Bolton NHS Foundation Trust – Board Meeting 25 July 2019

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

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09:00		Patient Story		Verbal	For the Board to hear a recent patient story to bring the patient into the room (Press and public may be excluded to preserve confidentiality)
09:20	1.	Welcome and Introductions	Chair	verbal	
	2.	Apologies for Absence	Trust Sec.	Verbal	Apologies noted
	3.	Declarations of Interest	Chair	Verbal	To note any declarations of interest in relation to items on the agenda
09:25	4.	Minutes of meeting held 26th June 2019	Chair	Minutes	To approve the previous minutes
	5.	Action sheet	Chair	Action log	To note progress on agreed actions
	6.	Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
09:30	7.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SUIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
09:40	8.	Quality Assurance Committee Chair Report	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
	9.	Finance and Investment Committee Chair Report – meeting held 23/07/19	FC – Chair	Report	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
	10.	Workforce Assurance Committee Chair Report – meeting held 19/07/19	CEO	Report	CEO to provide a summary of assurance from Workforce Assurance Committee and escalate any items of concern to the Board
	11.	Urgent Care Delivery Board Chair Report	CEO	Report	To receive a report on the Urgent Care Delivery Board
10:10	12.	Mortality Report	Medical Director	Report	To receive the Mortality Report
	12.1	Learning from Deaths Quarterly Report	Medical Director	Report	To receive the Learning from Deaths Quarterly Report

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
10:20	13.	Cancer Performance	COO	Report	To receive an update on cancer performance
10:30	14.	WRES/WDES	Director of Workforce	Report	To note the WRES/WDES
10:40	15.	Nurse Staffing update	Director of Nursing	Report	To receive the six monthly update on nurse staffing levels
10:50	16.	Performance Report	All	Report	To discuss the metrics on the integrated performance report

Coffee

Governance					
11.20	17.	Finance Committee Annual Report	F&I Chair	Report	To receive
	18.	Finance Committee Terms of Reference	F&I Chair	Report	To approve the revised terms of reference
11.30	19.	CNST submission approval		Report	To approve
	20.	Any other business	Chair	Verbal	
Questions from Members of the Public					
	21.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted				

Meeting	Board of Directors Meeting – Part One
Time	09.00
Date	27 June 2019
Venue	Boardroom RBH

Present:-

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

In attendance:-

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

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

Apologies

The Chair welcomed attendees and observers

Declarations of Interest

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

4. Minutes of The Board Of Directors Meetings held 30 May 2019

The minutes of the meetings held on 30 May 2019 were approved as a true and accurate reflection of the meeting.

5. Action Sheet

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

6. Matters Arising

There were no matters arising.

7. Chief Executive report

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

In response to a question about the planned HSE visit in September 2019, the Director of Nursing confirmed that the Trust would be working with iFM Bolton in preparing for this visit; Ms Ganz assured Board members that Health and Safety was a key priority for iFM Bolton.

Mr North shared feedback from the shadow board on the excerpt from the letter from Baroness Harding; the Director of Workforce confirmed that the full letter would be included in a report to the next Workforce Assurance Committee.

Board members asked that their thanks and congratulations following the announcement that the Trust is third in the country for 62 day cancer performance should be shared with operational teams.

Board Assurance Framework

The Board noted the updates to actions and controls to mitigate against the risks to the achievement of the strategic objectives. The Director of Finance advised that given performance in the year to date, the risk of achieving the delivery of the finance plan would be reviewed.

Resolved: the board noted the CEO update.

8. Quality Assurance Committee Chair Report

Mr Thornton, the NED Chair of the QA Committee presented a summary of the meeting held on 19 June 2019. Key points for the Board to note were as follows:

- Clinical Governance and Quality Committee received an update on nasogastric tube misplacement and the nutrition steering group report – QA Committee members agreed that an update on nutrition guidance would be presented to the Board in September
- Divisional quality report - The Committee commended the reports from the Elective and Family Care Divisions which provided a balance view of challenges and successes. Although no incidents have been reported, an action was requested to provide further assurance that actions taken to increase MRI capacity do not have an impact on patient outcomes
- The chief Pharmacist attended to provide his six monthly update focusing on actions taken to support the safe and effective use of medicines

across the organisation

- The Medical Director provided details of the new learning from deaths process. The Committee commended the report and process – follow up report to be provided in July and then a regular quarterly report
- The Committee received the bowel cancer screening report and noted that while some progress has been made in reducing waiting time this is reliant on additional capacity some of which has been provided by eternal partners. The system remains fragile with limited resources across GM - this challenge which has been discussed within GM and is impacting on all providers was flagged as an issue for Board members to be aware of.
- The team provided a summary of evidence prepared for submission to CNST a further update will be provided to the QA Committee in July prior to seeking formal Board approval in July 2018
- Committee members discussed the use of the CQC insight report and agreed a proactive response was required to seek assurance with regard to the actions being taken.
- The Committee reviewed three final SI reports – two reports were approved for submission to the CCG. Committee members felt that further detail was required for the third report relating to a surgical never event.
- The Committee received a number of reports from its sub- committees which included the report from the Mortality Committee which escalated the ongoing concern regarding mortality indicators. A full mortality report will be provided to the next Board meeting.

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

10. Finance and Investment Committee Chair Report

Mr Stuttard, the NED Chair of the Finance and Investment presented his report from the meeting held on 25 June 2019.

Key points for the Board to note were as follows:

- The Trust will receive an additional £0.5m following redistribution of PSF previously allocated to another trust – the accounts will be restated to include this payment.
- Financial performance continues to be a challenge, at the end of month 2 the Trust has a deficit of £4.6m against a planned deficit of £2.3m. the three main factors contributing to this are:
    - ICIP off track
    - Income under plan
    - Expenditure run rate worse than plan.

  Other GM Trusts are reporting similar pressures and work is being undertaken across GM to understand the challenge.
- The Director of Finance presented a proposed recovery plan including a range of actions to improve the financial position. Board members discussed the position and the challenge and acknowledged that although

the level of risk has on the BAF has not yet increased this will be reviewed at the end of the first quarter.

