Bolton
NHS Foundation Trust

Annual Report and Accounts 2017/18

This page is intentionally blank

Bolton NHS Foundation Trust
Annual Report and Accounts 2017/18

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

This page is intentionally blank

©2017 Bolton NHS Foundation Trust

Foreword

Contents

	Page
Performance Report	
Overview of performance	8
Performance analysis	12
Accountability Report	
Directors' report	23
Remuneration report	33
Staff report	40
Code of Governance disclosures	52
NHS Improvement Single Oversight Framework	63
Statement of accounting officer's responsibilities	64
Annual Governance Statement	65
Quality Report	
Part one – Statements on Quality	77
Part two – Quality Priorities	79
Part three – performance and assurance	125
Independent Audit Reports	128
Annual Accounts	129

Foreword

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.

During 2016/17, the Trust developed a wholly owned subsidiary for the provision of estates and facilities services.

Integrated Facilities Management Bolton (iFM Bolton - company number 10278178) was formally established in July 2016 and became operational on 1st January 2017 when cleaning and portering services previously provided by a private company were taken over by the Trust's own subsidiary.

On 31st March 2017 Estates, catering and procurement services were also transferred into iFM Bolton and contracts signed for the provision of an Operated Healthcare Facility from 1st April 2017.

2017/18 in Numbers



115,929 A&E attendances
32,535 arrived by ambulance



£325million operating expenses



16,354 patients had an operation



325,117 outpatient attendances

NHS Bolton NHS Foundation Trust



5279 staff



5,831 babies born including **82** sets of twins and **3** sets of triplets



749,214 community contacts



86,229 inpatient spells

Foreword

Preparation of Accounts and adoption of going concern

The annual report and accounts have been prepared in accordance with the direction issued by NHSI 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

After making enquiries, the directors have a reasonable expectation that Bolton 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. To ensure this the Department of Health (DoH) operates a system to provide cash support funding to Trusts in financial distress. Bolton NHS Foundation Trust received funding under this system in 2012/13 and 2013/14 but has not required any such funding since then.

In addition to the above the Board are assured that the accounts have been prepared on a going concern basis because of the following:

- Successful delivery of the 2017/18 financial plan gives confidence in the organisation's ability to deliver on its financial plans going forward.
- The Trust has the strongest cash position of £8.1m at year end.
- The Board has agreed the Bolton Locality plan which shows a sustainable financial future for the Bolton health economy and the Trust over the next five years.
- A detailed operational financial plan has been prepared to support the delivery of the planned £12.7m surplus for 2018/19.
- The planned £12.7m surplus consists of a £1.6m surplus rewarded by a £11.1m payment from the national provider sustainability fund. Delivering this surplus will further strengthen the Trust's cash position.

In terms of risk management the Trust has considered potential downside risk on the 2018/19 financial plan and the range of outcomes that might occur

The Trust is part of the NHS risk pooling scheme, the contributions for this are already fixed. Any risks as a result of litigation will not impact on the Trust's solvency position in 2018/19.

Overview of Performance

Chairman's Review - April 2018



As a Foundation Trust, we have dealt with huge challenges over the last few years and it's fair to say that 2017/18 will remain in memory as one of the most difficult ever faced and one where we again demonstrated our resilience and commitment to great patient care. Everyone will remember the terrible winter we have just emerged from and the impact it had on our services.

Throughout the country A&E departments were inundated and elective operations had to be cancelled to make additional beds available for emergency patients. I am particularly proud of the way we in Bolton responded and our staff deserve credit and the highest praise for the way they coped with the unprecedented and unrelenting pressure. Our thanks go to each and every one of them.

We must also remember the tragic events of the 22nd of May 2017 when a terror attack in the Manchester Arena devastated so many lives. The professionalism, compassion and dedication shown by our staff was remarkable and I know the families and friends of everyone affected truly appreciated the response and care they received in Bolton. Thank you all.

But we were not defined purely by these events. Throughout the year we continued to evolve as a Trust and our reputation continues to grow throughout the UK. Our new wholly owned subsidiary, iFM Bolton, effectively commenced its first full year of trading with the transfer of staff from some of our important support functions at the beginning of April. The aim in the coming year is to build upon their success in improving the quality of service offered to patients and staff alike through improved integration of our procurement, maintenance, cleaning and catering services.

The last financial year was also a year of change in many respects. Work continued to develop the Healthier Together proposals for emergency surgery previously agreed by the Greater Manchester Commissioners and we worked closely with our colleagues across Bolton to map out how to deliver the vision captured in the Bolton Locality Plan. Both of these initiatives are designed to transform the way we manage the ever growing demand on health and social care services and I am delighted with the level of engagement and collaboration achieved with all our partners.

The Trust also underwent an external Well Led Review in 2017 and the findings confirmed yet again that our governance arrangements, management systems, processes and leadership were all effective and gave assurance that the organisation is managed well with a keen understanding of the potential risks facing us.

And of course we faced further budget pressures. It is astonishing to think of the financial maelstrom the NHS nationally finds itself in with the majority of providers operating in financial deficit. Even more astonishing then, to consider that Bolton delivered a financial surplus for the fourth successive year, a feat almost unheard of. We can all be extremely proud of Dr Jackie Bene and her team for the stewardship over this period and the impressive act of balancing our finances with the delivery of great care. In terms of our surplus, we achieved an outturn of £11m. As in previous years, we will be investing this surplus into our capital programme. During the last twelve months we continued the improvements agreed by the board with further investments in A&E, Endoscopy, Maternity, IT, patient records and our restaurant

facilities. Much of this will continue into 2018/19 as we seek to update our aging estate and ensure that our clinicians have the best possible access to patient records.

Naturally we were both delighted and proud of our own Chief Executive, Dr Jackie Bene, when she was awarded an OBE in the Queen's Honours List. Jackie has worked tirelessly for many years in ensuring that our Trust is amongst the safest and most patient focused within the UK. She has been ably supported throughout the last year with tremendous contributions from our Nursing Director, Trish Armstrong-Child, our Medical Director, Steve Hodgson, Chief Operating Officer, Andy Ennis, our Finance Director, Annette Walker and our Trust Secretary Esther Steel. It is important that we acknowledge the leadership they offered throughout the year, the challenge and support they offered to the wider workforce and the sheer determination to make Bolton the best Trust in Greater Manchester. Well done and thanks to all of them.

Our Trust also lost a large number of long serving Governors as they came to the end of their terms. It is difficult to exaggerate the contribution our Governors make, through the championing of local patient needs, the challenge to the board on strategy and the insight on what our local population feel about our services. Our Foundation Trust is built upon the strength of the Governing body and the recent retirees can look back with satisfaction on what they have helped to build. Many thanks to all of you. I would also like to publically welcome the new cohort of Governors who are already making a really positive impact.

We saw several changes in the composition of the Board over the last twelve months with two of our Non-Executives coming to the end of their terms. Neal Chamberlain and Mark Harrison were both highly effective Non-Executive members of the board and we all appreciated the huge contributions they made. We welcomed Bilkis Ismail as a new Non-Executive Director and look forward to working with her over her term. Changes to the Executive team included the departure of Simon Worthington, our Finance Director, to a new post in Leeds Teaching Hospital and we welcomed Annette Walker as his replacement. We were also delighted to welcome James Mawrey as our new HR Director.

Finally, this year, the NHS reaches its 70th anniversary this year. Throughout the UK, and in Bolton, events will be held to mark this milestone and to demonstrate the uniqueness of the NHS and the place it holds in people's hearts as a much loved and treasured institution. Perhaps more importantly it is also an opportunity to highlight the very many real heroes we have working with us every single day. So please get involved and enjoy the celebrations.

I am aware that I always say that next year will be even tougher than last year but in this case I don't think that is necessarily true. We will face enormous strains on our resources as the demands upon us continue to grow; we will continue to develop our services in and out of the hospital, we will work with our colleagues across Greater Manchester in developing improved access and better outcomes and, of course, our heroes will continue to dispense great care. The pressures won't ease up but we are capable and ready for them. Thanks to everyone for a remarkable year.



David F Wakefield



Overview of Performance

Chief Executive Statement



A time to reflect

The Annual Report provides an opportunity to look back and reflect on the achievements and challenges we have faced and to consider the opportunities and risks ahead of us.

Challenges

Like every trust in the UK, we face the pressures of an ageing population, rising demand, staff shortages and limited funds. Despite these challenges, we have maintained and improved patient care and managed our budgets effectively for the fourth year in a row. None of this has been easy and it is testament to our hard working and committed staff that we have been able to achieve this.

There is no doubt that the unrelenting demand for urgent care has had a huge knock-on impact throughout the Trust. There are no quiet times in any of wards, clinical areas or community services anymore; we now face the reality that the rising demand is here to stay.

Bolton's A&E department remains the busiest in Great Manchester and we recognize the very real distress caused when patients cannot be treated within the four- hour target. However, we have always been one of the busiest departments and so we have always needed to be thinking ahead, innovating and developing alternative pathways for patients. As such we became one of the first Trusts in Greater Manchester last year to implement GP streaming in A&E and we are already developing other alternative pathways to hospital attendance or admission.

Future plans

We will build on the great work done by our community teams who work hard to support people at home or support alternatives to admission to hospital where safe to do so. We will also build on our collaborative links with our Commissioners, GPs and Local Authority in order to find further sustainable solutions to the pressures we all now face. We all recognize in Bolton that together we are stronger and it is strong partnership working that will be a major priority for us in 2018/19 as we progress the development of Bolton's Integrated Care Alliance.

Despite the pressure of demand for urgent care we have continued to provide overall excellent and timely access to planned care be that operations, diagnostics or out-patient appointments with only a temporary dip in performance in the very early part of this year from which we are recovering well.

Overview of Performance

Our commitment to patients with suspected or diagnosed cancer has remained very strong and we have been one of the best performing Trusts in the country for both patient experience and timeliness of interventions.

We have also seen a number of other significant successes over the last year including the continuation of our ambitious capital programme. This included an expansion of our A&E department, an ongoing programme to relocate and increase the capacity of our Endoscopy unit, a refresh of our IT systems and the opening of our new restaurant facilities. Our plans for next year are even more ambitious with further improvements to A&E, a refurbishment programme for our maternity wards and the introduction of an Electronic Patient Record.

Recognition

None of this would be possible without the continued work and support of our amazing staff, and while we were able to recognise individuals and teams in our annual and monthly staff awards I would like to take this opportunity to thank all staff for their valued contribution to the work of our Trust. Our most recent staff and patient feedback scores place us above the norm when measured against other trusts; a huge testimony to the resilience and determination of everyone involved.



Jackie Bene

Chief Executive Bolton NHS FT May 2018

Performance Analysis

Purpose and activities

Bolton NHS Foundation Trust is an integrated care organisation providing care and support in health centres and clinics, including the prestigious Bolton One complex in the town centre, as well as domiciliary and ill-health prevention services. We also provide intermediate care in the community and a wide range of services at the Royal Bolton Hospital.

Our vision is to be an excellent integrated care provider within Bolton and beyond delivering patient centred, efficient and safe service.

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 is 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

Performance Analysis

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 risks to the achievement of our strategic objectives, 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 65 of this report.

The following table sets out our key risks, and examples of relevant controls and mitigating factors. The Board considers these to be the most significant risks that may impact the achievement of our objectives. They do not comprise all of the risks associated with the Trust and are not set out in priority order.

Performance Analysis

Principal Risks 2017/18

Risk	Controls and mitigation
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	• Root cause analysis and incident reporting. • Year on year reduction in avoidable cardiac arrests • Educational initiatives for all staff on first responder rota • PatientTrack electronic call system implemented and will be used to audit response
Failure to reduce the number of hospital acquired infections as a result of poor compliance with policies and/or poor operational control.	• Infection Prevention and Control policies • Oversight through the infection control committee • Audit of key practices such as hand hygiene Further information in our quality section – page 76
Failure to meet minimum staffing levels because of vacancies and sickness could compromise patient safety and experience	• Continued programme of recruitment, including international recruitment • Recruitment of additional health care assistants to provide support. • Actions to reduce staff sickness absence • Temporary staffing solutions used to ensure safe staffing levels in clinical areas. Further information in the staffing section– page 40
Failure to implement our policies and to embed appropriate training could result in our patient's experiencing harm such as falls and pressure ulcers	• Falls and Pressure ulcer panels. • Ward based champions • BOSCA accreditation for wards • Incident reporting and root cause analysis
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	• Urgent care programme plan overseen by the Urgent Care Programme Board • Investment in the physical A&E department to provide increased assessment capacity
Failure to improve system resilience and to enable timely and appropriate flow could lead to an increased length of stay and impact on our A&E performance	• Continued engagement with the CCG and the local authority to develop a shared solution through the Bolton Locality Plan
Failure to deliver the financial plan could reduce the funds available for investment in the Trust and could ultimately result in regulatory intervention	• Financial performance overseen by the Finance and Investment Committee with regular reports to the Board.
There is a risk that commissioner and local authority led reconfiguration may reduce control of the Trust's future scope of services	• Development of the Trust's Clinical Service Strategy and engagement with local and GM partners through Greater Manchester Health and Social Care.

Performance Analysis

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.

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 2017/18, the Trust continued to work towards the goals agreed in the 2013 – 2018 strategy



Performance Analysis

Goal 1 – Quality of Care

A detailed review of performance against our quality priorities is included with our quality report starting on page 76 of this document.

Goal 2 – Operational Performance

For the first time in three years the Trust failed the 18 week referral to treatment time. The standard states that 92% of patients are seen and treated within 18 weeks. The Trust performance was … % for the year. This was due to a combination of factors including urgent care pressures which culminated in guidance from the Department of Health to cancel all routine elective activity in January. The Trust also saw a surge in referrals in the third quarter of the year which saw some capacity issues exposed. The CCG are supportive of the plans and the Trust expects to achieve this standard by Quarter Three of 2018/19. Although we did not achieve our 18 week target we have continued to achieve our 62 day cancer target and in 2018/19 92.4% of patients referred for cancer treatment began their treatment within 62 days of GP referral (target 85%)

The biggest challenge for the Trust remains urgent care. In 2017/18 81.92% of patients were treated within four hours. This compares to 82.6% the year before against a target of 95%.

Nationally, the expectation has been set that 90% of patients will be treated in four hours by September 2018, returning to 95% by March 2019.

The Trust continues to work with the Emergency Care Improvement Programme, the CCG and Local Authority partners to improve performance against the standard. In addition the Trust is investing in the Accident & Emergency Department estate to improve the environment for patients and staff. This will address one factor in that the Department is too small to cope with the volume of patients who attend, which has increased significantly over the years.

Goal 3 –Leadership and Improvement

The aims for 2017/18 related to maximising capacity and capability through a workforce that feel fully engaged in their work, are well recognised and fairly rewarded.

Our positive staff engagement levels have been sustained with all key finding scores greater than the average for our comparator Trusts. Appraisal and mandatory training compliance has been good and work is taking place to further improve appraisal rates and strengthen the link to development, for all staff groups, both patient facing and in support roles.

Managing sickness absence levels and supporting staff health and well- being remains a key priority.

Recruitment timescales have been consistently achieved and we continue to attract newly qualified nurses both locally, nationally and internationally including 22 registered nurses from the Philippines. The development of new and extended roles including Nursing Associates, Advanced Clinical Practitioners and the Physicians Associate are increasingly being identified through workforce planning to support role redesign and maximise available clinical capacity.

Further detail on our staffing metrics are included from page 40 of this report.

Goal 4 - to be financially viable and sustainable

Income and expenditure overview

The Trust planned to maintain strong performance by delivering a surplus of £10.1m in 2017/18. As can be seen from the summary statement of comprehensive income below this target has been achieved with the Trust delivering a surplus of £11.9m after excluding impairments.

This fourth year of surplus since the Trust's significant deficits in the period 2010/11 to 2013/14 maintains the sustained financial recovery seen in previous years.

The Trust Board agreed the 2018/19 financial plan at its March 2017 meeting. This plan identifies how the Trust can deliver a surplus of £12.7m in 2018/19.

Statement of Comprehensive Income	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/18	Plan 2018/19
Revenue	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**
Operating revenue from continuing operations (patient care)	266,791	271,537	285,485	300,302	298,905
Other operating revenue	24,771	21,004	34,474	34,425	32,309
Operating expenses	-309,474	-287,918	-318,192	-326,266	-314,370
Operating surplus (deficit)	**-17,912**	**4,623**	**1,767**	**8,461**	**16,844**
Finance costs:					
Finance Income	41	35	28	34	30
Finance costs	-849	-642	-702	-797	-1,175
Finance expense - unwinding of discount on provisions	-122	-12	-6	-6	0
Public dividend capital dividends payable	-2,535	-2,152	-2,059	-2,065	-2,739
Corporation Tax					-243
Net Finance Costs	**-3,465**	**-2,771**	**-2,739**	**-2,834**	**-4,127**
Gains / Losses on disposal of assets			-16	-3	
Surplus/(Deficit)	**-21,377**	**1,852**	**-988**	**5,624**	**12,717**
Impairment of fixed assets	-21,937	0	-16,565	-6,259	0
Underlying Trading Surplus/(Deficit)	**560**	**1,852**	**15,577**	**11,883**	**12,717**

Income analysis

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

Income	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/18	Plan 2018/19
	£,000	**£,000**	**£,000**	**£,000**	**£,000**
CCG's and NHS England	255,611	254,672	271,040	286,424	285,479
Local Authorities	8,538	10,450	12,082	11,311	9,979
Other	2,642	6,415	2,363	2,567	3,447
Sub total Total Income from activities	**266,791**	**271,537**	**285,485**	**300,302**	**298,905**
Other operating revenue	24,771	21,004	34,474	34,425	32,309
Total Revenue	**291,562**	**292,541**	**319,959**	**334,727**	**331,214**

There has been an increase of income between 2016/17 and 2017/18 of £14.8m. This can be explained by the following factors:

- NHS Tariff inflation
- Quality and performance investments funded by Bolton CCG
- Income improvements as part of the Trust's income and cost improvement programme
- Transformation funding £4.7m

- Wigan HIV Service £2m

The planned reduction in income in 2018/19 of £3.5m is mainly due to:

A reduction of £1.5m for Wigan Sexual Health Service

A reduction of £2m for CAMHS Service

Expenditure analysis

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

Expenditure Trend	**Actual 2014/15 £,000**	**Actual 2015/16 £,000**	**Actual 2016/17 £,000**	**Actual 2017/18 £,000**	**Plan 2018/19 £,000**
Employee expenses	203,002	205,073	214,365	227,560	219,520
Drugs	18,823	20,556	21,435	23,997	23,532
Clinical Supplies	19,975	20,588	20,920	20,544	25,655
Non Clinical Supplies	33,248	32,258	36,889	38,828	35,055
Depreciation and amortisation	5,536	5,539	3,610	4,638	6,108
Impairments of property, plant and equipment	25,255	0	16,565	6,259	0
Redundancy	97	0	28	0	0
Misc other operating Expenses	3,538	3,904	4,380	4,440	4,500
Total	**309,474**	**287,918**	**318,192**	**326,266**	**314,370**
Less impairments	(25,255)	0	(16,565)	(6,259)	0
Underlying expenditure trend	**284,219**	**287,918**	**301,627**	**320,007**	**314,370**

Impairments are excluded from this analysis as they do not count against the Use of Resources risk rating that is used by NHS Improvement to assess NHS Foundation Trusts financial performance.

There has been an increase in expenditure of £18.4m between 2016/17 and 2017/18. There is a planned reduction in expenditure of £5.6m in 2018/19.

The net increase of £18.4m in expenditure between 2016/17 and 2017/18 can be explained by the following factors:

Pay awards, increments, apprentice levy and non-pay inflation

Increase charges for Clinical Negligence Scheme

Savings delivered as part of the Trust's income and cost improvement programme

Investments in staffing to ensure quality and safety

Service developments with Salford

Quality and performance investments funded by Bolton CCG

Revenue consequences of capital investments in Estates and IT

The planned reduction in expenditure in 2018/19 can be explained by similar factors, although there is the cessation of the Child and Adolescent Mental Health Service and Sexual Health Services in Wigan and planned to be a greater level of cost improvement relative to investments and other cost pressures.

