstrates the breakdown of the feedback. 90.28% of respondents said that they would be either extremely likely or likely to recommend our services to Family and Friends.

Response Option	Responses	Percentage
1 - Extremely Likely	62,101	71.63%
2 - Likely	16,167	18.65%
3 - Neither Likely nor Unlikely	3,026	3.49%
4 - Unlikely	1,577	1.82%
5 - Extremely Unlikely	2,139	2.47%
6 - Don't Know	1,690	1.95%

All service areas are provided with monthly analysis of the feedback including both positive and negative comments against which an action plan is developed within their services to build on, continually improving the patient experience.

Inpatient Friends and Family Test

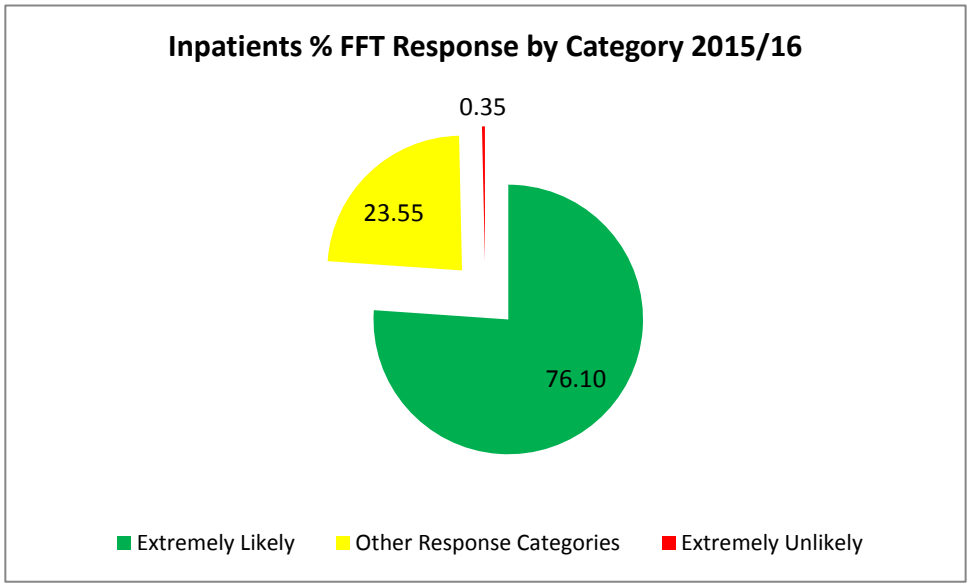
Inpatient FFT was collected via paper based system throughout 2015/16 and during this period of time a new electronic solution is being piloted with an external company (Meridian). Ipads have been deployed across the Trust allowing ward based staff to undertake FFT and also patient experience surveys in real time.

In 2015/16 6258 responses were received, 4766 patients reported that they would be extremely likely to recommend our services to Friends and Family with 22 patients reporting that they would be extremely unlikely to recommend.

Through this approach we have been able to adapt and individualise patient experience surveys by service area. We are currently working to connect the data sources.

One of the key advantages to using this new electronic solution is that we have started to look at correlations between Staff FFT results and Patient data (FFT, Complaints) at individual Ward level. Early results from this indicate that the Staff FFT Additional Question around receiving feedback & recognition from line manager has an important role in linking the quality of the

staff experience and the quality of the resultant patient experience; where this theme is strong within a Ward, patient satisfaction tends to be high and the number of complaints low. This relationship will be further analysed & explored through the work to use Meridian to capture integrated staff & patient feedback.



All inpatient areas are provided with a monthly report containing the data, % recommended and % not recommended. The reports also include the individual comments from patients. These are routinely published in patient facing areas on the wards.

The information from these reports are utilised in the 'You said, We did" ward boards for Friends and Family comments.

Lessons Learnt

In 2015/16 the Trust has continued to produce monthly learning slides sent to every employee in the organisation. These cover learning from incidents, complaints, claims, inquests, as well as the findings from Clinical Audit, and national alerts. These are reviewed annually, and in 2016/17, these will be extended to cover research and equality and diversity. The Trust also continues to send out urgent SBAR (Situation, Background, Assessment, Recommendation) alerts for single issues identified where there needs to be rapid widespread learning.

The Trust is committed to continuing to improve learning across the organisation. Learning themes from the Trust Harm Free Care Panels (Pressure Ulcers, Falls, VTE) and End of Life Care incidents will be reported to the Professional Advisory Group going forward, on a monthly basis to enable dissemination of this learning to be cascaded through the organisation.