- The Committee have recently focused on overdue debt with a total of circa £1m debt over 180 days. The Committee discussed actions to reduce this debt and will continue to receive monthly updates until the position improves.
- The Committee received a comprehensive update from iFM Bolton including a detailed ICIP plan. Overall iFM have reported a small profit and the F&I Committee were assured that appropriate processes were in place.
- The annual report of the F&I Committee was approved and will be presented to the Board in July 2019

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

10. Workforce Assurance Committee Chair report

The Chief Executive presented her Chair's reports from the Workforce Assurance Committee meeting held on 21 June 2019:

- The Committee considered the details of the WRES and WDES findings. It was noted that whilst improvement had been made in some areas significant work continues to be required.
- The Committee received the Integrated Workforce Performance Report. The report triangulated key workforce data to support informed discussions.
- Detailed discussions took place regarding key workforce metrics such as sickness, headcount, agency, recruitment and turnover.
- The Committee received an update from the GOSW (via the Medical Director). The Committee noted their disappointment at the quality of the report and discussed the changes required to provide the assurance needed.

Board members noted the update and asked if for future reports additional more detail could be provided in the actions column of the report.

Mr North advised Board members that the first meeting of the Shadow Board had been held earlier in the week, the development opportunity had been well received by participants. In response to a question regarding further and future development opportunities for current and future cohorts the Director of Workforce advised that this need was recognised and would be discussed further.

The Chair advised that further discussion on Board diversity had been scheduled alongside the presentation of the WRES and WDES.

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

11. Urgent Care Delivery Board

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

- The UC Board discussed actions to achieve reduction in length of stay, although ECIST are assured that SAFER is well embedded in the Trust and length of stay is reducing, there are additional opportunities especially around escalation of care and management of patients with mental health needs.
- Further work is also required to discharge patients earlier in the day thus freeing beds for admissions.
- The Care Home Transformation scheme has been evaluated, most schemes with the exception of Immedicare which did not have the desired impact will continue.
- The current rolling average for A&E performance is 86%

Board members discussed the provision of proactive and reactive support for patients of all ages with mental health needs with agreement that it would be useful to hear more from GMMH on system wide actions.

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

FT/19/36	System wide discussion/report on mental health including proactive approach

12. <u>Freedom to Speak Up Annual Report</u>

The Director of Workforce introduced Tracey Garde, the Trust Freedom to Speak Up (FTSU) Guardian in attendance to provide her first Annual Report since taking the role.

Tracey presented the annual report on FTSU and explained to the Board how the provision had been increased both with her appointment to the role on a three day per week basis and the appointment of a diverse network of champions- currently 13 FTSU champions but plans in place to increase and ensure there is representation in all divisions and roles.

The refreshed approach has increased the number of referrals and is hoped will develop a culture where staff are confident that all concerns can be raised.

During 2018/19, 16 cases were reported through the FTSU route, all cases have been resolved.

Board members discussed the potential learning from concerns escalated by staff and the importance of a culture where staff can confidently raise issues without any fear of reprisal. The Director of Workforce confirmed that further detail was included in the quarterly report to the Workforce Assurance Committee.

Resolved: board members noted the annual report, expressed their commitment to an open learning culture and thanked the FTSU for her work.

FT/19/37	share quarterly WAC report with Board members

13. Seven Day Services

The Medical Director presented a paper describing the revised seven day services framework and detailing the Trust's performance against the 10 required standards as well as relevant actions still required. Board members were asked to consider the evidence of compliance with the ten standards and to approve submission for the required return to NHSI.

Board members discussed compliance with the standards and the balance between providing the commissioned level of service and a full seven day service within the available resources. The Medical Director confirmed that priority is given to the sickest patients which at times might result in delays for less acute patients

Board members discussed the self-assessment and the proposed submission, in response to a question about potential implications of submitting a declaration with a number of red rated areas the Medical Director advised that a significant number of other Trusts would be in a similar position.

Resolved: Board members noted the update and approved the submission of the self-assessment.

FT/19/38	Verbal update on benchmarking, written update in six months

14. Integrated Performance Report

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

Quality

- The Director of Nursing advised that although there had been an increase in the number of cases of c. difficile, the root cause analysis for each case had not identified any significant areas of concern.
- Performance against mortality indicators remains a concern, a full mortality report will be provided to the Board in July.
- The Trust benchmark well for FFT response rate and feedback, qualitative data from patient surveys is reviewed within the PEIP Committee.
- In response to a question about the number of still births, the Director of Nursing advised that this was discussed with the division in IPM and at the QA Committee. All still-birth cases are reviewed, no themes or concerns have been identified, the division feel this is a natural variation but will continue to monitor closely.
- Additional narrative on home births will be added to the next report. Director of Nursing agreed to follow up to respond to a question about any impact from the change in the maternity booking process.

Operational

- Pressure on the 18 week RTT target remains and the number of 52 week waits has also increased. Discussions with regard to increased capacity are ongoing with the CCG.
- Although the ED four hour target is not being achieved performance continues to improve. Activity continues to be a challenge with a new daily record of 472 patients seen in the department on Monday 24th June 2019. Work done to improve streaming and work with NWAS has been recognised at GM level, the Trust is only one of two hospitals in the country to sustain performance for ambulance handovers.
- Initiatives to reduce attendances and admissions for the over 70s have had an impact however attendances have increased significantly in the working age population.
- The drop in TIA performance was discussed with the IPM meeting, the division have advised that they are confident that this will be achieved going forwards.
- The Trust has seen a 20% increase in referrals for patients on the two week breast pathway. The capacity to meet this need is being reviewed, including looking at opportunities to work with GPs to manage referrals. Despite this challenge patients who go on to require treatment are treated within the 62 day target time.

Productivity

- Model Hospital data is being reviewed to ensure regular scrutiny of the metrics, an invitation has been extended to the developer to attend the Board and provide a more detailed understanding of the benefits of Board oversight of these metrics

Resolved: the Board noted the integrated performance report

FT/19/39	next maternity update to include home births, still births and any impact following changes to booking process
FT/19/40	Further information for Board members on Model Hospital

15. Patient Story

Mr H, a 50 year old man with MS attended the Board to share his story with a focus on the support provided by community services. In relating his story Mr H praised the work of the Intensive Care at Home team and the wider intermediate care team who had recognised the importance of his independence and by really listening to his needs had balanced this with ensuring a safe home environment.