Performance Analysis

Income and cost improvements

	Actual 2014/15 £,000	Actual 2015/16 £,000	Actual 2016/17 £,000	Actual 2017/18 £,000	Plan 2018/19 £,000
Income and cost improvement	21,200	14,400	15,600	20,645	15,506
As % of income	7.3%	5.0%	5.4%	6.2%	4.7%

Over the last four years the Trust has delivered £71.8m of income and cost improvements, much higher than the national average.

Delivery in 2017/18 was slightly above the plan of £20.60m.

It should be noted that due to continuing investments that the Trust is planning to make in order to deliver the IT Strategy and Estates Strategy in addition to higher than average forecast cost pressures, is why the Trust is planning for a 4.7% income and cost improvement programme in 2018/19 when the national efficiency assumption is 2%.

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.

The Trust has secured funding of £13.1m (non-commercial loan) to implement Electronic Patient Records (EPR). The funding was agreed in quarter 2 of 2017/18.

Capital	Actual 2013/14 £'000	Actual 2014/15 £'000	Actual 2015/16 £'000	Actual 2016/17 £'000	Actual 2017/18 £'000	Plan 2018/19 £'000
Ongoing replacements	6,216	6,473	6,815	7,421	11,559	14,153
Estates Strategy	-	-	108	7,909	5,227	5,500
IT Strategy	-	-	2,390	819	2,173	1,047
Total	**6,216**	**6,473**	**9,313**	**16,149**	**18,959**	**20,700**

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. The cash balance increased in 2017/18 due to the large surplus and as a result of the national sustainability and transformation fund.

Cash	Actual 2013/14 £,000	Actual 2014/15 £,000	Actual 2015/16 £,000	Actual 2016/17 £,000	Actual 2017/18 £,000	Plan 2018/19 £,000
Total	408	5,265	1,470	7,025	8,070	10,040

Goal 5 - to be fit for the future

Our objective to be fit for the future set out the things we would do, many in collaboration with stakeholders and partners to ensure the future provision of health and care services to the people of Bolton and the surrounding area. We have made good progress in developing relationships with other organisations and set out our shared view of the future for Bolton in the Bolton Locality Plan – this is available online at:

www.boltonccg.nhs.uk/media/3027/bolton-locality-plan.pdf

Our relationship with the Local Authority and CCG in Bolton has matured and we are making good progress towards an Integrated Care Organisation within in which we will play a significant part.

We also continued our work with other Trusts in the North West Sector of Manchester and in particular with Wrightington, Wigan and Leigh NHSFT with whom we are starting to develop close collaborative links in order to improve the resilience of the workforce and therefore sustain services for local people.

The Trust also plays a full and important part in the wider Greater Manchester Health and Social Care partnership to develop the best possible services for the populations we serve.

Performance Analysis

Environmental impact

Sustainability

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of our social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions.

A vast amount of carbon management and reduction work is already underway at Bolton NHS Foundation Trust.

The Trust partnered with Breathe Energy Ltd for a 15 year guaranteed carbon and energy reduction contract to implement various carbon and energy saving measures within Bolton Hospital. The construction of these measures began in 2016 and was completed during 2017/18.

The measures include:

- New Bore Hole water supply and treatment
- Installation of a new gas steam boiler to replace two coal boilers
- Installation of a 1.2MW Combined Heat & Power Plant
- Replacement of failed Steam Traps
- Conversion of Calorifiers to Plate Heat Exchangers
- New LED street lighting

Bolton Hospital has a complex energy infrastructure and utilises steam as its main heat medium for hot water and building heating systems. Steam is also provided to the Hospitals steam infrastructure from a waste heat boiler owned and operated by SRCL who convert clinical waste incineration to steam energy.

Utility Cost and Consumption

	2017/18		2016/17	
Utility	Cost £	Consumption	Cost £	Consumption
Gas	499K	20,743,567 KWh	367k	11,643,278 KWh
Electricity from CHP	50k	1,845,441 KWh	N/A	N/A
Electricity	1,070k	11,750,518 KWh	1,392k	15,655,386 KWh
Water	599k	229,754 m^3	362K	157,562 m^3
Coal	0	0	52K	485 tonnes

The Trust started to benefit from carbon and energy savings from some of these measures in 2016/17. Approximately 125 tCO2e were saved from being produced from the replacement of steam traps in November 2016. Further carbon savings were made in the replacement of fuel to generate steam by the change from coal to gas boilers.

Performance Analysis

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.

All Trust policies include a monitoring section detailing how and where the application and effectiveness of each policy is overseen. For example, the Audit Committee have oversight of policies relating to anti bribery and corruption and the Workforce Assurance and Workforce Operational Committees play a key role in ensuring the Trust act as a fair and equitable employer. 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.

The Trust does not have any overseas operations

This performance report was approved by the Board of Directors on 24th May 2018

Signed on behalf of the Board

Jackie Bene
24th May 2018

The Following Accountability Report of this annual report comprising the following sections:

- Director's Report
- Remuneration Report
- Staff Report
- Code of Governance Disclosures
- NHSI Single Oversight Framework
- Statement of Accounting Officer's Responsibilities
- Annual Governance Statement

Was approved by the Board on 24th May 2018

Dr Jackie Bene

Chief Executive Bolton NHS foundation Trust

24th May 2018

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.

David is a Non-Executive Director of Crown Commercial Services; he also acts as a member of the Board of Ofqual and is the Chair of Leverhulme Academy Trust in Bolton. These appointments were 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.



Trish Armstrong-Child - Director of Nursing/Deputy Chief Executive 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.

Trish became the Deputy Chief Executive in June 2017.



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.

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



Annette Walker – Director of Finance

Annette was appointed as Director of Finance in 2017.

Annette has worked in the NHS since 1993 after graduating from Liverpool University with a degree in economics. She started her NHS career as a finance trainee and qualified as a chartered public finance accountant in 1997. She has held various NHS finance roles within Greater Manchester and Lancashire and has worked in Bolton since 2008, having been the Director of Finance of Bolton PCT and latterly the Chief Finance officer of Bolton Clinical Commissioning Group

James Mawrey – Director of Workforce



James has worked in the NHS since 2000 after graduating from Strathclyde Business School with a Master's degree in Business & Management. James is a qualified member of the Chartered Institute of Personal & Development and has held Senior HR roles in North Wales, Cheshire & Merseyside and on the Greater Manchester footprint. James has a passion for developing people and teams and provides Executive leadership for Workforce & Organisational Development.

Simon Worthington (ACCA) – Director of Finance and Deputy CEO (Feb 2013 – June 2017

Simon 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.

Mark Wilkinson - Director of Strategic and Organisational Development (on secondment to NHSI since July 2017)

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. Also Chair of the Trust's subsidiary company iFM Bolton.

Mark 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 is the nominated NED for whistle blowing.

Andrew Thornton



Andrew joined the Board as an interim Non-Executive in August 2014 and was reappointed in August 2017. 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 uses this experience and ethos to Chair the Trust's Quality Assurance Committee.

Andrew will take on the role of Vice Chair with effect from 1st April 2018



Jackie Njoroge – Chair of Audit Committee appointed September 1st 2016.

Jackie describes herself as a data geek and is therefore ideally suited to her role with us as Chair of our Audit Committee. She will be managing this alongside her full time role as Director of Strategy at Salford University and an additional part time role as Chair of Audit at Greater Manchester Waste Authority. Jackie started her career in finance on a national graduate traineeship with British Steel; she spent seven years working in finance in the steel industry before moving to the education sector, initially in the North East and more recently in Manchester and Salford.

Allan Duckworth - appointed January 2013, re-appointed in January 2016



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).

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

Ann Gavin Daley



Ann joined the Board in 2015. She 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.

Bilkis Ismail

Bilkis is dual qualified as a barrister and chartered tax adviser with experience of working in the private sector (both nationally and internationally), central government and local government.



Bilkis has experience of advising clients on the constitution of their boards, corporate governance issues and remuneration arrangements. Bilkis is keen to use her professional legal and tax experience combined with her commercial awareness and strategic business planning for the benefit of the Trust.

Bilkis is a Councillor for the Crompton ward of Bolton and sits on a number of panels, committees and working groups including as a non-executive director of Bolton at Home and Chair of the Corporate and External Scrutiny Committee. She is also a community governor at Valley Community School and joined the Corporation of Bolton Sixth Form College as a governor in March 2017.

Neal Chamberlain (term of office ended September 2017)

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.

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. The register is available on our website within the declarations section (updated every six months); access to the register can also be obtained on request from the Trust Secretary.

Political donations

The Trust does not make any political donations and has no political allegiance

Overseas Operations

The Trust does not have any overseas operations

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 33.

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

The income from car parking is £1,445k and the costs associated with this income is £1,317k

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 2016/17and 2017/18. The Trust has shown an improvement from 2016/17 in regard to % paid within terms however performance is still below the target.

	Year ended 31 March 2018		Year ended 31 March 2017	
	Number	£'000	Number	£'000
Total non-NHS trade invoices paid within the target	36,340	101,159	24,362	82,828
Total non-NHS trade invoices paid in the period	63,776	144,028	64,178	132,756
Percentage of non-NHS trade invoices paid within the target	57%	70.2%	38%	62.4%
Total NHS trade invoices paid within the target	998	12,177	589	9,079
Total NHS trade invoices paid in the period	2,715	30,095	2,528	30,803
Percentage of NHS trade invoices paid within the target	36.8%	40.5%	23.3%	29.5%

Statement of Emergency Preparedness Resilience and Response (EPRR) Performance:

The trust continues to provide assurance to governing bodies and meet its statutory commitment to emergency preparedness resilience and response. (EPRR)

- Achieved SUBSTANTIAL compliance level in the annual NHS England Core Standards.
- Overall EPRR risk rated as LOW following internal Audit by PwC

As well as continued multi-agency liaison and co-operation across Greater Manchester the trust maintains an annual work plan of testing, exercising and review to continually improve it emergency response. This is achieved by the delivery of training that ranges from individual and local departmental sessions to larger multi-agency events such as:

- Counter-terrorism exercise SHERMAN March 2017
- Outbreak exercise OVIDIOUS March 2017
- Regional major incident exercise SOCRATES March 2017.
- Business continuity exercise FERRANTI April 2017
- Communications exercise STARLIGHT August 2017
- Trust live major incident Exercise THORN September 2017

The Trust major incident response was activated and tested in real time following the Manchester Arena incident on 22nd May 2017. Prior testing and exercising of the major incident plan helped staff to ensure patient care was delivered professionally and with a high level of quality and compassion to those patients in most need on that evening. The excellent response by Bolton NHS Foundation Trust staff has been recognised at local and national level including a civic reception for responders hosted by the Lord Mayor of Manchester, letters of commendation from the Prime Minister and NHS England. Trust staff were also presented with a Pride of Britain award collected as a multi-disciplinary team on behalf of all Manchester medical and EPRR staff.

Learning from this event and all other exercises and incidents is reviewed and used to inform, update and improve future trust response.

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.

Statement of accounts preparation

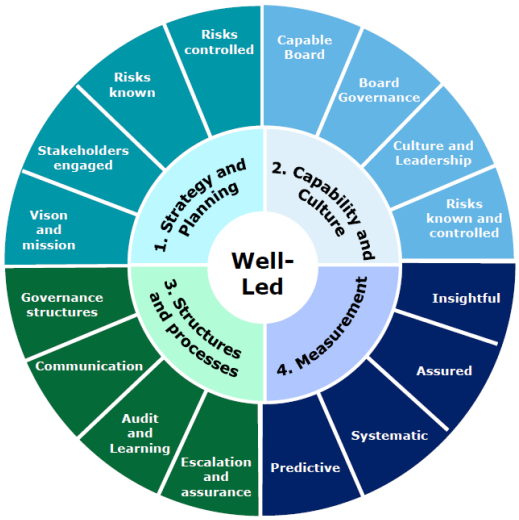
The accounts have been prepared under direction issued by Monitor, the independent regulator for Foundation Trusts, as required by paragraphs 24 and 25 of Schedule 7 to the National Health Service Act and in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

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

Quality Governance

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

In January 2017, the Board commissioned an external review using the "Well Led" Framework; this assessment covers the categories identified in the Quality Governance Framework. Deloitte LLP conducted the review – a summary of their findings is provided below.



Strategy

Board Members are consistent as to what the key strategic priorities are for the organisation and have refreshed the priorities for the organisation in partnership with key local stakeholders through the Locality Plan. Effective monitoring and challenge of strategic delivery takes place at the Board and Committees. The BAF in use at the Trust incorporates many aspects of good practice, including use of risk appetite. We observed the Board to make effective use of this tool, through challenge of areas where risks have remained unchanged or deteriorated.

There are clear processes for risk identification and escalation, of particular note are the annual risk clinics and the Executive led Risk Management Committee, both of which we consider to be features of good practice. We found robust arrangements in place for the identification and risk assessment of cost improvement schemes. This includes oversight through the Directors of Medicine and Nursing, and routine tracking of quality impact of schemes through meetings with divisions.

Many supporting strategies have been refreshed over the past year, however, it is widely felt that more work is required to develop implementation plans to support delivery of the People Strategy.

Engagement with commissioners, governors and other key stakeholders on strategy and the operational plan has been thorough, as was the work to engage over 1000 staff in the refresh of the Trust's values.

Capabilities and Culture

The nature of challenge and debate taking place at the Board, is robust, value adding and strategic in nature.

The Board is also a notably stable and cohesive entity, with little turnover in key positions over recent years. This is widely considered to have enabled the fostering of a consistent leadership culture within the Trust, and is felt to be a key factor in the organisations success.

Whilst we consider the Board to be made up from a broad and highly skilled group of individuals, with experience from across a range of sectors, there remains scope to seek to increase the diversity of the Board to more closely align its make up to that of the local population.

We found high levels of clinical engagement at the Trust, fostered by effective clinical leadership from the Director of Nursing, Medical Director and CEO.

There is a positive culture in relation to encouraging the raising of concerns and reporting of incidents. This is accompanied by clear reporting and escalation in relation to quality and safety through the Clinical Governance and Quality Committee, the QAC and ultimately the Board.

There are numerous examples at Board and committee level of reporting and analysis being used to identify areas for quality improvement and the effective tracking of actions to address these.

Process and Structure

We found Board committees to be consistently well chaired and effective, particularly in relation to escalation reporting from committee chairs to the Board.

Committee structures are clearly articulated, with very little duplication evident in current arrangements.

There is, however, scope to strengthen the assurance structures and reporting arrangements in place in relation to the workforce agenda, as it does not receive sufficient focus through current structures.

The Trust's performance management framework, known as IPM, is considered as a key factor in the Trust's success. We found it to be consistently applied and to work effectively in setting clear accountabilities, whilst also enabling delegation of autonomy to divisional teams.

Patient stories are used effectively at Board, committee and divisional level, not only to provide and set context, but also to identify and drive areas for improvement.

Engagement with staff is felt to be highly effective; this is reflected by positive staff survey results and the high degree of visibility of the Executive Team when compared with other Trusts.

Governors were overwhelmingly positive about the engagement they receive from the Board and the support they are provided with, through invitation to a number of key Trust fora to enable them to discharge their roles.

Measurement –

The Board receives clear performance reporting information via a monthly Integrated Performance Report. This includes many aspects of good practice, including good use of graphical and trend analysis and use of benchmarking where available.

The Board also use more innovative information such as ward heat maps across a range of quality metrics. We observed these to be used effectively in practice to inform Board service visits and to drive discussion and debate.

Data quality is an acknowledged area for improvement at the Trust and the Board are taking a number of steps to address this, for example through provision of support to the Business Intelligence Team.

The main recommendations arising from the Well Led review were with regard to ensuring a robust process for Workforce Assurance. The Trust responded to the review by establishing a new Workforce Assurance Committee.

For further details on Quality Governance please refer to the Quality Report and to the Annual Governance Statement.

There are no material inconsistencies between the Annual governance Statement, the Corporate Governance Statement, the Quality Report and the Annual Report.

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 76.

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 continue to 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.

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

Involvement in local initiatives

In addition to working with other hospitals in the North West sector of Greater Manchester, we are also working with colleagues in primary care, the CCG and social care to ensure we deliver the best possible services for the future health of the people of Bolton.

The Bolton Locality Plan sets out our shared vision to transform local health and care services. This plan formed the basis of Bolton's bid to Greater Manchester Health and Care Transition Fund to help transform such things as healthy lifestyles activity, primary care services, IT infrastructure and public engagement.

Partners in Bolton's Health and Social Care system have been awarded £28.8m transformation funding over the next three years to help improve health and wellbeing in local communities. It is a very significant investment in health and social care across Bolton, and is welcomed as it should help to address many of the pressures which the system is currently facing. The investment will be used to help make the changes which we need to support more people to stay well and be supported within their communities.

Consultation with local groups and organisations

We attend regular meetings with the Health and Wellbeing Board, our local HealthWatch and the 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.

Remuneration Report

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 2017/18. 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 - 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.



David Wakefield

Trust Chairman

April 2018

Remuneration Report

Board Nomination and Remuneration committee

The Board Nomination and Remuneration Committee met six times during the reporting period to consider the appointment, performance and remuneration of the Executive Directors. The Chief Executive 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	5/5
Neal Chamberlain	2/3
Allan Duckworth	4/5
Ann Gavin Daley	5/5
Mark Harrison	3/5
Jackie Njoroge	4/5
Andrew Thornton	4/5
Bilkis Ismail	2/2
Dr Jackie Bene	5/5
Esther Steel	5/5

Executive Remuneration

In 2017/18 the Committee were acutely aware of the financial context of both the local and national health economy and all decisions on remuneration reflected the current financial climate.

Two new executive directors were appointed during 2017/18, Annette Walker was appointed to replace Simon Worthington as Director of Finance and James Mawrey was appointed as Director of Workforce. The Nomination and Remuneration Committee also approved the appointments to the Board of iFM Bolton. The Trust used the services of Odgers and Berndtson to support the appointment of the Director of Workforce.

Benchmarking has been 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.

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.

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 is paid more than £150,000 per anum, 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 holder.

At the time of reporting the Committee are overseeing the appointment of a new Director of Strategic Transformation and a new Medical Director.

Remuneration Report

Governor Nomination and Remuneration Committee

The Governor Nomination and Remuneration Committee met three times during 2017/18:

- To receive the outcomes of NED appraisals.
- To appoint a new Non-Executive Director to replace Mr N Chamberlain
- To discuss succession planning and agree the process for Non-Executive appointments in 2018/19.
- To extend the appointment of Mr D Wakefield for one additional year – the Governors were aware that this would take Mr Wakefield to a total of seven years but felt this would ensure a robust succession plan.

Non-Executive Director Appointment

In 2017, Neal Chamberlain decided to step down at the end of his three year tenure to focus on a new substantive role, the Governor Nomination and Remuneration Committee oversaw the process to appoint his successor. Following an open advertisement including NHS jobs and social media and culminating with interviews with a panel of governors, Bilkis Ismail was formally appointed by the full Council of Governors in August 2017 and started with the Trust on 1st September 2017.

Performance Evaluation

During 2017/18, the performance of the Board as a whole and the Board committees was reviewed by Deloitte LLP as part of the Well Led Review.

The Chairman reviewed the performance of the Chief Executive and each of the Non-Executives through the Trust appraisal process, the Chief Executive reviewed the performance of the Executive Directors and the Senior Independent Director reviewed the performance of the Chairman

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.

Remuneration Report

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 reviewed in 2017/18 and Governors approved a 1% uplift in line with the offer to Agenda for Change staff. Governors also approved the award of an additional payment to the Chairs of the Finance and Investment and Quality Assurance Committees to recognise the additional time requirements to fulfil these key roles.