The Trust recognises that the key element in learning, is the implementation of change. The implementation of actions arising from Serious Incidents, Divisional Reviews, Complaints, Claims and Inquests are monitored through a weekly meeting chaired by the Head of Governance. Going forward, the Trust will be increasing the scrutiny at the review panels for serious incidents, to assess the potential impact and effectiveness of actions in reducing the risk to future patients. This will enable us to focus resources on those actions which make the greatest difference.

Dementia

In January 2015 the Dementia Steering Group at Bolton FT was reformed and one of the first objectives was to create a business case for appointing a Dementia Nurse Specialist as a single point of contact for this subject area; as per the National Dementia Strategy (2009). This process was completed and the Lead commenced in post October 2015. Prior to this the responsibility for delivering Dementia orientated tasks sat with various different personnel who themselves had broad portfolios elsewhere, making a focused approach difficult. Encouragingly, the appointment of the new lead 6 months ago has now allowed the Trust to approach the challenges Dementia will pose both now and in the future in a centred manner.

The following reflects both our achievements to date and our ambition for Dementia Care over the next two years. It is taken in part from the Trust's first Dementia Strategy (currently in draft form). The strategy has five aims which previously existed as a draft work plan for the Dementia CNS and his colleagues but which have now been refined so that the primary objective; ''improving the patient and carer experience'' within every area of Bolton FT, will be met by delivering on the other four.

Improving the Patient and Carer Experience

Patients can present at any stage of their disease progression in what to them is an unfamiliar and stressful environment. It is therefore up to us to be as welcoming and nurturing as possible. Yet with such a sporadic demand on our services, and in almost any department at any time, it will take organisational change to make this happen. Delivering well on our other key aims will do much for the experience, not just of the person with dementia but carers and staff also. This is particularly relevant where reasonable adjustment is concerned for those whose dementia is further complicated by Learning Disability or sensory impairment and these areas are considered in the Dementia Steering Group's Action Plan also. With open visiting cards having been introduced, and a system of identifying and providing for those with a Dementia Diagnosis in place we can start to improve care from admission to discharge.

Raising Awareness through Education and Training

The person with dementia and their family meet a whole variety of people on their journey into hospital, from the first volunteer who gives them directions to the Consultant on the Ward Round. So broad staff engagement is essential to the quality of care people can expect from us. The Dementia CNS, in tandem with Practice Educators provides training to staff based on continuing evaluation of our patient group versus their learning needs. Training is not restricted to clinical staff but instead, is aimed broadly across our organisation to ensure Bolton adopts a Dementia Friendly approach in all areas patients interact with. This training includes regular ''drop ins'' to the wards in order to workshop patients and educate staff in a person centered manner, as well as less formal Dementia Friends Training. Link Nurses have also been created to champion Dementia care in various wards and departments, and study days have been developed around Tier 2 Dementia Training and providing Enhanced Care.

Supporting Treatment & Early Diagnosis

The purpose of this aim is threefold; firstly, to ensure that those who come into our organisation for whatever reason receive the appropriate treatment from a medical point of view and that medical staff are adequately supported in delivering this. This is especially pertinent where delirium or depression complicate the picture. By developing protocols to

manage and promote early intervention for both, the Dementia Steering Group will ensure joined up working between the Rapid Access Interface and Discharge Team (as Bolton's Mental Health representatives) continues to be an essential part of our work to improve Dementia Care. Secondly, early diagnosis is essential for early intervention, and avoiding admission to hospital for patients in crisis. Case finding is also an important part of our preparation for the future and will help us to identify more specifically the volume of patients we can expect to present. In doing so we have reached the CQUIN target each time this was required of us, and the practice of assessment is expected to continue regardless of the incentive coming to an end, to ensure this element of the National Dementia Strategy (2009) is fulfilled.

Ensuring Best Practice by Delivering on Standards

This aim addresses the need to promote integration of services and systems to meet the needs of our clients. Ensuring joined up working across all areas as part of best practice will have a constructive impact on the patient's journey, with the overall benefit of improving the patient and carer experience in the process. Since the appointment of the Lead, we have ensured that Bolton Dementia Support Group are included as members of the steering group, and will be regularly consulted with regarding their work and ours. We have created a flagging system for all patients with a clinical coding of Dementia (though there will be many without) who come into our organisation. On a daily basis, their length of stay and location will be emailed for the attention of the Lead, to enable support of patients and families on repeat admission. The Forget Me Not Sticker to subtly identify patients with Dementia and Getting to Know me Booklet have also been embedded in the ward BSCA accreditation program to ensure a high standard of care is delivered. The hope is that this will become a greater priority as areas are audited and become more aware of their purpose. Finally, our e-learning is in the process of being improved, and drop in training is starting to be delivered in the Elective division by their PEF with hopes that this practice can be expanded if successful.