In discussing his in-patient stays, Mr H advised that while staff were courteous and friendly there were some issues with discharge planning and resources available on wards.

Resolved: Board members thanked Mr H for sharing his story which as well as

illustrating the services provided in the community and the need for neighbourhood key workers was effective in highlighting a number of points for action by the Director of Nursing and Chief Operating Officer.

15. Declarations for the NHS Provider Licence

The Trust Secretary presented the declarations required for condition FT4 (8)

Board members reviewed the statements, the risks to compliance with each statement and the mitigating actions and controls in place.

Taking each of the six statements by turn Board members agreed that they were happy to declare compliance with the corporate governance declarations.

In response to a question about the QIA process for ICIPS the Director of Nursing confirmed that along with the Medical Director she reviewed all QIAs through a formal monthly process. NEDs agreed that the internal audit team should be asked to review a sample of QIAs as part of their review of the ICIP process.

Board members also confirmed that they were satisfied that during 2018/19 a programme of training had been provided for the Governors to equip them with the skills and knowledge required to undertake their role.

Resolved: Board members approved the governance declarations for June 2019.

FT/19/41	internal audit to include review of QIA in ICIP review

16. Any other business

None

17. Questions from members of the public

No questions submitted

Date and Time of Next Meeting

25 July 2019

June 2019 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/19/01	31/01/2019	Patient Story	February PEIP meeting to focus on provision of support for patients with hearing impairments	TAC	Jul-19	verbal update
FT/19/18	29/03/2019	Patient Story	FA to follow up on comparison of different chemo treatments	FA	Jul-19	verbal update
FT/19/31	30/05/2019	Patient Story	PEIP to consider opportunities to promote support groups to patients	TAC	Jul-19	verbal update
FT/19/38	27/06/2019	Seven Day services	Verbal update on benchmarking, written update in six months	FA	Jul-19	verbal
FT/19/35	30/05/2019	iFM	Paper to outline future options to part two Board	ES	Jul-19	iFM update - agenda item
FT/19/43	27/06/2019	BCMS	Full presentation from development partners	TAC	Jul-19	agenda item
FT/19/42	27/06/2019	Chair report	List of all Governor meetings and sub committee meetings to NEDs	ES	Jun-19	complete
FT/19/37	27/06/2019	Freedom to Speak up	share quarterly WAC report with Board members	JM	Jul-19	complete
FT/19/12	28/02/2019	Gender pay gap	include update on actions within Workforce and OD strategy to Board in September	JM	Sep-19	
FT/19/29	25/04/2019	ICIP opportunities	future debate about business development opportunities	SM	Sep-19	
FT/19/34	30/05/2019	heatmap	review progress by reviewing with an earlier version	TAC	Sep-19	
FT/19/36	27/06/2019	Urgent Care Board	System wide discussion/report on mental health including proactive approach	JB	Sep-19	
FT/19/39	27/06/2019	performance report	next maternity update to include home births, still births and any impact following changes to booking process	TAC	Sep-19	
FT/19/40	27/06/2019	performance report	Further information for Board members on Model Hospital	AW	Sep-19	
FT/19/41	27/06/2019	Declarations	internal audit to include review of QIA in ICIP review	AW	Oct-19	

Key

complete	agenda item	due	overdue	not due

Agenda Item No: 7

Meeting	Board of Directors

Date	25 July 2019

Title	Chief Executive Update

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

Previously considered by	

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

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

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

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

1. Awards and recognition

Internal

Employee of the Month

Alex Watson, Volunteer, for his work supporting Friends and Family feedback

Team of the Month

ED Department – for their work on rapid assessment – reducing ambulance turnaround time from 12 – 13 minutes down to 8.

External

- Neonatal consultant Dr Ula El-Kafrawy was nominated for best educational supervisor in the PAFTAs – the Royal College of Paediatrics and Child Health's prestigious awards for training achievements.
- Ingleside Birth & Community Centre won two awards, and were highly commended in another at the Northern Maternity & Midwifery Festival. They picked up the award for Innovation, with the Student/Newly Qualified Award going to second year student Melissa Connelly. They were highly commended in the team category.
- Bolton's new endoscopy unit has been reaccredited by the Royal College of Physicians Joint Advisory Group (JAG) on gastrointestinal endoscopy. Accreditation is awarded to high-quality services and is a national standard.

2. News and Developments

2.1 Bolton

Trust's Nursing, Midwifery and AHP Conference 2019

"Practicing small noticeable things creates inspirational leadership". That was the key message from this year's annual Nursing, Midwifery and Allied Health Professionals Conference which focused on inspirational leadership and the importance of self-care to help build personal resilience.

Estephanie Dunn, Regional Director, North West Royal College of Nursing; Gill Walton, Chief Executive of the Royal College of Midwives and Jo Fillingham, Clinical Director, Allied Health Professionals all spoke personally and honestly about the challenges they'd faced on their own leadership journeys and the lessons they've learned along the way

Closure of Halliwell Children's Centre

Halliwell Children's Centre will be completely closed from Wednesday 31st July. The majority of services have been moving from the centre over the last 12 months. The paediatric audiology service is the final service to move into its new location at Breightmet Health Centre shortly.

2.2 North West Sector

An Exec to Exec meeting with leaders at WWL is scheduled for Tuesday 23rd July.

WWL have appointed a new CEO to replace Andrew Foster on his retirement in October. Silas Nichols has been working as CEO at Southport and Ormskirk Hospital Trust since April 2018, having previously worked as chief operating officer at University Hospital of South Manchester FT and Deputy Chief Executive and Director of Strategy at WWLFT

2.3 NHSI/NHSE

Learning Disability Improvement Standards

In June 2018, NHS Improvement launched the national learning disability improvement standards for NHS trusts. These were designed with people with a learning disability, carers, family members and healthcare professionals to drive rapid improvement of patient experience and equity of care.

The four standards, the first three of which apply to all NHS trusts, cover:

- respecting and protecting rights
- inclusion and engagement
- workforce
- specialist learning disabilities services.

Over 90% of acute, mental health and learning disability trusts took part in the benchmarking exercise commissioned last year from the NHS Benchmarking Network

Our individual benchmarking report which will be reviewed in detail through the Learning Disability sub group shows that we are not an outlier however as with many Trusts there are actions we can take to improve and this benchmarking will help identify where improvement efforts need to focus.