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 2017/18 salary scales for Executive Directors were agreed following a review of salary data provided by the NHS Providers.

Expenses paid to governors and directors

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

	Directors		Governors	
	17/18	16/17	17/18	16/17
Total number of Directors/Governors in office	20	14	37	38
Number of Directors/Governors receiving expenses	14	11	0	6
Aggregate sum of expenses	£10,012.48	£5,702.8	£0	£408

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, 24th May 2018.



Remuneration Report

		2017/18						2016/17					
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	-	-	-	-	60 - 65	60 - 65	-	-	-	-	60 – 65
Dr J Bene* Chief Executive	From 22/06/13	205 - 210	-	-	-	140.0 - 142.5	345 - 350	195 - 200	-	-	-	85.0 – 87.5	280 – 285
Mrs T Armstrong-Child Director of Nursing	From 13/05/13	135 - 140	-	-	-	172.5 – 175.0	310 - 315	115 – 120	-	-	-	87.5 – 90.0	205 – 210
Mr A Ennis Chief Operating Officer	From 01/01/14	115 - 120	-	-	-	145 - 147.5	260 - 265	115 – 120	-	-	-	92.5 – 95	210 – 215
Mr S Hodgson* Medical Director	From 01/09/13	175 - 180	-	-	-	35.0 - 37.5	215 - 220	175 – 180	-	-	-	37.5 – 40.0	215 - 220
Mr J Mawrey Workforce Director	From 05/02/18	15 - 20	-	-	-	20.0 - 22.5	35 - 40						
Mrs A Walker Director of Finance	From 17/07/17	90 - 95	-	-	-	140.0 - 142.5	230 - 235						
Mr S Worthington Director of Finance	18/02/13 – 30/06/17	40 - 45	-	-	-	65.0 - 67.5	105 - 110	160 – 165	-	-	-	72.5 – 75.0	230 – 235
Mr M Wilkinson Dir Strategic & Org Development	4/8/14 – 02/07/17	30 - 35	-	-	-	47.5 - 50.0	75 - 80	120 – 125	-	-	-	52.5 – 55.0	170 – 175
Non Executive Directors													
Mr N Chamberlain	1/10/14 – 30/09/17	5 - 10	-	-	-	-	5 - 10	10 - 15	-	-	-	-	10 - 15
Mrs C A Davis	01/09/11 – 31/08/16							5 - 10	-	-	-	-	5 - 10
Mr A Duckworth	From 01/01/13	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Mrs A Gavin Daley	From 01/08/15	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Dr M Harrison	01/04/12 – 31/03/18	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Ms B Ismail	From 01/09/17	5 - 10					5 - 10						
Mrs J Njoroge	From 01/09/17	10 - 15	-	-	-	-	10 - 15	5 - 10	-	-	-	-	5 - 10
Mr A Thornton	From 1/10/14	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15

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

Total Pension Entitlement

Name	Real increase in pension sum at pension age	Real increase in lump sum at pension age at 31 March 2018	Total accrued pension at pension age at 31 March 2018	Lump sum at age 60 related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2018	Real Increase in Cash Equivalent Transfer Value funded by Employer	Cash Equivalent Transfer Value at 31 March 2018	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	
Jacqueline Bene	5.0 - 7.5	7.5 - 10.0	75 - 80	210 - 215	1,325	134	1,472	
Stephen Hodgson	0 - 2.5	2.5 - 5.0	55 - 60	165 - 170	1,204	94	1,311	
Simon Worthington	0 - 2.5	minus	60 - 65	160 - 165	1,014	24	1,118	
Patricia Armstrong-Child	7.5 - 10.0	15.0 - 17.5	50 - 55	135 - 140	644	161	811	
Andrew Ennis	5.0 - 7.5	17.5 - 20.0	50 - 55	160 - 165	903	182	1,093	
Mark Wilkinson	0 - 2.5	0 - 2.5	50 - 55	130 - 135	819	76	903	
Annette Walker	2.5 - 5.0	7.5 - 10.0	35 - 40	95 - 100	481	83	608	
James Mawrey	0 - 2.5	0 - 2.5	20 - 25	50 - 55	247	5	281	

Figures for 2017 have been restated

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.

Staff Report

Introduction

An organisation can only ever be as good as the people who work in it. Our goal for Bolton people therefore remains 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.

The People Strategy will be refreshed during 2018 with a Workforce & Organisational Development Strategy. This will articulate the Trust's vision for a healthy organisational culture and a sustainable and capable workforce working in an integrated manner with partners.

The Human Resources & Organisational Development department continue to monitor the key characteristics of the workforce to inform the workforce strategy and departmental planning. The department continues to ensure alignment of the Trust clinical workforce with the delivery of care, based on both demand/flow and demographics/acuity.

Optimising leadership skills and potential remains essential and as such we continue to develop and improve our Leadership and Management offering. The Trust's values continue to be embedded in HR processes including recruitment, appraisal, remuneration and training.

We recognise that a stronger focus on enhancing the wellbeing of our workforce is required as the level of staff sickness has been increasing. In line with the Health & Wellbeing plan the Trust's flu vaccination rate for front line staff continued to improve and over 75% of our frontline staff received the vaccination in 2017/18. The Trust's vacancy rate is reported to the Board Committees and our rates remain low when compared to peer NHS organisations.

The main anticipated changes to the shape of the Workforce are as follows:

1. Medical staffing levels have increased over recent years, specifically within the consultant level positions. Whilst this increase has slowed, it is anticipated that consultant numbers will be maintained. Generally the Trust does not have significant problems in recruiting into senior positions although for a few 'hard to fill' areas bespoke plans are in place. The Trust has a range of measures in place in order to mitigate the anticipated reduction in Junior Doctors in this time period
2. The nurse vacancy rate remains low when compared to peer organisations. Recruitment of nurses has not traditionally been a problem for the Trust and a comprehensive recruitment and retention plan is in place.
3. Non-medical staffing is projected to reduce with reductions in administrative staff as systems and efficiencies become leaner and more streamlined, taking advantage of enabling technologies

A sharper focus on delivering the Health and Wellbeing Plan is required as staff sickness remains high at 5.15%, against a tolerance level of 4.2%. The chart below shows the percentage of FTE days lost to sickness during 2017/18.

The Trust remains committed to ensuring staff are regularly appraised and receive all of the required training to ensure they continue to be safe and effective in their roles. The Trust sets a stretch appraisal target of 85% and for the majority of 2017/18 rates have been within 2-3% of this stretch target. Mandatory training compliance levels are high at over 90%.

Staff Report

Staff costs

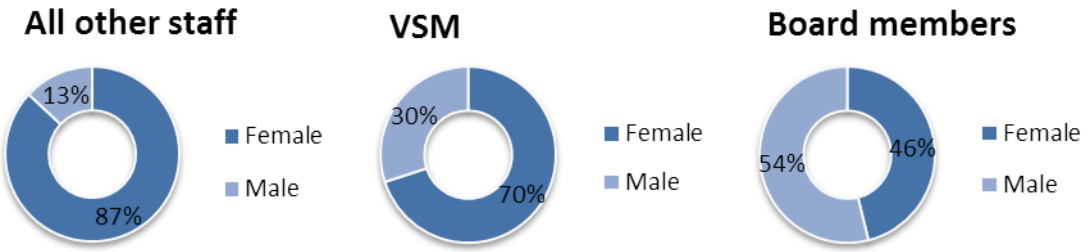
	Total £000
Salaries and wages	180,931
Social security costs	16,912
Apprenticeship Levy	835
Pension costs	20,126
Termination benefits	35
Temporary staff - agency/contract staff	10,274
TOTAL GROSS STAFF COSTS	**229,114**
Less Costs capitalised as part of assets	1,689
TOTAL STAFF COSTS	**227,425**

Staff numbers – by professional group (average full time equivalent)

	2017/18			2016/17		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	**520**	491	29	**501**	471	30
Ambulance staff	**0**			**0**		
Administration and estates	**1,253**	1,182	71	**1,109**	940	169
Healthcare assistants and other support staff	**1,065**	933	132	**905**	902	3
Nursing, midwifery and health visiting staff	**1,784**	1,687	97	**1,726**	1,643	83
Scientific, therapeutic and technical staff	**811**	787	24	**820**	791	29
Total average numbers	**5,433**	**5,080**	**353**	**5,061**	**4,747**	**314**

Number of employees (WTE) engaged on capital projects		54			20	

Staff groups by gender 2017/18

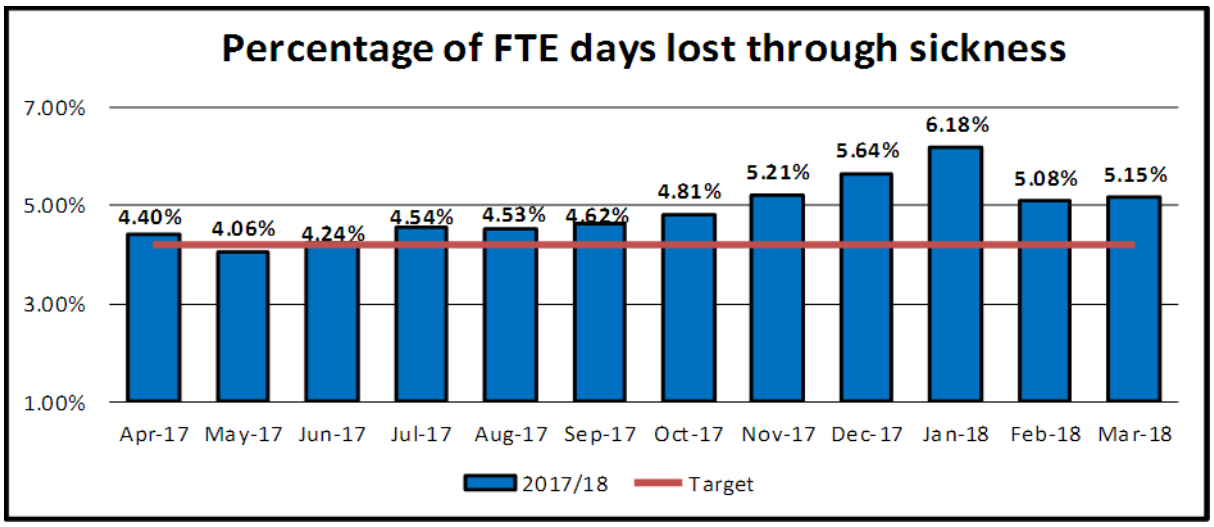


Sickness absence data

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 2017/18.



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:

We actively encourage applications from disabled individuals in accordance with the Equality Act 2010. As an organisation we are committed to employ, keep and develop the abilities of disabled staff and this is reflected in our Recruitment and Selection policy. During the recruitment process, we are committed to making adjustments where necessary. Candidates who have declared a disability need only to meet the essential criteria to be guaranteed an interview. The Resourcing Team ensure that any direct or indirect reference to discrimination is removed from all application forms and that equality and diversity information is removed from the shortlisting process.

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 is committed to supporting staff to remain in work and have a Supporting Staff with Disabilities policy which is used for both newly recruited employees with a disability who make their needs known at the recruitment stage and those staff who are currently employed by the Trust who become disabled whilst in employment. The policy ensures that NHS guidance, advice and necessary training is provided to managers.

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 continues to take many forms: we have a weekly bulletin, a monthly staff newsletter ('Our VOICE') and a monthly face to face team brief, alongside team meetings that cover a variety of practice-based topics. The Trust has implemented a range of innovative programmes as part of the Board's commitment to 'listen and act', including the Chief Executive's 'Listening lunches', divisional road shows and engagement meetings with staff. These meetings have proved extremely popular with staff as a means of both raising issues and keeping up to date with relevant information. To complement this 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 periods of transition, communication with staff is seen as a priority to ensure that all staff are fully informed at each step of the development, as well as being part of the on-going consultation process. The Trust will continue to engage, consult and work positively with staff side to foster true partnership working and ensure that the Trust and its employees are able to move forward and meet the challenges ahead.

The Trust has a number of formal vehicles where management and staff side meet to deal with employee relations issues, namely:

- The Joint Negotiation and Consultative Committee (JNCC), which meets monthly.
- The divisions have collaborative meetings which meet monthly and deal with pressing local issues within the divisions that can be dealt with quickly to enable good working relationships.
- The Local Negotiating Committee (LNC), which meets quarterly with local and regional medical representatives to discuss the strategic overview for the medical workforce, policies, workloads, clinical excellence awards, rotas, recruitment and junior doctors.

Facility Time

Facility time is time off from an individual's job, granted by the employer, to enable a rep to carry out their trade union role. In some cases, this can mean that the rep is fully seconded from their regular job, enabling them to work full time on trade union tasks.

Facility time covers duties carried out for the trade union or as a union learning representative, for example, accompanying an employee to disciplinary or grievance hearing. It also covers training received and duties carried out under the Health and Safety at Work Act 1974

In accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017 which took effect on 1 April 2017 the tables below which have been approved by our chair of Staffside provide information on facility time within the Trust.

Number of employees who were relevant union officials during 2017/18

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
8	8

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	6
51%-99%	1
100%	1

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	*Figures*
Provide the total cost of facility time	161,147.58
Provide the total pay bill	227,425,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.07%

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100* The Trust supports funded seconded release for staff representatives and therefore trade union activities are included in the facility time above and not differentiated.

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 2017/18 include:

- Involvement of clinical & non-clinical staff in 'Perfect Week' events in acute and community settings
- Involvement of clinical staff and partners from Bolton Council and Bolton CCG in a one day accelerated discharge event in March 2018
- Use of our Staff friends and family survey data in local sessions with teams to strengthen engagement and improve the staff experience

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 has been had one enforcement notice issued to the Trust by the Health and Safety Executive (HSE) during the reporting period (Microbiology). With the measures being taken this enforcement action was closed by HSE in August. Information on policies and procedures with respect to countering fraud and corruption

Measures to avoid 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 Report

Staff Survey

Summary of Performance –2017 NHS Staff Survey

Our response rate in the most recent Staff Survey is shown below:

	2016/17	**2017/18**		**Improvement/ Deterioration**
Response Rate	Trust	Trust	National Average	
	36.6%	**42.8%**	**40.4%**	Improvement

Overall, the results of the 2017 Staff Survey show a positive picture at Bolton NHS Foundation Trust. Many of the Trust's scores are significantly better than that of the sector, at question level and for four of the Key Findings. In addition, the Trust scores within the top 20% range of Acute and Community Trusts on many of the questions.

Our main changes from 2016 to 2017 have been as follows:

- Our overall Staff Engagement score has dipped slightly from 3.87 (2016) to 3.85 (2017). This is slightly higher than the sector score of 3.82.
- **2** key finding scores have shown **significant improvement** since 2016

  - KF15 % of staff satisfied with the opportunities for flexible working patterns

  - KF28 % of staff witnessing potentially harmful errors, near misses or incidents in last month
- 1 key finding score has shown significant decline since 2016

  - KF3 % of staff agreeing that their role makes a difference to patients/service users

	2016/17	**2017/18**		**Improvement/ Deterioration**
Top 5 ranking Key Findings	Trust	Trust	National Average	
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	**20%**	**24%**	Improvement
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.95	**3.90**	**3.73**	Deterioration
KF7. Percentage of staff able to contribute towards improvements at work	73%	**75%**	**70%**	Improvement
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	63%	**49%**	**53%**	Improvement
KF8. Staff satisfaction with level of responsibility and involvement	4.02	**4.01**	**3.89**	Deterioration

	2016/17	**2017/18**		**Improvement/ Deterioration**
Bottom 5 ranking Key Findings	Trust	Trust	National Average	
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	**3%**	**2%**	No change
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	16%	**15%**	**14%**	Improvement
KF24. Percentage of staff / colleagues reporting most recent experience of violence	74%	**66%**	**67%**	Deterioration
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	94%	**90%**	**90%**	Deterioration
KF16. Percentage of staff working extra hours	68%	**70%**	**71%**	Deterioration

Future Priorities and targets

- Our focus on strengthening Staff Engagement will continue during 2017-18, prioritised around embedding our new Trust Values model and using appropriate metrics to support improving the staff & patient experience
- We are again confident that our comprehensive Trust Action Plan will address the priority areas where our Survey scores have decreased; we will be developing specific engagement plans for 4 areas of the Trust that need particular support
- Our People Strategy now contains a 'Developing our Culture' theme; we have a range of initiatives planned that will reflect our continued journey towards a high-performance values-based healthcare organisation,

Expenditure on consultancy

Expenditure on Consultancy related spend was £0.2m in 2017/18

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 tables below provide detail of off-payroll engagements of more than £245 per day lasting for longer than six months

Existing off-payroll engagements as of 31 March 2018

No. of existing engagements as of 31 March 2018.	0
No. that have existed for less than one year at time of reporting.	0
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.	0
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

New off-payroll engagements and those that reached six months in duration between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	
Of which...	
Number assessed as within the scope of IR35	
Number assessed as not within the scope of IR35	
Number engaged directly (via PSC contracted to trust and are on the Trust's payroll	
Number of engagements reassessed for consistency/assurance purposes during the year	
Number of engagements that saw a change to IR35 status following the consistency review	

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

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

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce

	2016/17	2017/18
Highest paid director salary - (J Bene – includes consultant post and CEA	196,950	206,928
Median Salary	28,462	28,746
Median Salary Ratio	6.92	7.20
Employees receiving remuneration in excess of the highest paid director.	0	0
Remuneration range	6-197	8 - 207

The median salary ratio increased following an incremental pay award to the CEO.

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	
	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17
<£10,000			15	16	15	16	35	61
£10,001 - £25,000				3		3		40
£25,001 - 50,000		1				1		28
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Total	**0**	**1**	**15**	**19**	**15**	**20**	**30**	**129**

Exit packages: non-compulsory departure payments

Exit packages: other (non-compulsory) departure payments - 2015/16	Number of Payments agreed		Total value of agreements £000	
	17/18	**16/17**	**17/18**	**16/17**
Voluntary redundancies including early retirement contractual costs	3	7	9	28
Mutually agreed resignations (MARS) contractual costs		2		26
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	12	10	26	46
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval				
Total	**15**	**19**	**35**	**101**
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 2017/18.

Code of Governance Disclosures

Statement of Compliance with the Code

Bolton NHS Foundation Trust has applied the principles of the NHS Foundation Trust 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 15th 2018 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. A rolling bi-monthly programme is in place for Governors to meet with each Executive Director 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 agreed to focus on member engagement during 2017/18 and looked at engagement with members through the Newsletter and membership events. The Committee also discussed wider public engagement particularly around the topic of ensuring appropriate attendance at the Trust's Accident and Emergency Department.