Championing a Dementia Friendly Environment

Finally, it has always been the aim of Bolton FT to have a Dementia Friendly environment to support patients in their inpatient recovery. Promoting changes to the hospital environment with a view to becoming more Dementia Friendly is also an important goal of our service and comes in line with the National Dementia Strategy (2009). Though in part this is a long term aim, the Dementia CNS is now in place to act as a single point of contact to advise on procurement, way-finding and signage panels as well as providing our project management and estates teams with valuable evidence based guidance on the best features of an environment fit for Dementia patients, but accessible for all. This aim also looks at unique projects which can enhance the patient experience regardless of their surrounds to provide welcome distraction and respite from the ward environment. It is closely linked to the fortunes of the Donate £1 for Dementia Appeal, which is running well.

Mandatory training

Throughout 2015/16, the Organisational Development Team have continued to refine and embed the e-learning training for staff which has significantly reduced the amount of time spent on classroom based attendance for annual mandatory training updates.

We continue to offer a blended approach to delivery (where appropriate), with additional classroom based sessions offered to support elements of the mandatory training programme where face-to-face delivery of peer group interaction or the demonstration of physical skills i.e. moving and handling techniques is essential to further embed learning and increase understanding.

This approach has also allowed us to further develop the training within our Education & Training prospectus so that we can pro-actively support service development priorities.

We continue to work closely with universities and higher education institutions to ensure that our staff have access to undergraduate and postgraduate programmes of study that enhance their skills, knowledge and competence whilst keeping them abreast of advances in patient care and as a result, improving the quality of their patients' experience.

We now report separately on Mandatory and Statutory training compliance.

Our statutory training rate has increased from 92.4% in April 2015 to 95% in March 2016, against a target of 95%.

Our mandatory training rate has increased from 85.4% to 90.9% over the same period, against a target of 85%.

The Trust Workforce Committee monitors compliance and also determines what constitutes mandatory training, which can also be role-specific.

Appraisals

It is widely accepted, that there is a direct link between a satisfied and engaged workforce and the quality of care patients receive.

An appraisal provides both an individual and his/her supervisor with the opportunity to reflect on how well the individual has met agreed targets and objectives over the past year, to identify any training needs and areas for personal development and to review any issues or concerns that the staff member or supervisor may have.

Our completed appraisals have improved from 82.1% in April 2015 to 83.7% in March 2016 against a target of 85%.

We are incorporating our new Values into our appraisal process from May 2016, and have disseminated a senior leadership appraisal and objectives roll out in line with our agreement of the 2016/17 Annual Plan.

Quality Report

Achievement against the Monitor Risk Assessment Framework 2015/16

Indicator	Target	Apr 15 - Mar 16	Achieved	Apr 14 - Mar 15	Achieved
Referral to Waiting Times - incomplete	92%	95.20 %	✓	99.00%	✓
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	90.4%	✗	92.55%	✗
Maximum waiting time of 62 days from urgent referral to treatment for all cancers - from urgent GP referral to treatment	85%	89.6% *	✓	91.20%	✓
Maximum waiting time of 62 days from urgent referral to treatment for all cancers - from consultant screening service referral	90%	95.2% *	✓	97.40%	✓
Maximum waiting time of 31 days from diagnosis to treatment of all cancers - surgery	94%	99.2% *	✓	100%	✓
Maximum waiting time of 31 days from diagnosis to treatment of all cancers – anti cancer drug treatments	98%	100%*	✓	100%	✓
All cancers 31-day wait from diagnosis to first treatment	96%	98.5% *	✓	98.3%	✓
Cancer: two week wait from referral to first seen, all cancers	93%	97.4% *	✓	98.80%	✓
Cancer: two week wait from referral to first seen, symptomatic breast patients (cancer not initially suspected)	93%	98.6% *	✓	95.40%	✓
Clostridium difficile - meeting the C. difficile objective	19	26	✗	20	✓
Certification against compliance with requirements regarding access to health care for people with a learning disability	100%	100%	✓	100%	✓
Data completeness community service referral to treatment	**50%**	**99%**	✓	**99%**	✓
Data completeness community services - referral information	**50%**	**100%**	✓	**100%**	✓
Data completeness: community services - treatment activity information	**50%**	**100%**	✓	**100%**	✓

** data available to February 2016 only*

Statement from NHS Bolton Clinical Commissioning Group (CCG)

We have worked closely with Bolton FT throughout 2015/16 to gain assurances that the services provided were safe, effective and patient focused. The quality and performance of these services is monitored within a clinically led governance structure and we note that the content of the Quality Account is consistent with the information provided throughout the year. The CCG also acknowledges the progress made by the organisation which has resulted in the lifting of their FT licence breach.