Closing the gap in rates of disciplinary action between BME and white staff

One of the key aims of the Interim NHS People Plan is to make the NHS the best place to work for its entire workforce. Part of achieving this is a concerted focus to close the gap in the disproportionate rates of disciplinary action between BME and white staff across the healthcare system.

NHSE/NHSI recently published a new strategy *A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce.* This strategy outlines clear aspirational goals in this area for local NHS organisations, as well as national healthcare arm's length bodies such as NHS England and NHS Improvement to work towards.

The Trust WRES report is included on the Board agenda today and a Board Development session on EDI has been scheduled for September.

Medicines and medical products supply: no-deal EU Exit plans

The Government has confirmed further details of how it will maintain the supply of medicines and medical products in the event of a no-deal EU Exit. These include procurement exercises to secure extra freight capacity, continuing the build-up of buffer stocks, securing extra warehouse space and a range of additional measures

Launch of the NHS Patient Safety Strategy

The first national NHS Patient Safety Strategy has been launched. It sets a vision for continuous safety improvement, underpinned by a safety culture and effective safety systems. The strategy emphasises the need to support staff and look at systems rather than blaming individuals when incidents occur. Key features include a safety syllabus and training for all staff, a new incident management system, patient involvement and a national patient safety improvement programme.

We are currently looking to schedule a Board Development session on safety improvement.

Reportable Issues Log

Issues occurring between 20/06/19 and 18/07/19

3.1 Serious Incidents and Never events

The Trust reported three serious incidents, one in relation to a prescribing error and the other two in relation to delay in diagnosis – both incidents will be investigated in accordance with the policy with final reports presented to the QA Committee.

3.2 Red Complaints – non received

3.3 Regulation 28 Reports

3.4 Health and Safety Executive

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

3.5 Whistleblowing

No concerns to escalate to board

3.6 Media Coverage

We had a number of positive media stories in the press, including:

- Planning permission being granted for Bolton College of Medical Sciences. This story was featured in local, regional and specialist press.
- Ingleside's award success was featured in the Bolton News.
- Bolton College students project to make theatre a more pleasant place for children with animal themed wall art was featured in the Bolton News.
- Finally, Strictly Come Dancing stars Gemma Atkinson & Gorka Marquez had their baby at the Princess Anne Maternity Unit at the start of July. They were incredibly complimentary about their experience both on social media and within the Bolton News and Manchester Evening News.
- The ongoing record attendances at A&E due to pollen and temperatures continued to attract attention in the Bolton News

4 Board Assurance Framework

The full Board Assurance Framework (BAF) is used to record and report the risks to the achievement of the Trust's strategic objectives, the controls to reduce or mitigate these risks, any identified gaps in these controls and the assurance that the controls are effective. The full BAF is reviewed in detail within the Audit Committee and the Risk Management Committee with a summary provided to the Board on a monthly basis through the CEO report

A new Board Assurance Framework will be published alongside the new 2019 – 2024 strategy.

	Trust Wide Objective	Lead	I	L		July 2019	June 2019	April 2019	Jan 2019	Nov 2018	Key Risks/issues	Key actions	Oversight
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	4	-	16	16	16	16	16	Escalation of ill patients, Increase in HSMR/RAMI	Ensure that learning points are captured by Learning from deaths committee and that assurance fed back Ensure KPIS for E-obs/NEWS are agreed and monitored for improvement Ensure learning from deaths committee looks at diagnostic groups with greater than expected deaths using SJRs End of life strategy role out including education on identifying patients who are nearing end of life	Mortality reduction
1.4	Staff and staff levels are supported	DoW	4	5	-	16	16	16	20	20	Recruitment, limited pool of staff Staffing for escalation areas Sickness rates esp within AACD	Recruitment workplan in place overseen through Workforce Assurance Committee Targeted actions to reduce sickness absence New Workforce Strategy approved by the Board in September 2018	IPM Workforce Workforce committee
2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets	COO	4	5	-	20	20	20	20	20	Urgent Care pressure and increased demand on Diagnostic and Elective work Late decisions in A/E Beds coming up late Lower discharges at weekends Staffing in key departments Changes in pension rules	Urgent Care programme plan SAFER ECIP support Enhanced pathways as part of the new streaming model	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability – delivery of control total surplus	DOF	4	4		16	16	16	16	16	Delivery of ICIPs In year cost pressures Agency cost pressures (links to workforce) Income/contracting risk Commissioning decisions Transformation funding Cash flow iFM performance System wide savings PSF risk	PMO and ICIP escalation meetings IPM Integrated Care partnership development Actions to address agency pressures PBR review Develop links with specialist commissioners Development of joint budgets within local system Review of costs and income iFM development including strategy and business plan System wide savings governance	F&I committee Board IPM Transformation Board ICIP escalation
5.4	Achieving sustainable services through collaboration within the NW sector	Dir Strat.	4	4		16	16	16	16	20	Estates and IT challenges Healthier Together/GM devolution	Ongoing discussions with WWL Involvement in theme three work Development of local care partnership	Board F&I

Committee/Group Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	17 July 2019	Date of next meeting:	21 August 2019
Chair:	M Brown	Parent Committee:	Board of Directors
Members present/attendees:	D Hall, M Brown, J Bene, A Ennis, F Andrews, M Forshaw, R Sachs, E Steel. Representation from three of the four clinical divisions	Quorate (Yes/No):	Yes
		Key Members not present:	T Armstrong Child, A Thornton, J Njoroge, Acute Adult Division, H Bharaj