Code of Governance Disclosures

Public Governors

Name	Area	Date Elected	End of period of office	Meeting attendance
Anne Bain	Bolton North East	October 2013	September 2019	3/5
Barbara Ronson	Horwich NE	October 2014	September 2017	2/2
Bhagvati Parmar	Bolton South East	October 2016	September 2019	3/5
Carol Burrows	Bolton South East	October 2016	September 2019	2/5
Champak Mistry	Bolton South East	October 2013	September 2019	2/5
Christopher Mealing	Westhoughton	October 2016	May 2017	0/1
Geoffrey Minshull	Bromley Cross	October 2014	September 2017	1/2
Grace Hopps	Bolton West	October 2017	September 2020	2/3
Jack Ramsay ★	Bradshaw	October 2014	September 2017	1/2
Janet Whitehouse	Bolton West	October 2014	September 2020	4/5
Janice Drake	Bolton West	October 2017	September 2020	3/3
Jim Sherrington ★	Tonge with the Haulgh	October 2013	September 2017	2/2
Kantilal Khimani	Bolton South East	October 2016	September 2019	4/5
Kate Cowpe ★	Rest of England	October 2014	September 2017	1/2
Keith McManus	Farnworth	October 2016	January 2018	0/4
Ken Hahlo	Bolton West	October 2015	September 2018	5/5
Leela Joseph	Bolton West	October 2017	September 2020	1/3
Margaret Parrish	Bolton North East	October 2016	September 2019	4/5
Mohammed Iqbal Essa	Bolton North East	October 2017	September 2020	2/3
Naveed Riaz	Rest of England	October 2017	September 2020	1/3
Oboh Achioyamen	Bolton North East	October 2017	September 2020	2/3
Pat Groocock	Bolton North East	October 2017	September 2020	2/3
Pauline Lee	Bolton West	October 2015	September 2017	1/2
Rosie Adamson-Clark	Bolton North East	October 2017	September 2020	1/3
Sorie Sesay	Bolton South East	October 2013	September 2019	3/5

Staff Governors

Name	Area	Date Elected	End of Period of Office	Meeting Attendance
Dipak Fatania	All other staff	October 2013	September 2019	3/5
Tracey Holliday	Nurses and Midwives	October 2014	September 2020	2/5
Sarah Hulme	All other staff	October 2015	September 2018	3/5
Janet Roberts ★	Nurses and Midwives	October 2013	September 2019	1/5
Martin Anderson	AHPs and Scientists	October 2017	September 2020	3/3
Dan Hindley	Doctors and Dentists	October 2014	September 2017	0/2

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

Code of Governance Disclosures

Appointed Governors

Name	Representing	Date Appointed	Meeting Attendance
Shashkiant Merchant	Bolton Healthwatch	July 2016	1/2
Jim Sherrington ★	Bolton Healthwatch	October 2017	3/3
Jane Howarth	Bolton University	July 2014	0/5
Dawn Hennefer	Salford University	September 2014	1/5
Susan Howarth	Bolton Metropolitan Borough Council	April 2014	1/5
Debbie Newall	Bolton Metropolitan Borough Council	July 2016	2/5
Samir Naseef	Bolton Local Medical Committee	November 2012	0/5
Darren Knight	Bolton Local Council for Voluntary Services	May 2016	5/5
Leigh Vallance	Bolton Local Council for Voluntary Services	July 2014	4/5

Elections to the Council of Governors were held according to the constitution in September 2017. Results were as reported below.

Seat	Turnout	Governor Elected
Bolton North East	23.1%	Rosie Adamson-Clark Mohammed Iqbal Essa Pat Groocock Oboh Achioyamen
Bolton West	26.1%	Grace Hopps Janice Drake Leela Joseph Janet Whitehouse

The following seats were uncontested in the 2017/18 elections:

- AHPs and Scientists
- Rest of England

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 2017/18, 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 appointments with Ofqual, Crown commercial Services and the Leverhulme Academy.

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.

Regular training sessions are provided for Governors to ensure they gain a full understanding of the role. In February 2018, the Trust also arranged a training session for 100 Governors from across the North West to provide an opportunity for networking and shared development.

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.

Attendance at Board of Director meetings	
David Wakefield	12/12
Trish Armstrong Child	9/12
Jackie Bene	12/12
Neal Chamberlain	4/5
Allan Duckworth	10/12
Andy Ennis	12/12
Ann Gavin Daley	12/12
Mark Harrison	7/12
Steve Hodgson	11/12
Jackie Njoroge	10/12
Andrew Thornton	10/12
Mark Wilkinson	3/3
Simon Worthington	3/3
Esther Steel	12/12
Bilkis Ismail	7/7

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.

Code of Governance Disclosures

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.

As referred to elsewhere in this report, Deloitte LLP undertook a "Well Led" review of the Trust in 2017.

The external advisors used during 2017/18 have no other connections to the Trust.

Audit Committee

The Audit Committee met on five occasions during the period April 1st 2017 and March 31st 2018.

Audit Committee Attendance	
Members	
Jackie Njoroge	5/5
Ann Gavin Daley	5/5
Neal Chamberlain	3/3
Bilkis Ismail	1/1
Attendee	
Simon Worthington	2/2
Annette Walker	3/3
Esther Steel	5/5

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 2017 and March 31st 2018 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.

Chair of the Audit Committee

In September 2016, the Council of Governors appointed Jackie Njoroge to chair the Audit Committee.

The Chair of the Audit Committee presented the Annual Report of the Audit Committee to the Board of Directors in November 2017.

Code of Governance Disclosures

Auditor Appointment

External Auditor

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 £59,504 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 2017/18.

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 65)

Code of Governance Disclosures

Membership

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. Through our members, we can really get to know what the public wants and, more importantly, act on that as our services evolve.

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. Staff working for the Trust's subsidiary company iFM Bolton are also eligible for staff membership. 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.

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

Code of Governance Disclosures

Membership Statistics

Public Constituency	
At year start (1 April 2017)	4392
At year end (31 March 2018)	4535
Staff Constituency	
At year start (1 April 2017)	5189
At year end (31 March 2018)	5299

Analysis of current public membership

Public Constituency	Number of members	Eligible membership
Age		
0 - 16	4	4,721
17- 22	108	17,122
22+	4174	203,533
Not known	249	
Ethnicity		
White	3193	226,645
Mixed	34	4,892
Asian or Asian British	600	38,749
Black or Black British	89	4,652
Other	86	1,848
Not known	533	
Socio-economic group		
ABC1	1079	15,166
C2	1258	25,822
D	987	18,471
E	1186	27,966
Not known	25	
Gender		
Male	1673	140,997
Female	2793	143,076
Not known	69	

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place.

Segmentation

Bolton NHS Foundation has been assessed as **segment 2**

This segmentation information is the trust's position as at 13th April 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	**Metric**	**2017/18**				**2016/17**	
		Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	Capital service capacity	2	3	4	4	1	1
	Liquidity	2	4	3	3	3	4
Financial efficiency	I & E Margin	1	2	3	3	1	1
Financial controls	Distance from financial plan	2	2	2	1	1	1
	Agency spend	4	4	4	2	3	3
Overall score		3	3	3	4	3	2

Statement of Accounting Officer's Responsibilities

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

The National Health Service Act 2006 (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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Bolton NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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, items of other comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- assess the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

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 such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and 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. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Signed

Jackie Bene

Chief Executive, Date…24th May 2018

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 2018 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 Policy** 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 IT and 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). If following an SI the Board feel further assurance is required an external review is commissioned – an external review has recently been commissioned by the Family Care Division to provide assurance following a number of Serious Incidents within the division. Whilst there incidents were not thought to be linked it was agreed that a proactive review would provide assurance that there are no underlying governance or quality issues which require further action.

The executive team is supported by a divisional management structure consisting of four clinical divisions. Each division is led by a triumvirate team consisting of a Divisional Director of Operations, a Divisional Medical Director and a Divisional Director of Nursing. 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 structure and content of the

Board performance report was reviewed and after extensive consultation with users of the report including Board members and operational manager a new format report will be introduced for 2018/19.

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 implementation of the Risk Management Policy, all staff are provided with appropriate training opportunities 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

Principal Risks

The significant risks in relation to the Trust's strategic objectives are described in the Board Assurance Framework. During 2017/18, the most significant risks included:

- Maintaining workforce capacity and capability and supporting the processes to deliver safe and effective care to our patients
- Delivery of the financial plan, including compliance with the agency cap
- Supporting the Urgent Care System

These risks will carry forward as significant risks into 2018/19. The Trust has put in place controls and action plans to mitigate these risks and these are described in the Board Assurance 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.

Annual Governance Statement

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. Risk Register "clinics" are available to support managers in the development and management of risk registers.

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 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 assurance framework (BAF) was in place for the period 1st April 2017 – 31st March 2018

The BAF includes a description of risk appetite for each risk to the achievement of operational objectives and additional background information including links to associated risks on the risk register and 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.

Well Led Framework

The Well Led Framework was developed as an assessment tool for Trusts to use to benchmark their arrangements for effective leadership and quality governance in four categories:

- Strategy and planning
- Capabilities and culture
- Structure and processes
- Measurement

Annual Governance Statement

In 2017, we commissioned an external review using the Well Led Framework, this provided assurance that a strong framework is in place. (Further detail can be found within the Annual Report)

Strategy and planning - 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 2016, the Trust approved and adopted a new four year Quality Strategy.

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.

Structure and process- The Corporate Governance Structure is in place to ensure clarity of reporting between wards and departments and the Board and between the Board and its supporting committees. Integrated Performance Meetings ensure clear routes of escalation to the Executive team.

The Trust has clear processes 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 – The Integrated Performance 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 during quarter four we reviewed and revised the report to enhance the information and assurance provided.

In their review of our Quality Report, although there are still issues with regard to the recording of 18 week RTT, our Auditors identified a clear improvement trajectory compared to their review of this metric for the 2016/17 Quality Report

We will continue to take action in 2018/19 to address these issues and will report on our progress to the Audit Committee. Human error in data entry is often a factor in the discrepancies in reporting, the implementation of a full EPR will be a key factor and a robust solution to data quality

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:

- The CQC conducted a full inspection in March 2016 and gave the Trust an overall rating of Good.
- Divisional reports to the Quality Assurance Committee have been framed around the domains and standards set by the CQC. We recently established a new programme of inspections with the ambition of moving from good to outstanding. In addition to this in 2016 we established an internal accreditation scheme for wards and departments. The Bolton System of Care Accreditation (BOSCA) review is now well embedded and provides an evidence based framework for quality improvement.
- A "Better Care Together" group was established to coordinate the organisational journey from "Good to Outstanding". This group is leading the actions around our Quality Improvement Strategy. The Better Care Together group also receives update on BOSCA accreditations and outcomes from our "Good to Outstanding" inspections

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. As outlined elsewhere in this statement and within the annual report, a review using the Well Led Framework was undertaken in January 2016. The feedback provided further assurance with regard to our governance arrangements and identified good practice in risk management stating that the Board were well sighted in risks and committees operate well with good debate and clear escalation, accountability and delegation.

The Well Led Review provided assurance that previous potential risks to compliance with condition four of the NHS provider licence have been effectively mitigated through the processes described within this statement.

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 team 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

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

Finance

Successful delivery of the 2017/18 financial plan gives confidence in the organisation's ability to deliver on its financial plans. A detailed operational financial plan has been prepared to support the delivery of the planned £12.7m surplus for 2018/19.

Assurance is provided by:

Internal audit - PwC were appointed as the internal auditor in June 2013, this appointment was renewed for one further year in June 2017. The audit 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 "generally satisfactory systems and controls in relation to business critical areas however there are some areas of weakness and non-compliance which potentially put the achievement of objectives at risk.

The following table summarises the internal audit reports received during 2017/18, actions have been agreed to address the recommendations identified within these reports with the higher risk findings treated as a priority.

Report	Risk rated
Assurance Framework and risk management	Low Risk
Quality Governance (blood test process	Medium
Key financial controls	Low
Finance Transformation	Low
Information Governance GDPR	High
IT Strategy	Medium
NatSSIPs	High
Agency Staffing (Cost Improvement Plans)	
iFM Business case	Low
HR Sickness absence	High
HR MAST	Medium
Business Intelligence Function	Advisory report
Inpatient Discharging	High
Capital Projects – End to End	High
iFM Assurance Framework	Medium
Reactive Planned Maintenance	High
Waste Management	High

All internal audit reports are shared with the Audit Committee and where a report is high risk the lead executive is required to attend the meeting to explain the findings and planned actions.

Information governance and Data Security

During 2017/18, there were no serious incidents relating to information governance including data loss or confidentiality breach.

The Trust recognises the importance of data security and has robust measures in place to reduce the risks from cyber-attacks including ransomware and computer viruses.

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.

The above measures provided effective protection from the "Wannacry ransomeware attack that spread rapidly through a number of computer networks in May 2017.

In 2017/18 preparations were made to ensure compliance with the new General Data Protection Regulation (GDPR) which will come into force in May 2018.

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. NHS Improvement (in exercise of the powers conferred on 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 2017/18, 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 2018/19.

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 2016 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. The external audit report on our 2016/17 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. The external audit review of 18 week data undertaken for our Quality Account in 2017 identified issues with recording, with some cases incorrectly coded as 18 week pathways and others where the case continued to be included in the submitted data after the pathway had ended.

The following actions were taken in response to these findings:

- 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

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 system of internal control. In 2017/18 we established two new committees, a Workforce Assurance Committee and a Strategic Estates Board to provide increased assurance and control on key areas.

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 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.

Workforce Assurance Committee

In October 2017, we established a new Workforce Assurance Committee to improve the Board line of sight on workforce related issues. Key duties of the Committee include:

- Developing and overseeing implementation of the Trust's People Strategy and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process
- Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce
- Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors
- Oversight of staff engagement levels as evidenced by the results of the national and any other staff surveys
- Seeking assurance to ensure that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity

Strategic Estates Board

The Strategic Estates Board was established in January 2018 to oversee the management and delivery of the Estates Strategy. The Strategic Estates Board has adopted RIBA methodology to provide assurance that robust controls are in place for the management of the Trust estate.

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

Health and Safety Committee

The Trust and iFM Bolton (iFM) currently share responsibility for and work collaboratively to ensure that that staff, visitors, patients and contractors are kept safe whilst on Trust premises. The Trust and iFM share a monthly Group Health & Safety Committee which has dual reporting responsibilities to the Trust (Risk Management Committee) and iFM (Risk Management Committee). The Trust and iFM are committed to driving H&S quality improvement through the Group Health & Safety Committee by reviewing H&S audit intelligence and ensuring that notable H&S risks are duly escalated to the Risk Management Committee. As the iFM/Trust relationship is relatively new the Trust and iFM are fully committed to continuously understanding the fine detail of collaborative relationship in respect of H&S and increasing the appreciation of the H&S challenges the organisation faces mindful of relevant legislation and regulation.'

Annual Governance Statement

Significant Internal Control Issues

The Trust identified the following internal control issues during 2017/18. These have been or are being addressed through the mechanisms described in this statement.

Formation of iFM Bolton

In January 2017 The Trust established iFM Bolton as a wholly owned subsidiary responsible for the provision of estates and facilities services to the Trust. In setting up iFM Bolton a number of control issues have been identified, including the end to end process of capital investment and the management of reactive and planned maintenance. The Trust will work with iFM Bolton to ensure sound controls are established and embedded to support the Trust's capital investment programme and ongoing management of both hard and soft facilities.

Actions taken include the formation of a new Strategic Estates Board and a review of the structure of the iFM Board.

A & E Performance

The biggest challenge for the Trust remains urgent care. In 2017/18 81.92% of patients were treated within four hours. This compares to 82.6% the year before against a target of 95%.

The Trust continues to work with the Emergency Care Improvement Programme, the CCG and Local Authority partners to improve performance against the standard. In addition the Trust is investing in the Accident & Emergency Department estate to improve the environment for patients and staff. This will address one factor in that the Department is too small to cope with the volume of patients who attend, which has increased significantly over the years

Never Events

A total of 3 Never events were reported over the financial period of 2017/18

A vaginal swab was retained following the delivery of a baby (retained foreign object)

During surgery to remove the right ovary of a patient both ovaries were removed. (Wrong site surgery)

A tissue retrieval bag was briefly retained following surgery) retained foreign object)

For each of these events the Trust undertake an investigation followed by a report to the Board of Directors and an action plan which is overseen through the Quality Assurance Committee

Conclusion

The Trust has continued to make significant improvements to the system of internal control; the CQC rating of good provides assurance of the progress made to embed quality and good governance. There are however some areas where further improvement is required. Actions are in place to address the issues leading to the control issues described and the Board are confident that there is a robust system in place to oversee the implementation of these actions.



Jackie Bene

Chief Executive Date: 24th May 2018

Bolton NHS Foundation Trust Quality Report 2017/18



Quality Report – Section One

Statement on Quality from the Chief Executive

Over the course of 2017/18 the Trust delivered a great number of achievements all of which are down to the hard work of our staff, governors and volunteers. It is worth reflecting on some of these in this introduction as it gives an opportunity for us to consider, in these challenging times, that we have much to celebrate:

The diversity of our work never ceases to amaze me, for example, during the year 17/18:

- Health visitors saw nearly 22,000 patients.
- District nurses treated over 6,000 patients.
- A&E staff cared for over 100,000 patients.
- Therapists helped nearly 47,000 patients.
- Theatre teams performed over 17,000 operations.
- Midwives and obstetricians helped over 5,300 mums give birth.
- Porters escorted over 50,000 patients to clinical settings across the Trust.

Numerous other staff not only care directly for patients and their families, but also provide a wide range of support services.

I am particularly pleased with the way in which our community and hospital staff are working ever more closely together, and the way that our organisation is working collaboratively with partners.

To pick just a few examples:

- Our hospital based haematology nurses work with our community based IV team to provide chemotherapy in patients' own homes.
- Our staff work with those from social services, for instance providing intermediate care at Darley Court.
- We play an active role with primary care and social services in multi-disciplinary neighbourhood teams in the community.
- We work in clinical networks with other trusts in Greater Manchester and Lancashire and provide some services for neighbours such as midwifery in Salford and Bury.

The quality of the work our staff carry out for local people has been recognised this year at numerous awards, events and accreditations:

Our Paediatric Audiology Team became one of the few in the country to be accredited by UKAS for meeting the standards set by Improving Quality in Physiological Services.

- D4 ward was shortlisted for a Student Nursing Times Award, for work on the Synergy project supporting students.
- Midwife Martine Bayliss was shortlisted for a Royal College of Midwives Award.
- Six members of staff/teams were shortlisted in the Unsung Hero Awards.
- The STOPPIT-2 trial team won Research Team of the Year at the Greater Manchester Clinical Research Awards for work helping to prevent premature birth of twins.
- Andrea Bennett, the Trust's Deputy Finance Director, made the finals of the Healthcare Financial Management Association Awards, for Deputy Finance Director of the Year.
- Two of our medical photographers received bronze awards at the Institute of Medical Illustrators (IMI) annual conference.

- Several staff represented the Trust at national awards and events recognising our contribution to helping patients and families in the aftermath of the Manchester Arena bomb.
- The Trust's dementia specialist nurse made it to the finals of the National Dementia Care Awards for Best Dementia Lead.
- Of two tinnitus booklets developed by one of our consultants, one won the Children's Special Award and the other was commended at the British Medical Association's Patient Information Awards.
- The Acute Pain Team won Acute Pain Team of the Year at the National Acute Pain Symposium.
- Bethany Egerton won Informatics Apprentice of the Year at the North West Skills Development Network Informatics Apprentice of the Year Awards.
- Royal Bolton Hospital's paediatric department was named best training hospital by representatives of Health Education England's North West branch. The PAFTA (Paediatric Awards for Training Achievements) was awarded by trainee doctors who had worked on the department. The Trust was shortlisted for two Business Culture Awards, for the work done around values and culture. The Trust was one of only two NHS organisations to be shortlisted.
- We were shortlisted for two prestigious Nursing Times Awards. Our pain management nurses were shortlisted in the Surgical Nursing category for their work prioritising pain management after caesarean sections. Our Homeless and Vulnerable Adults Team was shortlisted for a HRH The Prince of Wales Award for Integrated Approaches to Care, for a project helping single homeless people.
- The Royal College of Anaesthetists accredited us under their Anaesthesia Clinical Services Accreditation Scheme – at the time one of only 17 trusts in the country to receive this accolade.
- We were selected as one of the CHKS Top Hospitals for performance for the third year running.
- We were Named Digital Hospital of the Month in Digital Health Age.

I am proud to be the Chief Executive and proud to be a doctor working with my colleagues throughout the Trust, determined that whatever our roles are we never stray from trying to get it right for each and every patient. We recognise that we can always improve and through a combination of a Quality Improvement approach and commitment to learning when we get it wrong that we will learn.

The years ahead will be challenging and exciting, collaborative working with partner organisations equally committed to doing the very best for patients will form the basis of our strategic approach.