The CCG notes the prescriptive requirements of the Account but considered the scale and format not necessarily to be the most appropriate for a public facing document and hope this can be reflected on in future years.

With the exception of the priority to reduce falls resulting in harm, the CCG noted that the FT failed to achieve the key priorities in last year's Account. However, we do acknowledge that initiatives remain in place to address these in the coming year and we expect this will result in significant progress.

The CCG is largely supportive of the three priority areas for 2016/17, although we would like to have seen greater reference to the Locality Plan throughout the Account. We note specifically that two of the priorities, namely stroke and end of life care, relate to areas which involve community and acute services and we expect a focus to be placed on the community aspect of these priorities throughout the year.

The CCG is encouraged by the positive feedback provided by the CQC following their visit in March and look forward to receiving the final report in the coming months. The CCG also acknowledge the openness of the FT in continuing to extend membership of various committees to the CCG e.g. Quality Assurance Committee and Mortality Reduction Group.

The clinically led collaborative approach to the development and delivery of the CQUIN schemes for last year resulted in a high level of achievement which we expect to be sustained and further improved upon in 2016/17.

The CCG acknowledges the significant developments with regards to the patient safety culture within the organisation which is reflected in their current standing in the 'Learning from Mistakes' league and within the National Reporting and Learning System framework. We also welcome the transparency of the FT with regards to the Royal College of Surgeons review into theatre culture and with investigations in to serious incidents and never events, which all lead to improvement in services.

In summary the CCG is pleased with the positive progress portrayed within the Account, but in acknowledging the significant challenges that remain, we expect the collaborative relationship developed last year to be sustained in order to optimise the further delivery of safe, effective and personalised care by Bolton FT.

Michael Robinson

Associate Director of Integrated Governance and Policy

Bolton CCG

Statement from Bolton NHS Foundation Trust - Trust Governors

As Foundation Trust Governors we have worked closely with the Directors of the Trust and will continue to do so during 2016/17. In the last year we have received additional briefings from the Executive Directors on the performance of the Trust, this has provided us with an opportunity to seek assurance and further our understanding of the challenges facing the Trust.

We welcome the publication of the Quality Report and congratulate the Trust on the results achieved particularly with regard to the reduction in falls with harm where the objective agreed last year has been achieved. We also note the progress made towards the other objectives and are assured that the agreed actions will continue. We recognise the success of the Trust in balancing the achievement of strong financial performance whilst also improving performance against a wide range of quality metrics.

The range of regular reports that are presented to the Council of Governors highlight the performance and compliance of the Trust against its many performance indicators and particular areas of focus.

As well as receiving strategic, performance and compliance information, Governors are invited to take part in regular safety visits and inspections which provide the opportunity for Governors and board members to visit operational areas and speak directly with patients, visitors and staff about their experiences at the Trust. We have been assured that although savings have been made this has not been at the expense of quality

We were particularly concerned as A&E performance has deteriorated despite the actions taken earlier in the year with the “Perfect week”. We have been made aware of the challenges in achieving this target and the actions taken and we expect the required improvements to be made.

With the devolvement of health and social care to Greater Manchester, we are also keen to ensure that the Trust plays a full part alongside Bolton CCG, Bolton Council and other stakeholders to ensure appropriate provision of care to the people of Bolton.

We hope that the same effort and determination will continue in 2016/17 and look forward to continuing to support the Trust in our role as critical friend, in the coming year.

Statement from Healthwatch Bolton

No statement received.

Statement from Overview and Scrutiny Committee

No statement received

Independent Auditor Report

BOLTON NHS FOUNDATION TRUST - ANNUAL ACCOUNTS 2015/16

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2016 have been prepared by Bolton NHS Foundation Trust under Schedule 7, sections 24 and 25, of the National Health Service Act 2006.



Dr Jackie Bene

Chief Executive 26th May 2016