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story		The Learning Disability Intensive Support team attended to provide the story of a vulnerable young female from a chaotic background who had been known to their services for a number of years. Over the course of her life K had suffered from abuse and exploitation both in her family and whilst homeless. Interventions from the team mean that she is currently in a place of safety	The Committee commended the work of the team and actions to make safeguarding personal. The Committee discussed the potential for future interventions through neighbourhood working to ensure a safety net is in place for vulnerable individuals within communities
Clinical Governance and Quality Committee Chair Report		One risk escalated regarding timely closure of SI actions	All outstanding SI actions to be completed with evidence of compliance presented for review at Risk Management Committee on 7 August 2019
Integrated Community Services divisional quality report		The Committee commended the report which provided a balance view of challenges and successes.	Report noted, Committee members discussed links between neighbourhoods and the voluntary sector
Quality Account priority – Diabetes		First quarterly report on the new Quality Account Priority to decrease the amount of inpatient hypoglycaemic incidences. All actions on track for Q1	Noted implementation of actions with debate focused on the need for preventative work and management of the diabetic foot
Care of Mental Health Patients in A&E		Report provided quantifying the increased attendance and length of stay for mental health patients in A&E. Data taken from April 2016 – June 2019 shoes an increase in the number of patients with mental health issues from an average of 346 patients per month to an average of 466 per month. Patients with a mental health condition are also spending longer in the department	Findings to be shared with GMMH and Bolton CCG. Although it is recognised that this is a challenge nationally the Committee felt that on the basis of this being a poor and potentially unsafe experience for vulnerable patients

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

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

Committee/Group Chair's Report

Bowel cancer screening data		The BI team attended to present findings following a review of data submitted for a national audit. A number of areas had been identified where the local methodology varied from national processes	Committee members noted the findings and were assured that for future submissions these variances will be addressed
CNST maternity incentive year two		The team provided a summary of evidence prepared for submission to CNST submission	QA Committee members agreed that the data provided assurance that the standards are being met. Full report to be approved by Board
SI report – Wrong Site Surgery		Amended report received. The Medical Director confirmed that action has been taken to ensure clear processes and accountability	Report approved
Patient Experience, Inclusion and Partnership Committee		The PEIP Committee received a number of reports focused on initiatives and actions to enhance patient experience – concern had been expressed with regard to one report (life after Prostate Cancer) where the PEIP committee had requested more work to understand patient experience and promote a support group	Report noted
Mortality Committee		Presentation received on audit of biliary tract deaths – no clinical concerns noted, actions identified within the audit for two patients	Report noted
Risk Management Committee		Report escalated three risks in relation to fire safety, the Chair of the Fire Safety confirmed that she was assured that action was being taken to address all risks and that appropriate mitigations were in place	Report noted
Strategy and Transformation Board		System savings board established – will provide oversight of transformational programmes	Report noted
Safeguarding Committee			Report noted, no issues identified for escalation
Comments			
Risks Escalated –			

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

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

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	23rd July 2019	Date of next meeting:	20th August 2019
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Jackie Bene, Martin North, Andy Ennis, Bilkis Ismail, Rachel Hurst, Andy Chilton	Quorate (Yes/No):	Yes
		Key Members not present:	Annette Walker, Catherine Hulme, Lesley Wallace

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
Month 3 Finance Report		Deputy Director of Finance (AC)	The financial position to the end of June 2019 (Month 3), excluding PSF, is a deficit of £5.3m, against a deficit plan of £2.9m, an overall shortfall of £2.4m. Taking PSF into account the deficit is £4.3m. The main reasons for the shortfall are: • Income is under plan by £1.0m • Expenditure is £1.4m worse than plan • ICIP is off track by £1.1m The Committee had a comprehensive discussion on each of the three areas identified above. With regard to income the Committee were advised of a number of actions that are being looked at including coding, recording of activity and the tariff. It is anticipated that this will result in some improvement in the income position and a detailed plan will be prepared. In terms of expenditure the main area of overspending is in respect of pay which has a year to date deficit of £1.9m. Non-pay is better than plan by £0.6m. The pay position was also considered in conjunction with a report on Trust staffing levels from the Director of Workforce. This highlighted a number of areas where the workforce had increased in terms of meeting vacancy levels and quality metrics. A particular focus of the discussion was on the variable elements of pay amounting to c£22.0m per annum in terms of the scope for identifying savings. Overall agency levels were in line with the Trust's plan.	For noting.

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

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

Committee/Group Chair's Report

			The ICIP is currently off track by £1.1m. A comprehensive report was also considered from the PMO in relation to tracking all the various schemes. The single main area of underachievement is in respect of the system savings with an annual target of £6.0m where the view is this will not be achieved at all. In respect of the divisional performance there is weekly/monthly reporting of the position but there is a recognition of significant pressures facing the Divisions in terms of the service requirement. In addition to the overall financial position the Committee also considered the Capital Programme. It was noted that as part of the overall national requirement to reduce capital expenditure the Trust's programme would be reduced by £3.0m to £11.9m. However, this has been achieved through a rephasing of expenditure and would not impact on the overall delivery of the schemes. Consideration was also given to the aged debt. It was noted that the overall debt levels over 240 days remained constant at £880.0k. However, of this sum c£500.0k related to NHS organisations and the Committee were assured that these would now be escalated for resolution. In summary, the Trust faces a very difficult financial position and the achievement of the Trust's Control Total is significantly at risk. However, there is work being undertaken through the Executives and the PMO with the Divisions to identify and deliver schemes to mitigate the position.	
ICIP Progress Report		Deputy Director of Transformation	The Deputy Director of Transformation presented a detailed paper on the delivery of the Income and Cost Improvement Programme and the recovery activities being undertaken to mitigate slippage with regard to the overall programme. As indicated, a number of aspects had been taken into account in the discussion on the financial position. In terms of the overall target of £15.6m, a total of £3.8m was confirmed as being delivered which still left a significant gap. However, the Committee were advised of detailed plans across each of the key divisional areas. However, as previously indicated, the system savings will not be achieved.	For noting.

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

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

Committee/Group Chair's Report

Analysis of Trust Staffing Levels		Deputy Director of Finance (AC)	The Committee considered a report from the Director of Workforce into the Trust's staffing levels. This report has also been considered by the Workforce Assurance Committee and was extremely helpful in enabling the Committee to understand the links between the workforce and the financial position.	For noting.
iFM Finance Paper		Director of Finance, iFM Bolton	The quarterly report from iFM indicated that they were currently on track to meet their financial targets. The actual profit at the end of Month 3 was £171.0k against a plan of £174.0k. It was noted that a number of the ICIP savings for iFM were scheduled for the second half of the year but there was a comprehensive tracker in place to monitor delivery of the schemes.	For noting.
Procurement Quarterly Update		Head of Procurement	The Committee received a report from the Head of Procurement setting out a range of initiatives for the current year. Total savings of £974.0k had been identified although £507.0k were identified as cash releasing which were part of the ICIP. The Committee were advised of a number of both local and GM initiatives on procurement although concern was expressed with regard to the national model.	For noting.
Tender Update		Deputy Director of Finance (RH)	The Committee were advised of one tender which the Trust had requested further information on although it was a very specialist service area.	For noting.
Other updates		Chief Executive/ Chief Operating Officer	The Committee also received updates in respect of: • Capital & Revenue Investment Group. • Strategic Estates Board – the Committee received an update on the Bolton College of Medical Sciences. It is likely that the Full Business Case for the BCMS development will come to the F&I Committee for scrutiny in September/October. • Digital Transformation Board – the Committee received an update on progress with EPR which is now approaching the critical period in preparation for go live.	For noting.