To the best of my knowledge, the information we have provided in this Quality Report is accurate. We hope that this report provides you with a clear picture of how important quality improvement, patient safety and experience are to us at Bolton Foundation NHS Trust



Dr Jackie Bene, Chief Executive

24th May 2018

Quality Report – Section Two

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 to prepare Quality Accounts for each financial year. NHS Improvement 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 NHS 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 2017/18 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 2017 to (the date of this statement)
    - papers relating to quality reported to the board over the period April 2017 to (the date of this statement)
    - feedback from commissioners dated 21/05/2018
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2017 national patient survey
    - the 2017 national staff survey
    - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2018
    - CQC inspection report dated 10/08/2016
- 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 and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the 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



Dr Jackie Bene

Chief Executive

24th May 2018

Quality Report – Section Two

How Quality Initiatives are Prioritised in the Trust

This Quality Report identifies the progress made against the quality and safety agendas in 2017/18 and identifies the quality improvement priorities for 2018/19. Following extensive consultation with our stakeholders including commissioners and Foundation Trust members and Council of Governors, the following key improvement priorities for 2018/2019 have been chosen:

Key Improvement Priorities for 2018/2019:

1. Reduction of medication errors
2. Improving timely recognition and treatment of sepsis
3. Acute kidney Injury

Continuous improvement of clinical quality is further incentivised through the contracting mechanisms that include quality schedules, penalties and commissioning for quality and innovation (CQUIN) payments. The Trust held a comprehensive workshop with our commissioners and our clinicians to setup our CQUINs for 2017/2018 and agree a workplan for the delivery of these.

Quality Performance in 2017/18:

In our Quality Report for 2016/17 we set ourselves a series of key priorities for improvement, these were:

1. Pressure ulcers
2. Increasing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions
3. Improving timely recognition and treatment of sepsis

Progress against each priority is summarised on the following pages:

Quality Report – Section Two

Priority one: Pressure Ulcers

A pressure ulcer is an injury that breaks down the skin and underlying tissue and is caused when an area of skin is placed under pressure. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. It is estimated that just under half a million people in the UK will develop at least one pressure ulcer in any given year. (*Information taken from the NHS Choices website*)

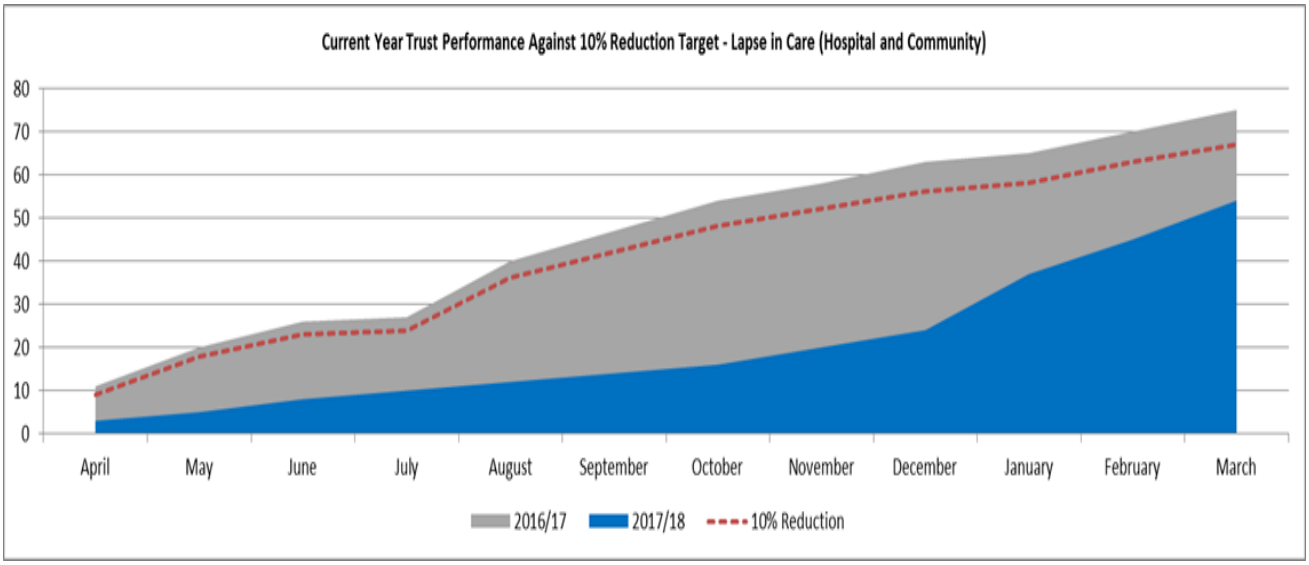
Our aim 2017/18:

AIM: 10% reduction by 31/03/18 in lapses in care that result in a pressure ulcer

OUTCOME: 28% reduction in lapses in care that result in a pressure ulcer (17/18 compared to 16/17)



ACHIEVED



YTD	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 (baseline)	11	20	26	27	40	47	54	58	63	65	70	75
10% reduction (target)	9	18	23	24	36	42	48	52	56	58	63	67
2017/18 (actual)	3	5	8	10	12	14	16	20	24	37	45	54

Other measures include:

Category 4 Pressure Ulcers:

- In 2017/18 there were zero Category 4 pressure ulcers acquired in the hospital setting.
- In the community setting, there were 17 Category 4 pressure ulcers, one of which was attributed to lapses in care.

Outcomes:

Throughout 2017/18 we had a comprehensive pressure ulcer improvement work plan; the key drivers and interventions are summarised below:

1. Education and Training

- Education and training in pressure ulcer prevention and management undertaken in formal and informal manner e.g. classroom based learning, ad hoc training on wards and departments, team meeting attendance as the need arises.
- Our second annual "Stop the Pressure" Conference was held in November 2017 to raise awareness of pressure ulcer prevention and management, with attendance of over 100 delegates from Bolton FT, Bolton locality nursing homes and local authority care homes
- University of Bolton student nurse training continues, along with training on the preceptorship programme, Trainee Nurse Associate training and HCA Clinical skills days.

2. Equipment and devices:

- Monthly audit of pressure relieving/reducing devices available within hospital settings.
- Tender for new pressure relieving equipment contract (acute) - review of available equipment and trial of hybrid mattresses.
- Emergency Department (ED) trolley mattresses – review of planned trolleys and scope suitable mattresses.
- Improve the use and availability of Repose heel protectors and wedges - monthly audits in hospital setting regarding availability of products.
- Use of cameras in the community to improve clinical discussions at Harm Free Care panel - all community teams have cameras available, with a standard operating procedure to ensure appropriate use.

3. Documentation:

- Review of Pressure Ulcer Prevention and Management Policy – link to NHS Improvement workstream to review national pressure ulcer classification and reporting methodology.
- Embed and sustainment of SSKIN bundle (a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers)trust wide – Pressure ulcer prevention and management feature on clinical induction, with supporting materials and ongoing monitoring of standards and support to ensure sustainment.
- Documentation rolled out to Emergency Department.

4. Pressure ulcer prevalence:

- Quarterly thematic analysis of pressure ulcers and subsequent actions presented to Quality Assurance Committee.

5. Timely review of harm:

- Harm free care panels for all pressure ulcers - a learning event for all staff attending with the sharing of minutes from these panels allowing for wider learning.

6. Collaborative working:

- Joint Pressure Ulcer Collaborative with Bolton NHS Foundation Trust, Bolton Clinical Commissioning Group (CCG) , Local Authority and Hospice to provide a whole system collaborative approach to reducing pressure ulcers within the Bolton Health and Social Care Economy, including:
    - Health economy wide pressure ulcer prevention and management education.
    - Scoping of a Harm Free Care Nurse Educator post.
- Work with NHS England Greater Manchester Pressure Ulcer Collaborative Group – scoping co-ordinated work across Greater Manchester.
- Establishment of monthly Pressure Ulcer Working Group - to share good information and good practice to drive further changes and improvements in pressure ulcer prevention and management.

Further improvements for 2018/19:

- Continuation with Pressure Ulcer Forward Plan.
- Continue with pressure ulcer prevention and management training.
- Improve attendance at Pressure Ulcer Working Group.
- Divisions to develop a training needs analysis to support staff who require training and agree training objectives.
- Work with Procurement to secure new pressure relieving equipment contract.
- Pressure Ulcer Prevention and Management Policy review in line with NHS Improvement's work around a nationally recognised pressure ulcer classification and reporting methodology.
- Pressure ulcer prevention and management care plan reviews in line with Electronic Patient Record.

Priority two: Increasing Do not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions

The aim of this improvement priority is to improve early and open discussions with our patients to enable them to make informed and appropriate DNACPR decisions in line with their wishes and ensure this is appropriately documented in patient records.

Our aim 2017/18:

AIM: 25% reduction by 31/03/18 of patient resuscitated that should have been DNACPR (upon review at cardiac arrest root cause analysis clinic)

OUTCOME: 25% reduction in patients resuscitated that should have been DNACPR



ACHIEVED

	2017/18	2016/17 Outturn	2017/18 Target (equating to 25% reduction)
Number of arrests	117*	121	
Should have been DNACPR (lower is better)	19**	27	20 or less than
Proportion of Cardiac arrest Root cause Analysis (RCA) reviewed that should have been DNACPR (lower is better)	18.4%	24.5%	18.4%

** Out Hospital/ Paediatric Arrest NOT included in figures, therefor RCA is N/A*

***Data taken from RCA validation clinic – in cases where this is not available (i.e. pre-validation) the initial outcome RCA data is used.*

Outcomes:

1. ***Strengthened cardiac arrest root cause analysis (RCA)***

- Revised Cardiac Arrest Root Cause Analysis standard operating procedure.
- Escalation process established in event of delayed return of cardiac arrest RCA.
- Scoping meetings chaired by Medical Director, where potentially avoidable cardiac arrest identified.
- Ongoing work to co-ordinate learning from cardiac arrest RCA with that of mortality review process.
- Review of coding of patients who have had a cardiac arrest.

2. Documentation and process to include

- Consultant DNACPR leads/advisors recruited in Acute Adult and Elective Care Divisions to support doctors in training to enable and engage in timely discussions with patients and relatives regarding DNACPR.
- Implementation of ward round checklist in all acute adult wards.
- Trial of ward round checklist in surgical and orthopaedic wards.

3. Audit of DNACPR

- Annual audit of DNACPR decisions took place in September 2017, below is a summary of areas performing well from 2017 audit:
  - Number of GP forms that were completed and brought in with the patient, demonstrating that not only are these conversations taking place outside of the hospital but also that the patient is transferring this information with them.
  - 92% of forms had a recorded discussion with patient and/or family.
  - 96% of forms had reasons for DNACPR decision documented.
  - Approximately 50% of DNACPR forms were found to be completed by the lead clinicians
- DNACPR audit feedback, with education package for foundation year doctors.

Further improvements for 2018/19:

- Consultant verification/countersignature of DNACPR when completed by junior doctor.
- Focus on revision of DNACPR after the hospital episode.

Quality Report – Section Two

Priority three: Sepsis

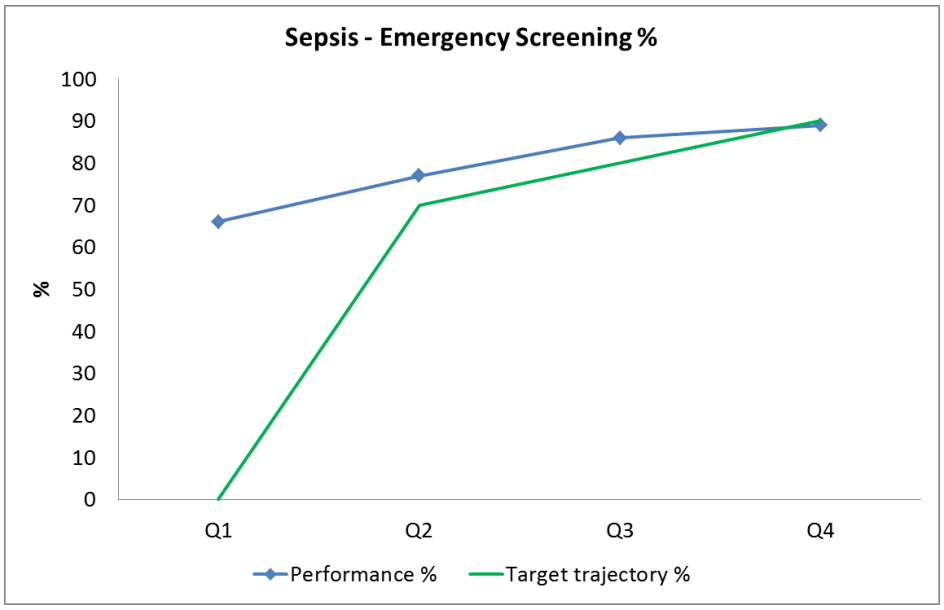
Every year in the UK there are 250,000 cases of sepsis, resulting in approximately 44,000 deaths – more than bowel, breast and prostate cancer combined. Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis can be caused by a huge variety of different bugs, most cases being caused by common bacteria which we all come into contact with every day without them making us ill. Sometimes, though, the body responds abnormally to these infections, and causes sepsis However, timely recognition and treatment is key to improving chances of survival and recovery. (Information from UK Sepsis Trust Website).

Our aim 2017/18:

AIM: By 31/03/18 90% of applicable patients admitted as an emergency are screened for sepsis

OUTCOME: 89% of applicable patients admitted as an emergency were screened for sepsis – by quarter four 2017/18 (within the Sepsis CQUIN

PARTIALLY ACHIEVED



Other measures include:

- **Time to antibiotic delivery in red flag sepsis**
  - 83% of patients admitted as an emergency **and diagnosed with Red Flag Sepsis** received treatment within 60 minutes of diagnosis (within the Sepsis CQUIN sample)*
- **Screening and antibiotic delivery for inpatients meeting the criteria of sepsis and red flag sepsis.**
  - 38% of inpatients scoring above three on the National Early Warning Score (NEWS) were screened for sepsis (within the Sepsis CQUIN sample)
  - 100% of inpatients diagnosed with Red Flag Sepsis received treatment with 60 minutes of diagnosis (within the Sepsis CQUIN sample)*

**Data must be interpreted in light of NHSE methodology resulting in a low denominator.*

- **Sepsis mortality and number of unexpected deaths**

- Hospital mortality rates for sepsis have continued to decline year on year, for example in 2005/6 mortality rates were 50.2%, 2016/17 16.1%, 2017/18 14.3% (to latest available data on Comparative Health Knowledge System (CHKS) capturing all patients with a primary and secondary code for sepsis).
- Number of unexpected deaths has also reduced year on year. In 2014 39.2, 2015 34.1, 14.8, 2017 -2.3 (to latest available data).

- **Critical Care Admissions with High Risk Sepsis**
  - For Intensive Care Unit and High Dependency Unit admissions with sepsis are high but at a low risk, which suggests patients are being escalated, seen and admitted in a responsive manner**. *Data source - Intensive Care National Audit and Research Centre, **this data looks at all sepsis admissions and risk stratifies them. It is generally seen as worse to have a high number of high risk admissions as this would suggest an issue with escalation of care, availability of outreach or critical care response time.*

Outcomes:

Throughout 2017/18 we had a comprehensive sepsis improvement work plan; the key drivers and interventions are summarised below:

1. Policies, guidance and documentation

- Revision and ratification of sepsis policy, pathway and screening tools aligned with NICE guidance.
- Introduction of new inpatient screening tool and pathway, in line with NICE guidance to ensure Trust standard is to screen any patients scoring Early Warning Score 3+.
- Benchmarked Trust compliance with NICE Quality Standards QS161: Sepsis. On RAG rating we are red against one out of the six standards: People with suspected sepsis who have been stratified as at low risk of severe illness or death are given information about symptoms to monitor and how to access medical care.
- Revisions of Trust KPI observations standards.
- Review and understand requirements of NEWS 2 (December 2017) - scope requirements and establish trust response to local implementation – action plan to be developed to take forward in 18/19.

2. Education and training

- Revision of materials for Sepsis Study Day and reference materials in line with policy and pathway changes
- Awareness raising with wards regarding changes to sepsis policy, pathway and tools
- Scoping of sepsis e-learning package to supplement face to face learning
- Recognising and responding to patient deterioration – pilot training programme commenced September 2017.
- Acute Illness Management training delivered on a monthly basis.
- Sepsis Study Day delivered quarterly.
- Junior doctor sepsis teaching.
- Primary Care Education Day.
- Awareness week with ED nursing staff looking at observations standards, NEWS, escalation and triggers re-enforcing standards

3. Monitoring, governance and quality improvement

- Delivery against national sepsis CQUIN.
- Establishment of Deteriorating Patient Operational Working Group.
- Initial data analysis of Patientrack system (hospital at night task management system).
- Escalating cause for concern staff questionnaire to identify areas for improvement
- Ongoing work to ensure temporary staff have the required knowledge and skills regarding NEWS observation standards and competencies.
- **Sepsis Virtual Clinic** - Quarterly case note review by the multi-disciplinary Sepsis Forum review to benchmark care provided to patients, who had sepsis coded at any stage in their hospital stay or on their death certificate, against trust and national standards. The first clinic targeted deaths in November 2017 when a spike in mortality was noted through live CHKS tracking. Findings from first clinic are below:
- All patients were emergency patients going through the ED. Average time to antibiotics for the sickest patients from observations being recorded was under an hour and from time seen by clinician less than 20 minutes.
- Of those patients that did not get screened none had red flag sepsis and all went on to have senior reviews and appropriate therapy commenced.
- KPI Improvement Project – Focus on fluid balance KPI standard due to the potential changes in NEWS (2). Ten wards identified with measurement for improvement methodology supporting improvement work.
- Review of Sepsis CQUIN data collection to include outcome if patient did not have treatment within 60 minutes of Red Flag Sepsis diagnosis.
- Research: enrol into EPIC-III (the extended study on prevalence of infection in intensive care) and ADAPT-SEPSIS Clinical Trial.
- NEWS score on Extramed (patient flow system) in ED to act as a visual trigger for rapid assessment and treatment.
- Test of new ambulance handover to rapid assessment model (testing since December 2017).

Further improvements for 2018/19:

- Improvement in detection and management of patients diagnosed with sepsis continues to be a key priority for Bolton NHS Foundation Trust and so will remain a quality account priority. Please refer to page 18 for key areas of focus for 2018/19.

Key Quality Priorities for 2018/19

2017 saw the launch of our second Quality Improvement Strategy (2017-2020), which outlines a number of key themes and ambitions that we believe, will lead to demonstrable improvements in safety and patient experience. We would, however, like to highlight the following areas as Bolton Foundation NHS Trust's key improvement priorities for 2018/19:

Priority one: Reduction of Medication Errors

Background:

It is recognised that when patients come into hospital they are at risk of omitted doses of medicines. This is where the medicines they are prescribed are either significantly delayed or not administered to them by staff. This can be for a variety of reasons such as prescribing errors or availability of the medicines; however in certain situations it may be reasonable to withhold medicines due to the nature of a patient's illness.

The National Patient Safety Agency (NPSA 2010) identified that the majority of medicines omissions cause no harm, but when certain medicines are omitted the risk can increase significantly, causing severe harm or death. These are defined as critical medicines, such as anticoagulants and insulin, which should be given as close to the prescribed time and must be within two hours of the prescribed time.

Reducing the omission of critical medicines for non-clinical reasons continues to be a key improvement priority for the Trust, and features as a key deliverable of the Trust's Quality Improvement Strategy.

Aims and measurement:

The overarching outcome aim is to achieve a 10% reduction in omission of critical medicines for non-clinical reasons by 31/03/19.

Other measures we will monitor include:

- Omission of non-critical medicines.

What we will do

We have a comprehensive improvement workplan. The key drivers and interventions for 2018/19 are summarised below:

a) Education and Training

- Strengthening of e-learning medicines management package to provide a greater emphasis on omitted medicines and critical medicines.
- Annual Medicines Safety Week with focus on medicines omissions.
- Strengthen induction and in-service training for all professional groups involved with medicines.
- Raise awareness of critical medicines omissions incident reporting.
- Develop medicines link nurse scheme with focus on critical medicines omissions.
- Continue to encourage patients to bring their medicines into hospital with them.

b) Equipment and Devices

- Review and assess storage facilities for storage of patients own medicines
- Evaluate the re-introduction of a medicines trolley to wards and departments

c) Documentation

- Review the medicines policy related to omitted medicines and critical medicines list, with a focus on how to obtain critical medicines in a timely manner.
- Review and update the omitted medicines audit paperwork.
- Develop patient information to encourage patients to challenge delayed or omitted medicines

d) Critical medicines omission prevalence

- Monthly audit of medicines omissions and analysis of omissions.

e) Timely review

- Medicines Safety Group review of audit data and analysis.

Reporting our progress:

- All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress.
- The forums and governance committees which will provide progress, oversight and accountability for critical medicines omission reduction are summarised below:
    - Pharmacy Governance
    - Medicines Link Nurse Group
    - Medicines Safety Group
    - Clinical Governance and Quality
    - Quality Assurance Committee.

Priority two: Sepsis

Background:

At Bolton, sepsis remains our second leading cause of death although mortality rates have dropped year on year through the work of the Sepsis Forum and engagement with the national CQUIN. The latest 2017/18 data shows the trust admitted 1365 cases of sepsis with 201 deaths. The Sepsis Forum has always viewed the management of sepsis as part of a larger and interconnected strategy involving the recognition and response to the deteriorating patient. To this end Bolton has been lauded for its early adoption of the original National Early Warning Score (NEWS) and being one of the leading trusts providing dedicated sepsis teaching, as recognised by Dr Ron Daniels, CEO of the UK Sepsis Trust.

Aims and measurement:

Outcome aim: Implementation of National Early Warning Score 2 (as recommended by NHS Improvement) by 31.03.19.

Other measures we will monitor include:

- Update of e-learning package
- Mortality and unexpected death rates
- Adherence to national sepsis CQUIN measures (screening and treatment within 60 minutes of diagnosis of Red Flag Sepsis)
- Trust monthly KPI observation standards relating to Sepsis

What we will do

We have a comprehensive improvement workplan. The key drivers and interventions for 2018/19 are summarised below:

a) Policies, guidance and documentation

- Introduce the new National Early Warning Score (NEWS2) along with revised criteria for sepsis screening.
- Align policy, pathways and documentation to NEWS 2.
- NICE QS161: ensure compliance with all standards – specifically the provision of patient information.
- Electronic observations: work with the steering group to implement a specific sepsis track and trigger pathway and measure its impact clinically and for data collection.

b) Education and Training

- Targeted education in support of NEWS 2 and revised sepsis documentation.
- Sepsis Study Days and reference material.
- E-learning package.
- Sepsis patient information leaflets.
- Trust Deteriorating Patient Awareness Week.
- Comprehensive guide to the management of sepsis at Bolton.

c) Monitoring, governance and quality improvement

- National Sepsis CQUIN: detail to be reviewed and agreed with CCG.
- Review of audit beyond sepsis CQUIN in ED.
- Continue to embed rapid assessment ambulance handover model in ED.

- Scope Patient Group Directive (PGD) for administration of antibiotics in ED.
- Review of ED roles regarding initial assessment and antibiotics administration.
- Quarterly sepsis virtual note clinics with thematic analysis to inform areas for improvement.
- Further changes to sepsis coding by NHS Digital.
- Introduction of pro-calcitonin blood test: allows for more specific identification of bacterial causes of infection.
- Use of CHKS and other national data to measure sepsis mortality and unexpected deaths.
- Use of e-observations and patient track data to understand and focus sepsis management.
- Quality improvement project:
- Focus on a single inpatient ward.
- Establish needs for the recognition, management and escalation of patients with sepsis.
- Development local solutions including ideas such as the “Sepsis Drawers” (a dedicated resource drawer which contains everything required in event of suspected sepsis)
- Roll out completed programme to neighbouring wards.

Reporting our progress:

- All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress.
- The forums and governance committees which will provide progress, oversight and accountability for improved recognition and response of sepsis are summarised below:
    - Sepsis Forum.
    - Mortality Reduction Group.
    - Better Care Together.
    - Clinical Governance and Quality.
    - Quality Assurance Committee.

Priority three: Acute Kidney Injury

Background:

Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to not work properly. It can range from minor loss of kidney function to complete kidney failure. One in five people admitted to hospital in the UK each year as an emergency have AKI (Wang et al 2012). In the UK up to 100,000 deaths in hospitals are associated with AKI and it is estimated that up to 20% could be prevented with the right care and treatment (NCEPOD 2009). The cost to the healthcare economy is £434-620m per annum.

AKI normally happens as a complication of another serious illness and can happen for a variety of reasons including infection, severe dehydration, some medications and other medical conditions. It is essential that AKI is detected early and treated promptly, without which abnormal levels of salts and chemicals can build up in the body, which affects the ability of other organs to work properly. (NHS Choices).

Aims and measurement:

The overarching outcome aim is to ensure 85% of patients with AKI are treated following the guidelines produced by 31/03/19.

What we will do

The AKI Steering Group has a comprehensive improvement workplan; the key drivers and interventions for 2018/19 are summarised below:

a) Nursing

- Review of nursing infrastructure supporting the deteriorating patient and consideration of further appointments if considered necessary.

b) Education and Training

- 85% of junior doctors to be trained in the management of AKI by six months of commencement of employment.
- Increase nursing staff awareness and appreciation of the key points to ensure multi-disciplinary adherence to AKI guidelines and treatment via regular communication over 2018/19.
- Practice educators and outreach team to enhance knowledge amongst key ward staff with dedicated education sessions and standardised slide pack.
- Education of patients through the distribution of patient information leaflet via wards.

c) Documentation

- Clear documentation of process of guidelines – evidence by employment of AKI stickers.
- Review of patient's AKI status on ward rounds on ward round proformas by September 2018.
- Patient information leaflets given out documented in the medical records.

d) Use of checklist prevalence

- Monthly audit of performance against checklist to measure improvement and identify areas for improvement.

e) Timely review

- AKI Steering Group review of audit data and analysis.
- Regular meeting of AKI Steering Group with robust attendance and engagement.

Reporting our progress:

- All our improvement projects and workstreams follow an established governance structure which monitors and measures performance and progress.
- The forums and governance committees which will provide progress, oversight and accountability for acute kidney injury are summarised below:
    - Acute Kidney Injury Steering Group.
    - Mortality Reduction Group.
    - Clinical Governance and Quality.
    - Quality Assurance Committee.

Statement of assurance from the board

Review of services

During 2017/18 Bolton NHS Foundation Trust provided and/or sub-contracted 11 relevant health services (as defined by the CQC) across 38 specialties

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

The income generated by the relevant services reviewed in 2017/18 represents 100**%** of the total income generated from the provision of NHS services by Bolton NHS Foundation Trust for 2017/18.

Participation in Clinical Audits and Research Activity

The NHS published a list of 59 Quality Accounts

During 2017/18, **44** national clinical audits (including Clinical Outcome Review Programme) covered relevant health services that Bolton NHS Foundation Trust provides.

During that period Bolton NHS Foundation Trust participated in **42** national clinical audits.

The table below indicates which national clinical audits and national confidential enquiries Bolton NHS Foundation Trust was eligible to participate in.

Table 1: National Clinical Audits projects participant – 2017/18

Project Name and Work Stream	% cases submitted (no of cases submitted as a % of cases required)
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	100%
BAUS Urology Audits PCNL	100%
Cardiac Rhythm Management (CRM)	Figure not available
Case Mix Programme (CMP)	100%
(Endocrine and) Thyroid National Audit	100%
Elective Surgery (National PROMs Programme) Groin Hernia Hip Replacement Knee Replacement Varicose Vein	 40% 91% 93% 39%
(FFFAP) Inpatient Falls	100%
(FFFAP) National Hip Fracture Database	>100%
Fractured Neck of Femur: Care in emergency departments	100 %
Head and Neck Cancer Audit *Trust not due to submit any audit data for 2017/18 period until the Autumn*	*NA*
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	150

Project Name and Work Stream	% cases submitted (no of cases submitted as a % of cases required)
Learning Disability Mortality Review Programme (LeDeR)	14 %
Major Trauma Audit	48%
Myocardial Ischaemia National Audit Project (MINAP)	100%
National Audit of Breast Cancer in Older People (NABCOP)	
National Audit of Care at the End of Life (NACEL) *Start in March 2018*	*NA*
National Audit of Dementia (in General Hospitals)	100%
National Audit of Intermediate Care (NAIC)	100%
National Bowel Cancer (NBOCA) *Trust not due to submit any audit data for 2017/18 period until the Autumn*	100%
National Cardiac Arrest Audit (NCAA)	100%
COPD Audit programme : Pulmonary rehabilitation	Did Not Participate
COPD Audit programme : Secondary Care	16%
NHSBT: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	100%
NHSBT: 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	1005
NHSBT: Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016	100%
Adults National Diabetes Foot Care Audit	100%
Adults National Diabetes Inpatient Audit (NaDia)	100%
Adults National Core Diabetes Audit	Did Not Participate
Adults National Pregnancy in Diabetes Audit	100%
National Emergency Laparotomy Audit (NELA)	76%
National Heart Failure Audit	100%
National Joint Registry (NJR)	Figure not available
National Lung Cancer Audit (NLCA)	100%
National Neonatal Intensive and Special Care (NNAP)	97%
National Oesophago-gastric Cancer (NAOGC) *Trust not due to submit any audit data for 2017/18 period until the Autumn*	NA

Project Name and Work Stream	% cases submitted (no of cases submitted as a % of cases required)
National Ophthalmology Audit	100%
National Paediatric Diabetes Audit (NPDA)	Figure not available
National Prostate Cancer Audit *Trust not due to submit any audit data for 2017/18 period until the Autumn*	NA
National Vascular Registry	N=25 Angioplasty Procedures April 2017 – October 2017
Pain in Children (care in ED)	100%
Procedural Sedation in Adults (care in emergency departments)	100%
Sentinel Stroke National Audit programme (SSNAP)	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	100%
UK Parkinson's Audit Physiotherapy occupational therapy speech & language therapy Elderly care & Neurology	 100% 100% 0% 0%

Clinical Outcome Review Programme

1. National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

NCEPOD covers the Medical and Surgical Programme and the Child Health Programme. Below are the topics which took place in 2017-2018

Table 2: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Study Title		Required	Submitted	%
Chronic Neurodisability	Admission Questionnaires	5	5	100%
	Lead Clinician Questionnaires	4	3	75%
	Copy of Case notes	5	5	100%
Young People Mental Health	Admission Questionnaires	6	3	50%
	Copy of Case notes	6	5	83%
Cancer In Children, Teens and Young Adults	**Please note this study is not applicable to the Trust*			
Acute Heart Failure**	Organisational Proforma	1	1	100%
	Admission Questionnaires	-	-	

Study Title		Required	Submitted	%
	Copy of Case notes	-	-	
Perioperative Diabetes **	Surgical Questionnaires	4	2	50%
	Anaesth. Questionnaires	4	1	25%
	Copy of Case notes	4	4	100%

*** Please note study is still open and the figures have not been finalised*

2. Maternal, New born and Infant Programme (managed by MBRRACE UK)

- Perinatal Mortality & Morbidity confidential enquiries
- Maternal Mortality surveillance & mortality confidential enquiries

All Neonatal deaths, stillbirths, late miscarriages and maternal deaths are entered onto the MMBRACE database. **56 cases** were submitted to MMBRACE between since 1st April 2017 to 31st March 2018. All cases are reviewed locally on a monthly basis through the perinatal group meeting.

3. Learning Disabilities Mortality Review Programme (LeDeR)

Since participation in March 2017, there have been **14 cases** reported. There have been significant delays in starting the reviewing of the cases due to issues and concerns with the documentation. These issues have been resolved and we have currently reviewed the first two cases and plan to review the remaining 12 over the next four months.

At present there are five trained members of the team working on the reviews and additional training is scheduled to ensure the review process is sustainable moving forward. Applications to NHS England for additional funds have been sought to support the process.

To support the process the Trust will devise an action plan to ensure learning and good practice is shared. Workshops are also planned in April 2018 to review the process and consider how we facilitate this role alongside competing priorities once the backlog reviews are cleared.

Table 3: National Clinical Audits: Actions to Improve

The reports of **21** national clinical audits were reviewed by the provider in 2017/18 and Bolton NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<tr><th>Project Name and Work Stream</th><th>Progress</th></tr>
<tr><td>Case Mix Programme (CMP)</td><td>✓ Fully engaged
Many processes by which BHFT directly link it to audit as many of the metrics and outcomes are composites i.e. mortality rate has multifactorial inputs</td></tr>
<tr><td>Elective Surgery (National PROMs Programme)</td><td>✓ Good Participation rates
<table>
<tr><th>Monthly PROMs Returns</th><th>Groin Hernia Q</th><th>Hip Replacement Q</th><th>Knee Replacement Q</th><th>Varicose Vein Q</th></tr>
<tr><td>Apr-17</td><td>7</td><td>19</td><td>20</td><td>3</td></tr>
<tr><td>May-17</td><td>9</td><td>9</td><td>16</td><td>1</td></tr>
<tr><td>Jun-17</td><td>8</td><td>18</td><td>18</td><td>1</td></tr>
<tr><td>Jul-17</td><td>9</td><td>7</td><td>15</td><td>3</td></tr>
<tr><td>Aug-17</td><td>12</td><td>15</td><td>17</td><td>3</td></tr>
<tr><td>Sep-17</td><td>9</td><td>13</td><td>24</td><td>3</td></tr>
<tr><td>Oct-17</td><td>11</td><td>18</td><td>16</td><td>3</td></tr>
<tr><td>Nov-17</td><td>7</td><td>14</td><td>15</td><td>3</td></tr>
<tr><td>Dec-17</td><td>8</td><td>10</td><td>13</td><td>0</td></tr>
<tr><td>Jan-18</td><td>7</td><td>21</td><td>26</td><td>4</td></tr>
<tr><td>Feb-18</td><td>13</td><td>14</td><td>22</td><td>5</td></tr>
<tr><td>n</td><td>100</td><td>158</td><td>202</td><td>29</td></tr>
</table>
The Trust is now registered to now receive Patient Level Data via SEFT (NHS Digital)</td></tr>
<tr><td>National Hip Fracture Database</td><td>
<table>
<tr><th></th><th>RBH 2017</th><th>National Standard</th></tr>
<tr><td>Case Ascertainment</td><td>109%</td><td>100%</td></tr>
<tr><td>Crude proportion of patients having surgery on the day or day after admission</td><td>62.6%</td><td>85%</td></tr>
<tr><td>Crude perioperative medical assessment rate</td><td>100%</td><td>100%</td></tr>
<tr><td>Crude proportion of patients documented as not developing PU</td><td>100%</td><td>100%</td></tr>
</table>
Action for Crude proportion of patients having surgery on the day or day after admission</td></tr>
</table>

Project Name and Work Stream	Progress
	1. Anticoagulants - Review current process for checking when patients last took their anticoagulant medication. It may be that it was 12 hours prior to admission, allowing them to go to surgery 12 hours earlier, potentially within the 36 hour window – Leads: Alun Wall/James Mace/Samuel Carney **Current Progress:** Discussion taken place at Hip Fracture meeting. It has been agreed that questions regarding when they last taken their medication does need to be asked. To be discussed at governance and a plan put in place. **2. Radiology/Delayed scans -** Reduce the time to scan and reporting time - leads: Gemma King/Samuel Carney **Current Progress:** Gemma to monitor and escalate any delays to OBM of the day and/or OBM for T&O **3. Awaiting plan/decision regarding treatment -** Number of breaches with reason 'awaiting plan' could the department improve speed of decision making? – No further action – delays caused due to pre-optimisation and/or clinical reasons to watch and wait prior to surgery **4. Evening trauma lists -** Evening trauma lists are not always well utilised – arrange meeting with Anaesthetics and Theatres to discuss ongoing issues – Lead: Rayaz Chel – **Current Progress** - Meeting in process of being arranged.
(FFFAP) Inpatient Falls	✓ Fully engaged Since this report the Trust has initiated multiple work streams generated from the Gap Analysis (2015) and themes from incidents and Root Cause Analysis presented at falls harm free care panel to improve patient safety. Much of the work has been initiated within the falls and dementia steering group 2016/2017 and 2017/2018 Action plans and Quality improvement measures including an inpatient falls collaborative and Red2Green campaign to name but two. 2018/2019 ongoing work includes: ✓ Royal College of Physicians guidance for lying/standing BP has been embedded as part of the individualised falls assessment and rolled out throughout the Trust. ✓ A Delirium Training needs Analysis has been completed and the "Pinch me" mnemonic included in the new Cognitive Impairment Care Plan. ✓ Fear of Falling question to be embedded into Nursing Assessment. ✓ Pharmacy and medical staff to consider falls risk during medicine review (Dec 2017). New Guideline being trialed on D1/D2. ✓ Pharmacy Sticker to be introduced to help highlight patients who require medication review. ✓ Education to all medical staff to be rolled out on lying and standing blood pressure and ✓ The Royal College of physicians "care fall" online certified training to be encouraged. ✓ Provision of 'Information to prevent falls' to be available in various languages (Dec 2018).