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

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

Committee/Group Chair's Report

Risks escalated

The Committee considered the overall risk in relation to the financial position which is currently rated at 16 (4 x 4). The Committee decided to maintain this level subject to the work being undertaken as described earlier in this report which would enable a more comprehensive risk analysis to be undertaken in terms of the financial forecast for the year. The risk would then be reviewed in the light of this information. The aim would be to report back to the Committee at its meeting in August.

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

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

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Urgent & Emergency Care Board	Report to:	Board of Directors
Date of Meeting:	9th July 2019	Date of next meeting:	13th August 2019
Chair:	Su Long	Parent Committee:	Board of Directors
Members Present:	All System representatives present	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Demand and Capacity Review	Green	NECS	Presentation given by North East Commissioning Support (NECS) team on how they are going to approach the demand and capacity review in Bolton	Revisions requested and presentation noted
Analysis of mental Health Assessment and Bed Capacity	Amber	GMMH	Analysis (based on the month of May only) showed timely initial assessment – 72.9% within one hour up to 89% within 4 hours of referral. Of these 12 required an in-patient bed and average wait for the bed (in A&E) was 7.5 hours. Work on going to improve response rate but no comment on bed availability just efforts to develop admission avoidance pathways	• Presentation noted • Pointed out that after initial assessment many patients wait (inappropriately placed) in A&E whilst awaiting other things – eg sobering up, tests and mental health sectioning processes • Pointed out that we need to be doing more work pre-hospital for patients approaching crisis
Presentation from GM Clinical Assessment Service – new service integrated with NHS111, NWAS and GP OOH service to avoid attendance by alternative community pathways	Amber	Steve Barnard	Presentation on a new service integrated with NHS111, NWAS and GP OOH service to avoid attendance by alternative community pathways Early results of pilot look promising.	• Presentation noted
Comments Review of dashboard noted overall improving metrics.				
Risks escalated **None**				

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

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

Agenda Item No: 12

Meeting	Board of Directors

Date	25th July 2019

Title	Mortality update

Executive Summary	This paper looks at recent Trust mortality figures and explains the work on going to understand them in detail with detail on assurance and action plans

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

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

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

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

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

Introduction

A previous paper to board has highlighted the reason for the increasing SHIMI and has explained a number of factors that explain the rise such as taking out ambulatory care cases, and the effect of a large number of pneumonia cases affecting mortality. This paper seeks to explain further background to these figures and explains the steps being taken to provide assurance for the Trust Board.

Current mortality statistics

1. Crude mortality.

Technically, crude mortality should not be compared between Trusts but is more a tool to measure trends over time. The mortality has increased from 2.1 to 2.2 over the last year, and this is likely to be due to day case attenders being excluded from the denominator (note that these are separate from ambulatory care cases) from July 2018 onwards. Clinical conditions measured are based Clinical Classification System (CCS)- the NHS system used to classify diseases and other health conditions, based on ICD-10.

2. RAMI

The Risk Adjusted Mortality Index (RAMI) is useful as it covers a more recent time period (March 2018 – February 2019) and the latest value is 96.9 which is significantly higher than expected when compared with the peer group. It excludes ambulatory care cases, deaths within 30 days of discharge maternal and neonatal deaths and palliative care deaths. Furthermore, for co-morbidities, RAMI uses the highest risk diagnosis anywhere in the spell and provides greater differentiation compared to the use of Charlson co-morbidities used in SHIMI. The RAMI score for Bolton FT has been above peers since May 2018. This is largely due to a higher RAMI than expected for pneumonia deaths. Further analysis shows that apart from the diagnosis 'other connective tissue diagnoses' (observed deaths 8, expected 3.3), all other diagnosis groups as are 'as expected' for mortality. The excess connective tissue deaths will be examined via MRG shortly. What this tells us is that apart from pneumonia, other conditions alerting as higher than expected differences between expected and observed deaths may be due to purely the different ways of measuring mortality.

3. HSMR

The latest HSMR for October 2017 to September 2018 is 117.8 for weekdays (higher than expected) but is 114.6 for weekends (as expected). This is completely contrary to what would be expected as the concern throughout the NHS has always been that less availability of doctors may be associated with a higher mortality. The reason for this is unknown (and difficult to hypothesise) and further expert advice will be sought from CHKS. The number of deaths in the categories for fluid and electrolyte disorders and pneumonia are highlighted as greater than expected. Fluid and electrolyte disorders deaths were investigated last year via the mortality reduction group and the investigation found that patients actually died of other conditions rather than of the fluid or electrolyte disorder, but the first consultant episode was listing the first diagnosis as hyponatraemia (low sodium-for example, a type of fluid and electrolyte disorder) rather than the actual underlying condition causing the electrolyte disorder. No concerns were found with the management of these patients

4. SHIMI

The SHIMI (Summary Hospital Mortality Indicator) measures observed/Expected deaths and is used to compare Trusts. The latest SHIMI is 119, covering the period January 2018 to December 2018, and was published in the public domain on 16th May 2019. This figure is higher than expected and has increased further from the figure of 113 for the last quarter. Again, most of the contribution to the higher than expected SHIMI come from pneumonia deaths.

How mortality is currently being monitored

The Mortality Reduction Group actively monitors a number of statistical measures of death including Crude rate, RAMI, HSMR and SHIMI. The HSMR is monitored via the CQC insight report at Mortality reduction group (MRG) The other statistics are monitored at MRG via provision from NHS digital previewer (SHIMI) and CHKS (SHIMI in detail, crude mortality and RAMI). An important aspect to note is that we have developed a much more productive relationship with CHKS and as a result one of the key services they are now able to provide is the ability to use a system based on tracking variances in mortality rates across a wide range of conditions. These are known as Cusum charts. Using this system means that we are able to get a much earlier sign that a mortality measure for a given clinical condition is starting to become significantly different from our peers. This has recently been utilised as described below.