Project Name and Work Stream	Progress
	✓ Evidence of Health promotion and Education to Patients, Families and staff via establishment of a task and Finish Group (March 2018). ✓ Record Keeping Audits, Training, Good Practice and gold Standards to be introduced. ✓ Minimum of one hour falls awareness training to be completed by all staff either face to face or online. ✓ 'Teach-back' technique to be embedded into practice for use of call bells. ✓ Falls sensor daily check recording to be embedded into daily practice. ✓ Continued quality improvement initiatives including Trust wide Learning week on Falls
IBD Registry Biological Therapies Audit.	Involvement with the IBD registry, this has enabled the Trust too: • Effectively search for patients who receive Biologic Therapy • Easily review patients in the virtual clinic as clinical activity scores and PROMS are entered by our clinical admin • Allows us feed into and be involved in the National Audit so that we can bench mark our practice • Future Plan are to promote the use of the registry to other clinicians *(currently only used by IBD specialist nurses)* • Using the Registry is time consuming and requires admin support to enter data
Major Trauma Audit	Continuous Data Submission. N=221 cases submitted
Myocardial Ischaemia National Audit Project (MINAP)	**Compliant with all 6 standards** need emphasis the importance of Standard 3 relating to sufficient resources allocated to clinical audit activity - it is vital that MINAP Coordinator is protected to ensure good quality complete data. Feedback of reports via Cardiology Governance group enables us to ensure that we maintain performance. A target for us has been to ensure that patients with NSTEMI are moved to a cardiology ward within 24 hours of admission. Audit data have enabled us to see that we need to change the process of admission to a cardiology bed by prioritising and "pulling" patients through to a cardiac bed using the consultant cardiologist on call and the ward staff.
National Audit of Dementia	✓ Work is ongoing to improve and monitor assessing delirium in people with dementia and is being embedded in to training ✓ Delirium Policy in place and training of Nurses and Doctors includes delirium advice and awareness, with plans to increase this incrementally ✓ Cognitive tests are administered on admission but not on discharge as patients are referred to their GP for follow up as per the national CQUIN and not re-screened. Trust to discuss whether we plan to do this on discharge also. ✓ There is an identified need to create a delirium screening pro-forma to sit alongside our current practice of recording and recognizing Delirium based on clinical need. This should aim to mirror our existing Delirium Care Plan.
National Audit of Intermediate Care (NAIC)	✓ After participation the initial benefits for patients are that the Trust is to benchmark against other services across the country in relation staffing mix and outcomes. Alongside this the audit also provides patient feedback and

Project Name and Work Stream	Progress
	outcomes of our intervention so provides the Trust with some patient experience and information if we are making a difference to patient's quality of life. Intermediate Care are currently working with AQUA completing a flow redesign project, so they have a complete diagnostic period - this includes reviewing services, processes and systems , looking at patient and staff feedback .Participating in the National Audit of Intermediate Care allows the Trust to look at other care services and their staffing models/ outcomes and financial spend.
National Cardiac Arrest Audit (NCAA)	The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland, commissioned by HQIP in 2012. Locally, we piloted this audit on our Medical Assessment Units and rolled this out gradually. Overtime this audit has grown into a successful example of how National Audit can influence Local practices. Every in-hospital cardiac arrest is captured and submitted to the National Database within 24hours. This National output then generates the beginning of our local process. A Root Cause Analysis is completed by every parent team. This has led to noticeable improvement in completion of DNAR. To facilitate further improvement the process of evaluation has changed by implementation of a review panel, meeting monthly combining of mandate reviews and potential Critical incident for those applicable. The Trust, in comparison with other similar sized hospitals has a robust system where parent teams complete own RCAs. Bolton adapted RCA proforma has been further developed by RCA group and has been shared with other organisations following a presentation at the National Conference in London. Between 2016-2017 the Return Rate of completed Root Cause Analysis for Cardiac Arrest Patients was 93%, compared to previous year of 86% (2015-2016). The projection for 2017-2018 is looking to excel previous years. In 2014-2015, admissions 82,675 the total number of arrests attended were 96 of these there were **33 Avoidable Arrests.** In 2015-2016, admissions 82,867 the total number of arrest attended were 102 of these there were **27 Avoidable Arrests.** In 2016-2017, admissions 84, 651 the total number of arrest attended were 124 of these there were **8 Avoidable Arrests**.
COPD Audit programme : Secondary Care	Six metrics are measured through the audit will be used by the Care Quality Commission (CQC) as part of the National Clinical Audit Benchmarking (NCAB) project to measure trust performance. The following hospital level data will be provided to the CQC on a six monthly basis regarding the percentage of patients receiving: Metric 1. Specialist review within 24 hours **Yes 78% No 22%** Metric 2. Prescription of oxygen to stipulated target oxygen saturation **Oxygen 88% -92% n=76% , Oxygen 94% -98% n=15% , Oxygen other range n=5% , Target not stipulated n=4%** Metric 3. Was NIV within 3 hours of arrival

Project Name and Work Stream	Progress
	Yes 9% No 91% Metric 4. Prescribed smoking-cessation pharmacotherapy (for documented current smokers) **No n=31.5, Offered but declined n=25, Yes n=21, Not recorded n = 14** Metric 5. BTS, or equivalent, discharge bundle for admission **No n=72%, Not clear n=11%, Other n=0.5%, Pt self-discharged n=2.5% Yes n=14%** Metric 6. Spirometry confirming FEV1/FVC ratio <0.7 recorded in case file **<0.7 n=28%**
National Diabetes Audit - Adults National Diabetes Foot Care Audit	1. Minimise the time from foot ulcer development to first expert assessment 2. Review and develop current foot care pathways, in particular for inpatients
National Diabetes Audit - Adults National Diabetes Inpatient Audit	1. In-patient pathway has been designed and approved. It is in the process of being implemented. 2. Regular ward Nurse Training. 3. Development of in-house training on Moodle which will be accessible to all staff. 4. Development of training grid for Moodle training after Training needs analysis was done for each staff group. 5. Continued participation in In-patient audit to evaluate these changes. 6. The Trust welcomes incident reporting and has a higher than average number of reported hypoglycaemic events. As a result the Trust looked at local hospital data to validate time, frequency of hypos, by ward area and if there was a correlation with mis-match of meal time. This has been presented via poster presentation at NMP and annual nursing / allied health conference. As a result of this the Trust has developed hypo stickers to replace hypo books and a new CBG chart. 7. Continuing work on appropriate meals project by working with dietetics and catering to get carb volumes listed on the menu.
National Emergency Laparotomy Audit (NELA)	In 2016, an Action Plan was developed to be reviewed at General surgery governance, which outlined that what was previously retrospective data collection would now move to 'real-time' data collection. It was agreed that all consultant surgeons and anaesthetists are responsible for completing online forms. There are minimal datasets that need collecting retrospectively, which the Clinical Effectiveness Department facilitates, such as Outcome at Discharge. These changed have dramatically improved the way in which we manage this National Audit and current reports reflect that Year 4 Data (2017-2018) was closed IN February 2018, with results published later in the year.

<table>
<tr><th>Project Name and Work Stream</th><th>Progress</th></tr>
<tr><td></td><td>
<table>
<tr><th>Bolton Hospital NHS Foundation Trust</th><th colspan="2">Proportion of patients for which each process of care was met (%)</th></tr>
<tr><th></th><th>2015</th><th>2017</th></tr>
<tr><td>Final Case Ascertainment</td><td>0-49%</td><td>80-100%</td></tr>
<tr><td>Consultant Surgeon Review within 12hrs Emergency Admission</td><td>0-49%</td><td></td></tr>
<tr><td>CT Reported before surgery</td><td>50-79%</td><td>50-79%</td></tr>
<tr><td>Risk Documented preoperatively</td><td>80-100%</td><td>80-100%</td></tr>
<tr><td>Arrival in Theatre timescale appropriate to operative surgery</td><td>50-79%</td><td>80-100%</td></tr>
<tr><td>Pre-operative review by Consultant Surgeon and Consultant Anaesthetist *</td><td>50-79%</td><td>50-79%</td></tr>
<tr><td>Both consultant surgeon and Anaesthetist present in Theatre*</td><td>80-100%</td><td>80-100%</td></tr>
<tr><td>Consultant Surgeon present in Theatre*</td><td>80-100%</td><td>80-100%</td></tr>
<tr><td>Consultant Anaesthetist present in Theatre*</td><td>80-100%</td><td>80-100%</td></tr>
<tr><td>Direct postoperative admissions to Critical Care*</td><td>50-79%</td><td>80-100%</td></tr>
<tr><td>Post-operative assessment by MYCOP specialist in patients 70years></td><td>0-49%</td><td>0-49%</td></tr>
</table>
</td></tr>
<tr><td>National Heart Failure Audit</td><td>Changes from April 2017 mean that data for the audit will need to be submitted < 3 months of discharge instead of having 12 months. This is progress as will enable us to use the data to improve local practice in a timely fashion but will be a challenge for the audit staff and will need to ensure that we can achieve this.

Historical data from the audit demonstrated that we lacked capacity to provide follow up within 2 weeks of discharge by a heart failure specialist nurse and we did not provide a rehabilitation programme for heart failure which influences mortality and rate of re-admission.

In the light of this transformation fund money has enabled a business plan for a rehabilitation programme to be set up: we have appointed a physiotherapist, a clinical psychologist and a second heart failure nurse post is to be interviewed and appointed on 16.3.18 with a view to starting the programme in May 2018.</td></tr>
<tr><td>National Neonatal Intensive and Special Care (NNAP)</td><td>NNAP is an ongoing real-time benchmarking audit where the results are monitored at division level every month. The NNAP measures are on unit's departmental dashboard and are kept under constant review.</td></tr>
<tr><td>National Paediatric Diabetes Audit (NPDA)</td><td>Currently compliant with the relevant recommendations from NPDA as per our operational procedures and working practices</td></tr>
<tr><td>Sentinel Stroke National Audit programme (SSNAP)</td><td>The overall standards required for a Stroke multi-disciplinary team as identified within the RCP clinical guidelines are prospectively audited via SSNAP with the latest results demonstrating that Bolton is a 'B' rated service – an additional 2.7% for audit compliance would have meant an 'A' score:

Results from SSNAP are monitored by the service through the Governance programme over a continuum in order to detect emerging themes and trends as well as areas for improvement. All areas in the following table are described within the team's action plan and RAG rated accordingly. The current areas that are denoted in red are:

All applicable Stroke patients receive access to Speech and Language therapy for 45 mins 5 days per week. – As a service we currently have access to 0.3WTE speech and language therapist for the Stroke service. In order to mitigate</td></tr>
</table>

Project Name and Work Stream	Progress
	shortfalls in the current service: • All nursing staff on H3 are trained to undertake the Stroke Water Swallow Assessment – this is part of the induction package for new staff and competency of existing staff is assessed regularly. • The ASLT team is in the process of developing a training plan for the current therapy assistants on the unit in order to provide additional support for the service. We have chosen this plan as typically ASLT are very hard to recruit to and train it is felt that this is the most effective use of current resources.
Cardiac Rhythm Management (CRM)	Data from the CRM audit provides information regarding the numbers of implants and compliance with best practice guidelines published by NICE. Data released in 2017 for the 2015-16 annual report have confirmed that 100% of Secondary prevention ICD implants in Bolton comply with NICE standards but have highlighted a lack of compliance with best practice in the primary prevention implants. All of these case notes are being reviewed to determine if this a data entry issue with missing information relating to ejection fraction. These data may be resubmitted if needed. As of 1.4.18 data entry will be via web portal which will enable data input at time of implant to ensure completeness and we are in process of redesigning listing forms for complex devices to ensure that NICE criteria are fulfilled or a clear rationale for implant outside guidelines documented to provide assurance for commissioners. Submission to the audit enables to be assured that our center is meeting minimum numbers for competence as defined by BHRS and allows tracking of complication rates. For 2015-16: 124 New Pacemaker implants, 148 New complex implants/Upgrades (>110% minimum standard). % Physiological pacing for Sick Sinus syndrome 96% (UK National average 91.7%)
Medical & Surgical Clinical Outcome Review Programme NCEPOD	**NIV- Inspiring Change** Gap analysis completed and presented at specialty and divisional meetings. Areas of improvements required are: • Staffing ratios • Standardised proformas • Governance Arrangements for NIV Actions Implemented cover: • Yearly audit now started • Reported to divisions and MRG • NIV MDT Group Formed • NIV Prescription Chart • NIV Continuity of care
National Lung Cancer Audit (NLCA)	Proportion of patients seen by lung cancer nurse specialist shown as 46% in this audit – this is not a true statistic we see all patients referred to the cancer clinics on a 2 week rule and endeavor to see patients on the wards with new diagnosis, however acknowledge that some of the ward patients may not be seen e.g. Stage IV at presentation with symptoms are more appropriate for the palliative care team to see & some patients actually die within a short timeframe post admission. Certainly we see more than 46%. The national data is from the Somerset system

Project Name and Work Stream	Progress
	where we need to tick a box in the diagnosis page of each patient we see in 2016 this wasn't done due to lack of awareness hence the statistic. Action: the LCNS now ensures the appropriate box is ticked so we anticipate when the 2017 patients are audited an improvement will be seen – it has been an administrative error One year survival statistics are poor & usually are similar to other areas with the same population e.g. Wigan. Various projects like faster diagnosis all aim to diagnose patients earlier, One of Manchester Lung Cancer Pathway Board is to push to co-ordinate resources & provide resources to help diagnosing patients faster & are helping to streamline services to achieve a quicker diagnostic pathway. Other 'drives' in the community happen to raise awareness for people to get checked out earlier & not ignore symptoms. Unfortunately with lung cancer many symptoms are not there I have seen a significant number of patients in clinic with extensive disease who look & feel well so this is difficult. Screening pilots have been done within the Manchester area with low dose CT scans but currently there is no viable screening process. Surgery at 24.8% is better than it used to be. A lot of work has been done by Wythenshawe by the surgical team there to get patients treated as quickly as possible & they also operate on people with N2 node disease now whereas not long ago they were not considered. Low proportion of patients receiving chemotherapy with advanced disease – the key to this is for diagnosing at an earlier stage for which work is ongoing. A lower percentage of patients not receiving chemo with advanced disease is not necessarily a bad thing for non-small cell lung cancer; effective chemotherapy may only extend life by weeks/months. Chemo has potential side effects that have significant risks so is not taken lightly. Essentially it is the oncologist/patient decision. Low proportion of small cell lung cancer patients receiving chemotherapy – small cell lung cancer is a fast growing cancer the earlier it is diagnosed the better chance of a longer survival as previously stated work is being undertaken to diagnose earlier. Again patients need to be at a safe fitness level for chemotherapy. We discuss borderline fitness patients with the oncologists as sometimes they can admit patients to Christie to try single agent chemo initially & if they respond increase regime to standard chemo All these issues are discussed at the North West Sector lung cancer AGM looking at any actions we need to take forward as a sector

Local Audits:

205 local audits were registered between April 2017 and March 2018.

The reports of **65** local clinical audits were reviewed by the provider in 2017/18. Below is a selection of those action plans with a brief narrative of what action Bolton NHS Foundation Trust intends to take to improve the quality of healthcare provided to our patients.

Table 4: National Clinical Audits: Actions to Improve

Audit Title	Learning
Compliance with Paediatric Antibiotic Guidelines in RBH	We have improved compliance with antibiotic prescribing from this guideline since previous the previous audit achieving 82% adherence. However there are still some paediatric conditions / infections which are not specified within the guideline (16% patients audited) and it would be useful to include these conditions. The current guideline is under review and due for updating very soon. Additional conditions (including for example infected eczema, Pertussis and sickle cell disease amongst others) have been included within the new edition. The clinical staff managing and treating children on the paediatric wards and outpatients will be able to continue to prescribe according to local guidance, providing the best evidence based and locally consistent treatments for children.
Neonatal Jaundice Guidelines (NICE QS57)	Achieved 100% compliance with the NICE Quality Standard 3 (treating infants appropriately for neonatal jaundice). We did identify some areas for improvement including improved documentation around blood group results and documenting giving out information leaflets to families. The need to complete all areas of our local phototherapy charts (including blood group results) has been cascaded to junior staff and will continue to be included within junior doctor induction. It will also be included in a new Paediatric Handbook for junior staff within the next few months. The need for nursing staff to document when they give out information leaflets has been cascaded by senior nursing staff. We continue to deliver a high standard of care to infants with neonatal jaundice and are compliant with NICE guidance and Quality Standards. We are addressing some issues around documentation to improve standards further still.
Ovarian Cysts Re-Audit	Risk of Malignancy (RMI) calculated for all patients presenting with ovarian cysts. Appropriate follow up according to RMI including discussion at MDT if moderate or high RMI. RMI aid & Ovarian cysts flowchart available. Appropriate management & follow up of moderate & high risk (RMI) Ovarian Cyst patients.
Low Risk Induction of Labour	Update of local guidelines. Improved patient & staff awareness. Patient's suitability assessed & where appropriate risk level patient offered Induction of Labour at home.

Audit Title	Learning
Obstetric Cholestasis	Documentation of counselling, tests & management plan. Postnatal at 6/52 LFT by GP. Development of checklist. Documentation in postnatal notes. Patient management & follow up improved.
Handover of Obstetric and Gynaecology patients in RBH	Staff education & Training around requirements for handover. Full documentation at handover. Improved safety.
Breech and ECV management	New RCOG guideline 2017 followed. Rescheduling with assigned days and operators for ECV. Appropriately experienced clinicians available for ECV.
Surgical site infection audit - breast surgery	Increase patient awareness to hygiene. Staff Awareness for wound cleaning and dressing Teaching on 'wound care, signs of infection and management' Risk of surgical site infection following surgery reduced.
Management of Sever Pre-eclampsia	Ensure criteria for starting on Severe PET regime are achieved. Adherence to local guideline. Documentation, monitoring & escalation as appropriate.
Decision to delivery interval for cat 1 LSCS	Adherence to local guideline. Decision for LSCS after a failed /abandoned instrumental delivery to reflect the time decision was made to deliver. Transfer of patients to theatre no more than 10 minutes after decision time.
Gynaecological surgery readmissions - Audit of readmissions < 30 days of Gynaecological surgery	Reinforce good practice (ANTT/ IV Abs prior to incision/chloroprep) Consultant review <12hrs Documentation AB prior to incision, EBL Prophylaxis for constipation post major surgery. PGD for nurse led prescribing of analgesia and laxatives as TTO.
Gynaecological surgery returns to theatre - Audit of returns to theatre within 30 days of Gynaecological surgery	Monitor trends by annual re-audit. Monitoring of higher BP when checking haemostasis – details on theatre board
Melatonin use in ABR testing	Information for parents around methods of calming their child to allow behavioural tests to be performed. All children given milk prior to melatonin as a natural sleep aid. Patient management improved with potential of calmer patient at behavioural tests.
Blood Culture Reporting - The impact of non-24 hour Blood Culture Reporting	Delay in blood culture samples being incubated minimised. Blood cultures available promptly. Antibiotics stopped if the blood cultures are negative. Duration of antibiotic treatment appropriate.
Warfarin and administration time	No evidence based medical reason for prescribing warfarin only between 4 and 6 pm Delay in prescribing warfarin Delay in patients receiving warfarin. Warfarin being prescribed predominantly by the on call team. Change in timing of patients receiving warfarin to around 12 noon

Audit Title	Learning
	Pilot change in practice on cardiology ward before rolling it across the trust. Warfarin audit discussed at hospital thrombosis committee meeting. Consistent practice of patients receiving warfarin in a timely manner during normal working hours. Responsibility of prescribing warfarin with the parent team rather than on call team Safe prescribing of warfarin
Unified do not attempt cardiopulmonary resuscitation (uDNA CPR) with a focus on communication	Ensure uDNACPR forms verified by consultants at earliest possible opportunity. Extra Med icon for all patients with a DNA CPR in situ. Effective communication between secondary and primary care. Introduction of a ward round 'prompt' to ensure uDNACPR forms are verified by consultants at earliest possible opportunity. Development of an Extra Med icon for all patients with a DNA CPR in situ. Introduction of a DNA CPR 'tick box' prompt on Ascribe to facilitate effective communication between secondary and primary care. DNACPR at earliest opportunity. Icon to alert clinicians. Effective communication between secondary and primary care.
Barratt's Surveillance	Appropriate management according to NICE guidance. LGD patients repeat endoscopy in 6 month. If LGD is found in any of the follow -up OGDs and is confirmed by an expert GI pathologist, the patients offered Endoscopic Ablation Therapy and review by the specialist MDT. If ablation is not undertaken, 6 monthly surveillance is recommended.
Sunlight Exposure 2017 Re-Audit of documented advice on sun protection	Appropriate sunlight exposure advice provided to patients with history of skin cancer (Melanoma)
Visual Impairment in patients with falls	Post fall assessment document to include visual assessment. Education of complex care staff. Potential to reduce falls in patients with visual impairment.
Diabetic referrals audit	Not all staff aware of the procedure for triaging diabetic referrals. Biomechanics staff educated on correct process for triaging diabetic referrals. Diabetic patients with foot and ankle pain are seen in a timely manner, with the equipment and staff skill set needed to deal with any diabetic foot complications that may arise.
LIFT procedures at RBH	The fistula workload remains sizeable. The Audit has demonstrated outcomes (fistula healing) in-line with other published series. It is hoped that results will improve slightly with increased experience. Continue the Audit process and continue to offer LIFT operation to appropriate patients. LIFT operation remains the gold standard of care for certain fistula patients.
Slide sheet usage in CT Re-Audit	Correct moving and handling is reliant on provision of slide sheets from wards.

Audit Title	Learning
	Supply of slide sheets provided by ED and completion of slide sheet check to ensure that we do not run out. Better experience for patients when correct procedure is used for moving them; faster imaging when we do not have to look for slide sheets.
Immediate/delayed check list for breast reconstruction	Education of Breast Care Nursing team to be able to use the document electronically. Standardisation of how to use the document. To ensure that document is used as a form communication between Breast Care Nurse and oncoplastic surgeon. Offering support to the team and guidance on how to use the check list. Breast Care Nurses to email document to oncoplastic surgeon and paper copy to be filed in clinical notes Improvement in documentation of written evidence on breast reconstruction consultation between patient and Breast Care Nurse. Improvement in communication between Breast Care Nurse and oncoplastic surgeon.
Oculoplastic Surgical Outcomes - Auditing the unauditable - what to do about unmeasurable Oculoplastic Surgical Outcomes?	A tool has been developed and is user friendly and provides auditable information on surgical outcomes. Now undergoing full implementation to enable auditing of oculoplastic surgical outcomes. This will allow us to identify trends. Ensuring surgical outcomes are monitored and early trends identified to identify areas which require improvement. Also provides scrutiny for patients and commissioners.
Strabismus - Use of the Adult Strabismus 20 (AS-20) Questionnaire as a measurement of Quality of Life in Adults with Strabismus Pre and Post-Operatively	The AS-20 questionnaire provides useful information that adult strabismus surgery is valued by patients and leads to direct improvement in quality of life. Continue to offer adult strabismus surgery in Bolton. Provides evidence for commissioners that squint surgery results in significant improvements in quality of life.
ENT Re-Admissions	Need for O2 sats monitoring & repeat bloods prior to discharge. O2 sats monitoring for all patients who are being treated for OSA, repeat bloods prior to discharge. Avoid early discharge and make sure clinical improvement before discharge.
Assessing the image quality of portable adult chest x-rays	Application of pre- exposure markers needs to improve and artefacts need to be removed. CPD session to staff to remind them of importance of these actions. Better quality imaging.
Compliance with IR (ME) R Regulation : Procedure for carrying out and recording an evaluation of a medical exposure	NICU Imaging is not compliant with delegation of evaluation of image. Lead clinician in NICU informed; re-audit to take place. Compliance with IRMER.
Assessment of the requirement/necessity of Entonox gas during	Pain scores need to be documented pre and post procedure. Staff in this area informed to document pain scores.

Audit Title	Learning
Hydro Dilation of the shoulder examination in Radiology	Better pain management.
Impact on patient throughput of using old styles ED trolleys v's new trolley	New trolleys are needed to image patients from ED. Business case submitted for trolleys by ED. Lower radiation dose, better quality image and faster examination.
Red Cell Dosage calculator app	Use of the web app is an effective method of predicting the volume of red cells required by a non-bleeding patient to reach a target haemoglobin level, and reduces the amount of red cells used by the Trust. Evaluating possibility of making the app 'open-access' for NHS organisations as shared good practice. Reduction in the level of over and under-transfusion in non-bleeding patient compared to pre-implementation level. Improved patient safety through reduced donor exposure and reducing the risk of transfusion-associated circulatory overload by avoiding over-transfusion. Better use of donor red cells which are a limited resource.
Ionising Radiation Regulations 2000 for Orthopaedic theatre use of mini c-arm. Audit of post procedural request cards	Request cards are not being completed appropriately. Discussion at orthopaedic audit meeting; reminder to individual consultants. Compliance with IRMER.
Cataract Referral audit	Referral patterns from optometrists show that a significant proportion of patients are not being listed for surgery. Plan to undertake further teaching with community optometrists to best utilise the direct referral pathway. Will result in fewer unnecessary appointments for patients and more efficient use of staff time in eye unit.
ARC and ward attender Audit	Large numbers of referrals, although no increase on previous audit undertaken for a week. An acute referral working group to be set up to look at improved referral process. E-referrals in place for some providers, with an aim to eliminate the faxed referral in time. More robust system of accepting referrals improving efficiency, safety (no unnecessary delays for patients with sight-threatening emergencies) and patient experience.
Temporal artery biopsy outcomes	Educational session to general surgeons undertaking this procedure to raise awareness of biopsy length recommendations and technical/anatomical aspects of the procedure.
Day 0 mobilisation following elective orthopaedic surgery for hip and knee replacements	Ward based training to increase awareness of early mobilisation of patients. Earlier mobilization of patients with improved outcomes.
Physiotherapy home	Written instructions in sheet & diagrams of the exercises. Patients feel

Audit Title	Learning
exercise programme	more confident in completing exercises at home & are more compliant with exercise programme.
Ankylosing Spondylitis 2017	Audit indicates 100% compliance with guidance. Continue to endeavour to provide the best care to the patients by following the latest evidence, NICE guidelines and the GMMMMG guidelines.

Participation in Clinical Research

The number of patients receiving health services that were provided or sub-contracted by Bolton NHS Foundation Trust were in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee **1123**.

55 National Institute for Health Research (NIHR) Portfolio Research studies with Health Research Authority (HRA) / Research Ethics approval, were open to recruitment at Bolton NHS Foundation Trust in 2017/18

Goals agreed with Commissioners: use of the CQUIN payment framework

A proportion of Bolton NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Bolton NHS Foundation 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.

In 2017/18 Bolton NHS Foundation Trust received £5.674m of its CQUIN target agreed with commissioners

In 2016/17 Bolton NHS Foundation Trust received £5.642m of its CQUIN target agreed with commissioners

Further details of the agreed goals for 2017/18 and for the following 12 month period are available on request via Rachel.hurst@boltonft.nhs.uk

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 2017/18.

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 reported in August 2016 and achieved an overall rating of "good". Please see below CQC ratings grid:

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

The report included 21 recommendations to further improve the services provided by the Trust. The Trust's internal auditors provided assurance that 18 of these have now been fully implemented with evidence that the remaining three are in continual review via the quarterly integrated governance report process.

Data Quality

Bolton Foundation NHS Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data: (as at March 2018)

- **which included the patient's valid NHS number was:**
  - *99.9%* for admitted patient care;
  - *100%* for outpatient care; and
  - *99.4%* for accident and emergency care.
- **which included the patient's valid General Medical Practice Code was:**
  - *94.6% for admitted patient care;*
  - *99.9% for outpatient care; and*
  - *99% for accident and emergency*

Action to Improve Data Quality

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

- The Data Quality team continues to validate data and highlight issues as they arise. Error reports have been designed to highlight issues and errors in a timely manner. When necessary staff are spoken to individually to make them aware of errors and prevent further errors occurring.
- Users are encouraged to contact the Data Quality team for advice and guidance. This has resulted in departments being more proactive at contacting the department for advice when setting up and or making changes to services.
- A new Data Quality strategy is being written which will enable the team to drive forward the importance of good quality data.
- Much of the data the trust holds is benchmarked nationally using CHKS Methodology. In addition to this we receive assurance on the accuracy of our data quality through an annual report on non-financial data from our internal auditors, a review of metrics included in this report performed as part of the audit conducted by our external auditors and other external audit reports as appropriate.

Information Governance

Bolton Foundation NHS Trust Information Governance Assessment Report overall score for 2017/18 was 85% and was graded "**Green**".

Clinical Coding Audit

Bolton Foundation NHS Trust was not subject to the Payment by Results clinical coding audit during 2017/18.

Learning from Deaths

During *2017/18* 1266 of Bolton NHS Foundation Trust patients died.

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 273 in the first quarter;
- 263 in the second quarter;
- 330 in the third quarter;
- 400 in the fourth quarter.

By 31/03/18, 514 case record reviews and 8 investigations have been carried out in relation to 1266 of the deaths included above. In 8 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 91 Case record reviews in the first quarter; Investigations = 0
- 128 Case record reviews in the second quarter; - Investigations = 2 (cardiac arrest root cause analysis)
- 126 Case record reviews in the third quarter; Investigations = 2 (cardiac arrest root cause analysis)
- 170 Case records reviews in the fourth quarter; Investigations = 4 (2 cardiac arrest root cause analysis and 2 Serious Incident investigations)

0.63% (8/1266 x 100) **–** of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 2 representing 0.16% (2/1266 x 100) for the second quarter;
- 2 representing 0.16% (2/1266 x 100) for the third quarter;
- 4 representing 0.32% (4/1266 x 100) for the fourth quarter.

These numbers have been estimated using the data provided within the cardiac arrest root cause analysis reports and mortality review process

The following learning has been disseminated as a result of case record reviews and investigations:

- Take into account the patient's condition when transferring to a different ward
- The importance of target oxygen saturations on admission

- Importance of communication and handover following a patient deteriorating
- Appropriate escalation of raised lactate

The following actions have taken place as a result of the learning described above:

- Sepsis Policy and Screening Tool updated to remove out of date documents
- Ward Managers instructed to ensure Sepsis Screening Tool is available in all areas.
- The impact of any actions will be assessed via the audit cycle during 2018/2019.

Zero case record reviews and zero investigations completed after 31/03/17 which related to deaths which took place before the start of the reporting period.

0 % of the patient deaths before the reporting period (April 2017) are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the review methodology of the mortality review forms, cardiac arrest root cause analysis and secondary review forms.

0 % of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Seven day services.

Bolton NHS Foundation Trust takes an active part in the biannual national seven day hospital services audit with demonstrable progress being made against the following priority clinical standards:

- Standard two – "Time to first consultant review within 14 hours of admission to hospital" has improved from 54% (March 17) to 71% (September 17) for weekday and weekends 73%. Improved performance has been helped by redesign of Medical Assessment Unit ward rounds. Ongoing actions include redesign of the consultant physician on call rota to increase weekend presence and generation of a business case for an additional Consultant General Surgeon to enable twice daily ward rounds.
- Actions to improve adherence to standard five –"access to diagnostic tests" and standard six "access to consultant directed interventions" consist of the redesign of Consultant Radiologist job plans towards seven day working and increased collaboration with neighbouring trusts.

Seven day service action plans are monitored quarterly at the Joint Leadership Group with Bolton CCG and will be driven internally at our Medical Workforce Improvement Group. We feel that we are currently on track to meet our target of 100% compliance with the seven day services priority standards by 2020.

Quality Report – Section Two

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 NHS Digital. 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 Report 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	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
Mortality: The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for 10/16 – 09/17 latest published data available	SHMI value = 1.060 Band 2	SHMI value = 1.00 Band 2	SHMI Value = 0.72 Band 3	SHMI Value = 1.22 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 • Recognising and responding to deteriorating patient workstream • Mortality review process • Cardiac Arrest Root Cause Analysis	SHMI value = 1.045 Band 2 as expected	SHMI value = 1.004 Band 2 as expected

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
% patients deaths with palliative care coded at either diagnosis or specialty level for the period 04/16- 03/17 Latest published data	31%	31.1%	11.2% The Queen Elizabeth Hospital, King's Lynn	58% Royal Surrey County Hospital	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: • 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 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	28.5% (10/15 – 09/16)	20.28% (13/14)
Patient reported outcome scores for groin hernia surgery Apr17 – Sept17 latest data available	83.3%	82.6%	96.6% Surrey and Sussex Healthcare	40.2% Barts Healthcare NHS Trust	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.	77.7% (04/16 – 03/17)	31.4%
Patient reported outcome scores for varicose vein surgery Apr17 – Sept17 latest data available	70.9%	78%	94.9% Emerson's Green NHS Treatment Centre	39.5% Oxford University Hospital		77.0% (04/16-03/17)	53.0%

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
Patient reported outcome scores for hip replacement surgery Apr17 – Sept17 latest data available	33.7%	56.2%	90.7% Springfield Hospital	11.1% East Sussex	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	51.6% (04/16-03/17)	85.6%
Patient reported outcome scores for knee replacement surgery Apr17 – Sept17 latest data available	65.5%	57.2%	88% BMI the Ridgeway	5.5% North Lincolnshire and Goole NHS Trust		56.1% (04/06-03/17)	81.8%
28 day readmission rate for patients aged 0 – 15	[redacted]		0.0% Aintree University Hospitals NHS Foundation Trust	13.6% North Cheshire Hospitals NHS Trust	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	12.82%* (11/12)	13.78% (10/11)
28 day readmission rate for patients aged 16 or over			0.0% Barts Health NHS Trust	13.5% The Lewisham Hospital NHS Trust		10.04%* (11/12)	10.17% (10/11)

*The latest published national data for 28 day readmission rate provided above is for 2011/12.

Local data for Bolton NHS Foundation Trust readmission rate for 2017/18 is 12.8% *(based on PBR national guidance, exclusions apply)*

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
Responsiveness to inpatients' personal needs: national inpatient survey score 2017	76.1%	76.7%	88% Queen Victoria Hospital NHS FT	70.7% Lewisham and Greenwich NHS Trust	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 • Procurement of single software provider to capture real time patient feedback • Launch of Always Events in 2018	76.1%	73.4%

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
Percentage of staff who would recommend the provider to friends or family needing care – Friends and Family Test	66%	79%	93% The Clatterbridge Cancer Centre NHS Foundation Trust	47% Northern Lincolnshire and Goole NHS Foundation Trust	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	73%	

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
% of admitted patients risk-assessed for Venous Thromboembolism Q3 17/18	97.77%	95.36%	100% Essex Partnership University NHS FT	76.08% Mid Essex Hospital Services NHS Trust	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	97.53% Jan 17 – Mar 17 latest data available	97.20%

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
Rate of C.Difficile per 100,000 bed days (amongst patients 2 of over)	15.0	N/A	N/A	N/A	Bolton Foundation NHS Trust considers that this data is as described for the following reasons: 28 trust assigned cases between April 2017 and February 2018 (11 months). Bed data taken from KH03 return, Quarters 1-3, and using Q4 from 2016/17 (as current quarter not yet available) adjusted for 2/3 months of final quarter. 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 • IPC link nurse development programme • Recruitment of an IPC audit and surveillance clerk	18.1*** *** national data available from PHE/HPA	14.1***

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
Number/Rate of patient safety incidents per 1000 bed days Oct 16 – Mar 17 latest data available (NRLS)	54.81 per 1,000 bed days N = 5,717	32.52 per 1,000 bed days	23.13 per 1,000 bed days Maidstone and Tunbridge Wells NHS Trust	68.97% per 1,000 bed days Wye Valley NHS Trust	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: • Risk management strategy • Risk management training for clinical risk managers • 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	50.81 per 1,000 bed days Apr16 – Sept16 latest data available (NRLS)	38.91 per 1,000 bed days (2014/15)
Rate of patient safety incidents per 100 admissions that resulted in severe harm or death 04/16 – 09/16) latest data available	0.15	0.38	0 - Great Ormond Street Hospital for Children NHS Foundation Trust	0.53 - Kettering General Hospital NHS Foundation Trust		0.15	0.1
Inpatient Friends and Family Test To January 2018 - latest data available	97%	96%	100% Clatterbridge cancer centre NHS Foundation Trust	80% Sheffield Children's NHS FT	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	94.0% March 2017	96%

Indicator	2017/2018	National Average	Where Applicable – Best Performer	Where Applicable – Worst Performer	Trust Statement -	2016/17	2015/16
Accident and Emergency Friends and Family Test To January 20178-latest data available	88%	88%	100% Liverpool Women's NHS FT	45% Mid Essex Hospital Services NHS Trust	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	82.0% March 2017	85.7%

Quality Report – Section Three

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 2016/17

	Indicator/Measure	2017/18	2016/17	2015/16
Patient Safety Outcomes	Mortality - SHMI	See page 40		
	C.Diff – number of cases	See page 43		
	Pressure ulcers by category: • Cat 2 • Cat 3 • Cat 4 *Data source – Bolton NHS Foundation Trust's incident reporting system*	 164 59 13	 176 61 16	 142 58 19
Patient Experience	Friends and Family Test inpatients • response rates • Recommendation rates *Data source – captured locally, submitted nationally and published by NHS England*	 34.0% 96.8%	 32.3% 98.0%	 18.3% 79.0%
	Lessons Learnt	See below		
	Dementia Training* ** HEE Tier 1 Dementia Awareness* *Data source – captured via local training and development system (Moodle and ESR)*	100%	89.8%	82.1%
Effectiveness	Sickness rates *Data source – captured via local attendance management system (E-roster and ESR), submitted nationally and published by NHS Digital*	4.95%	5.3%	4.58%
	Appraisal rates *Data source – captured via local ESR and reported locally for Board report*	82.8%	82.1%	83.1%
	Mandatory Training compliance *Data source – captured via local training and development system (Moodle and ESR)*	89.9%	89.0%	88.7%

The above data is reflective of 2017/18 performance; national comparable benchmarking data for the same period was not available at time of Quality Account publication. Where applicable/available the above indicators are governed by national standard definitions.

Lessons Learnt:

The Trust strives to continually learn from incidents, complaints and litigation. Learning slides are provided on a monthly basis by the Deputy Director of Governance which includes learning from incidents, complaints, claims and inquests in addition to learning generated as a result of research and development and activity around equality and diversity. Where an issue has been identified through any investigation process that requires urgent dissemination Trust wide, an urgent SBAR (Situation, Background, Assessment, Recommendation) slide is circulated by the Deputy Director of Governance.

The trust recognises the importance of learning from incident investigations and the implementation of change. In 2017/18, the Trust increased the scrutiny in relation to completion of action plans and introduced the audit cycle to measure the effectiveness of any changes in practice which will be further developed in 2018/2019.

Performance against the relevant indicators and performance thresholds (Risk Assessment Framework and Single Oversight Framework)

Indicator for disclosure (limited to those that were included in both RAF and SOF for 2016/17)	**2017/18**	**Target**	**Achieved**	**2016/17**	**2015/16**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (average for the year)	88.3%	92%	✗	92.1%	95.3%
A&E: Maximum waiting time of four from arrival to admission, transfer or discharge (average for the year)	81.9%	95%	✗	82.1%	90.4%
All cancers: 62-day wait for first treatment from:					
Urgent GP referral for suspected cancer (as at March 17)	94.8%	93%	✓	98.8%	97.5%
NHS Cancer Screening Service referral (as at March 17)	87.5%	90%	✗	97.3%	95.7%
Clostridium difficile - meeting the C. difficile objective	30	19	✗	29	28
Summary Hospital-level Mortality Indicator included in "**Reporting against core indicators" section**					
Maximum 6 week wait for diagnostic procedures *Definition – proportion of patients referred for diagnostic tests who have been waiting less than 6 weeks*	97.7%	95%	✓	99.6%	99.5%
Venous thromboembolism (VTE) risk assessment included in "**Reporting against core indicators section"**					

Quality Report – Section Three

Statement from NHS Bolton Clinical Commissioning Group (CCG)

The CCG has again worked closely with Bolton FT in 2017/18 to gain assurance that the Trust has provided safe, effective and patient focused services. A collaborative and clinically led governance process continues to monitor quality and the content of this account is consistent with the information shared throughout the year.

The CCG is pleased to see the Trust acknowledge the close working relationship between community and hospital staff and expect that this will further extend to colleagues in primary care and the local authority to enable Locality Plan delivery. It is also pleasing to see individual achievements recognised within the Account.

In reference to performance against last year's priorities, the CCG were pleased to see that the aims for pressure ulcer reduction and DNACPR were met and that work is on-going in these areas to build on these positive outcomes. The CCG also note the commitment to the Sepsis priority and that although this was only partially achieved the focus on improvement is continuing both within the 18/19 Quality Account and as a CQUIN.

The CCG were pleased to be consulted on regarding the 18/19 priorities and although our recommendations have not entirely aligned with the areas chosen we acknowledge that AKI, sepsis and medication errors are key priorities and we are confident the FT can achieve the outcomes stated. The CCG note the SMART measures that are in place to aid this.

There have been some challenging performance issues throughout 17/18, namely against the national targets for A&E, mixed sex accommodation, referral to treatment times and cancer screening. The CCG has worked closely with the FT to be assured that there is minimal impact on patient safety, the effectiveness of care or the patients overall experience with regards to these.

The CCG continues to appreciate the open and transparent culture within the FT and the willingness to collaborate with the CCG and the wider community to support quality improvement. Examples of these are the collaborations around pressure ulcers, medicine safety, infection control, mortality reviews and falls. There have been noticeable improvements in data quality within the FT but there is still much work to undertake here and we look forward to supporting the FT with this. This partnership work will enable a population approach to health and social care and the delivery of the Bolton Locality Plan and we further emphasise the need for the FT to support its workforce.

We are pleased with the progress detailed in the Account, acknowledge the challenges that remain but expect our collaborations will be sustained and enable the further delivery of safe, effective and patient focused care throughout the locality.

Dr Jane Bradford - Clinical Director for Governance and Safety

Michael Robinson - Associate Director of Integrated Governance and Policy

Independent Auditor Report

BOLTON NHS FOUNDATION TRUST - ANNUAL ACCOUNTS 2017/18

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2018 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 24th May 2018