Examples of conditions reviewed via MRG in response to alerts on mortality figures:

1. Biliary Tract (CCS149)-flagged as 6 excessive deaths-rising trend spotted in November 2018 for 5 of 6 previous months. Average age 80, average 3 comorbidites, 50% patients had frailty syndrome. Three patients palliated on admission due to extreme frailty and co-morbidities. One patient wrong category (liver failure). One patient delayed antibiotics but otherwise good MDT management and appropriate early ERCP. Died of hospital acquired pneumonia after initial improvement. Remaining patient age 84, dependent on care for all needs, managed well but after improvement suffered fatal heart attack.
2. Congestive heart failure, non-hypertensive (CCS 108). Crude mortality rate for calendar year 2017 11%, for 2018 14.3 %. HSMR was 141 for 2018 compared to 106 previous year. Audit results showed for year 2018 a higher percentage of patients admitted to Bolton fall into the more severe categories: 50% in HRGS EB03A and EB03B compared to peer of 34% Higher percentage with more complications admitted in 2018 than in 2017-see figure 3:

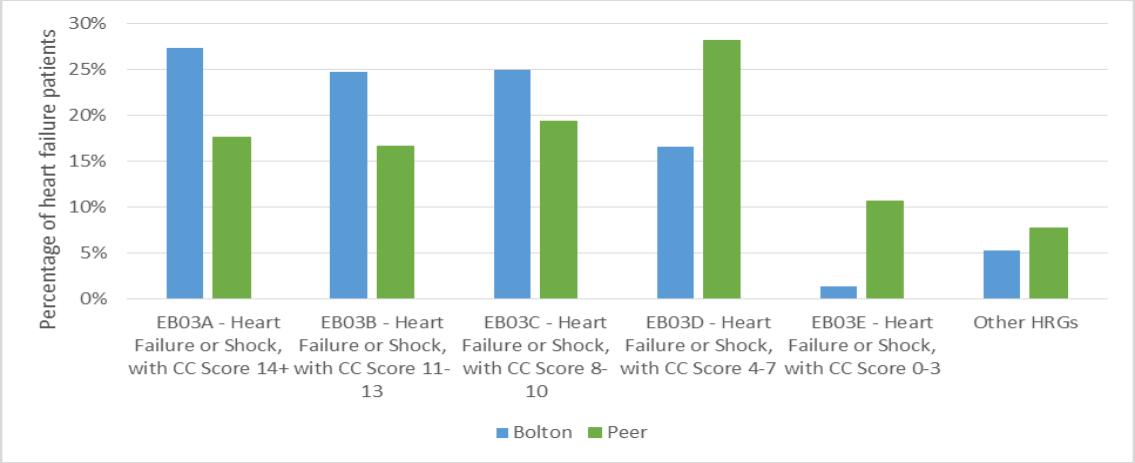


Figure 1: comparison of admissions to Bolton compared with peers, most severe categories on left, score CC 14+.

Reason for the rise in severity of patients admitted with more severe heart failure not fully understood but comprehensive action plan including Major Service changes since July 2018 including comprehensive Cardiac Rehabilitation for heart failure established with revised guidelines and testing strategy. A review of heart failure deaths is under way and this will also be looked at through the learning from deaths committee that will look for any problems in care.

3. Rise in unexpected deaths from Short gestation, low birth weight, foetal growth retardation CCS group. A detailed review undertaken by the Families Divisional Director has shown the reason is due to changes in recording of still births in Greater Manchester requested by the coroner. This data shows that the increase in early neonatal death has come from the group of infants previously classified as miscarriages. There has been no deterioration in practice (as shown by consistent rates of pregnancy loss) but rather the increase has come about as a result of staff recording any signs of life in infants ≤22 weeks gestation and therefore classifying them as born alive rather than miscarriages.

Learning from Deaths and contribution to understanding mortality

The learning from deaths committee and process has now been established and has met monthly, starting in April 2019. There are 37 trained reviewers who undertake a validated Subjective Judgement Review (SJR) on cases. Some cases are mandated (for example deaths in patients with learning disability, severe mental health problems, issues raised by family or staff, deaths in elective areas, or SHIMI alarm diagnosis such a s pneumonia) as well as a further random sample of deaths-we are aiming to achieve 10% by September 2019. Of all the cases reviewed so far, there has been only one case in quarter one where it was felt that the death was more likely than not to have been due to problems in care. This refers to a patient initially treated as pneumonia but actually wasn't, and turned out to be a missed myocardial infarction.

In the first three months of the learning from deaths programme, 66 pneumonia cases have been scheduled and so far 30 cases have been reviewed using SJR. Of these, three have had a second mortality review because the overall quality of care was graded as poor. All three turned out to be very frail and elderly and were scored as poor overall (even though all were scored as being treated appropriately for

pneumonia) as the concern was that end of life care needs were not met soon enough and that for all three this aspect of their care was rated as poor. For the remaining 27 pneumonia cases reviewed, there were no concerns with the care of three patients

This finding is important because a multidisciplinary and independent group of SJR reviewers unconnected with the original 2018 audit again has found that no deaths for pneumonia were more than likely to have occurred due to problems with care, which further validates the original Trust audit of 80 cases performed in early 2019 and reported to the CQC. This earlier audit didn't find any consistent major problems in care that could explain the apparent higher pneumonia death rate

As from July 2019, deaths from congestive heart failure (Non-hypertensive) will be reviewed using the SJR process in a similar way to pneumonia cases.

Pneumonia

So far, 2 audits have demonstrated that there is no concern about the quality of care but it is essential that it is understood better. The SHIMI is case adjusted by including the following components:

Gender, admission method (acute/elective), Charlson comorbidities, age, diagnosis, sex.

The SHIMI for pneumonia at Bolton NHS FT remains significantly higher than expected. Likely non-contributory factors for pneumonia SHIMI are gender, admission method, age and sex-as these would be the expected to be roughly the same for all acute trusts. This leaves co-morbidities and diagnosis. Recent analysis work undertaken by Dr Emma Donaldson (acute Medicine Consultant) has suggested that initially it looks as if we record less charlson comorbidities than other north-west trusts. However, when maternity cases are excluded from this analysis, then the difference in co-morbidity coding is abolished. Moreover, RAMI scores for pneumonia are higher than expected despite RAMI using the highest risk diagnosis in any spell which should mean that there is less variability between trusts. Therefore it is unlikely that recording (or not) of comorbidities is unlikely to be the dominant factor.

We know from the previous 2019 CQC audit that nearly 1 in 4 cases were coded as pneumonia when in fact they were not. There are a number of reasons for this-incorrect diagnosis, or possibly the use of the phrase 'treat as pneumonia' for patients who may be suspected of it but have not yet had the diagnosis confirmed e.g. by a chest X-ray. Although we have assumed in the 2019 CQC audit that there are no coding issues, the next step is to audit jointly with the coding department what is actually being recorded by medical staff in terms of how the diagnosis is recorded (ensuring that the CXR is carefully looked at) and to understand what is then happening on the first consultant episode post take consultant ward round in terms of whether any diagnosis errors are being corrected to that the right diagnosis is recorded, and linking this to what this actually coded.

There are alternatives to this approach which could include using an outside agency to provide further expert insight (such as the Royal College of Physicians) or to work with another trust of a similar size to Bolton with a much lower pneumonia mortality to try and compare cases (for example look for differences in mean age of patients and other

factors) and processes. Both approaches would be time consuming and carry considerable expense.

Summary

This paper describes the mortality metrics that are tracked by the Mortality reduction group and explains the actions taken to provide assurance that unexplained higher than expected figures are examined to look at the reasons for the rise including quality of care. This work is being supplemented by the Learning from deaths committee. The SHIMI for pneumonia remains higher than expected and although it is clear that there are no concerns around the quality of care, further work may be required to understand the figures further

Agenda Item No: 12.1

Meeting	Board of Directors

Date	25th July 2019

Title	Learning from deaths quarterly report

Executive Summary	Trusts are required to collect and publish on quarterly basis specified information on deaths, and this has to be reported to trust board. This data includes the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care, and be accompanied by relevant qualitative information and interpretation. This paper describes the Q1 summary from the learning from deaths programme at Bolton NHS FT

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

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

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

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

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

Introduction

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

Methodology

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

Results from Q1 2019-2020

Total number of inpatient deaths	**April**	**May**	**June**	**Total for quarter**
number	96	100	75	271

Overall breakdown of cases with total scores by month

Month (2019)	April	May	June
Number Cases (Sample)	31	35	32
COMPLETED	23	22	6
Return %	**74.2**	**62.9**	**18.8**
Source			
Pneumonia (Alert Diagnosis)	20	25	21
Unexpected Death (R265)	1	7	2
Learning Disability Death	0	0	1
Mental Health Death	6	1	4
5% random sample	4	2	4
Family/Staff Concern	0	0	0
	31	35	32
Overall Score			
1 (Very Poor)	0	0	0
2 (Poor)	4	3	1
3 (Adequate)	7	6	0
4 (Good)	9	11	5
5 Excellent	2	2	0

Clearly all cases that are identified for SJR review should be completed in a timely manner and 4 weeks is allowed for this, followed by reminders sent out by the clinical effectiveness team. The list of cases for review is sent out in the first week of the month so the four weeks for review will cross over into the following month. However, this completion rate will be closely tracked through the committee. Another likely explanation is that no reviewers have been granted specific extra time in job plans to complete these reviews, which require at least an hour to complete (longer for very complex cases) but as more experience is gained then the time taken to complete will improve and in addition the shared learning at the learning from deaths committee will help reviewers understand how to be more focused in completing the reviews.

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

One case out of the 51 reviewed was judged to be a death that was more than likely to be associated with problems with care (estimate therefore 2% of cases).

Learning points

Learning points are identified from each case that has a secondary review and depending on the nature of these, a specific action owner is identified or fed back to the appropriate directorate and tracked for evidence of action and completion. This has been registered on the Trust Audit plan where all learning/action plans/Assurance will be recorded centrally.

Specific learning points from quarter one include

- understanding of patient's wishes, preferred place of care, and advanced care planning to avoid sub optimal end of life are experience. This is part of a Workstream programme led by palliative care
- Importance of medical review following recurrent hypoglycaemia
- Timely escalation patient's deteriorating NEWS score to avoid cardiac arrest
- Importance of advanced care planning in life-limiting chronic disease in order to avoid futile interventions
- Development of a daily ward board round to ensure review of sick patients on daily basis-this will be developed as part of 7 days services.

Learning points from each month's learning from death committee will be collated and added to the governance team monthly learning slide set which is presented at directorate governance meetings

As the tracking system has only just commenced, future learning from death reports will give detail on specific learning points, action plans and assurance.

Conclusion

The learning from deaths process is now fully operational at Bolton FT and we are able to provide the board with the data required including an estimate of the number of deaths that were more than likely to have occurred due to errors in care. Learning themes have been identified but more work is required to be able to track the progress and implementation of learning themes.

Appendix 1: Breakdown of scores by category of review

	23 completed					25 Completed					6 completed				
	April					May					June				
Overall Score	**Pneumonia**	**Unexpected Deaths**	**LD Deaths**	**MH Deaths**	**5% Sample**	**Pneumonia**	**Unexpected Deaths**	**LD Deaths**	**MH Deaths**	**5% Sample**	**Pneumonia**	**Unexpected Deaths**	**LD Deaths**	**MH Deaths**	**5% Sample**
1 (Very Poor)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2 (Poor)	2	1	0	1	0	1	2	0	0	1	0	0	1	0	0
3 (Adequate)	2	0	0	2	3	3	3	0	1	0	0	0	0	0	0
4 (Good)	6	1	0	1	1	8	3	0	0	0	4	0	0	0	1
5 Excellent	1	0	0	1	0	3	0	0	0	0	0	0	0	0	0
Unknow identifier	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Agenda Item No: 13

Meeting	Board of Directors

Date	Thursday 25th July 2019

Title	Cancer Performance Briefing Paper

Executive Summary	The purpose of this paper is to advise the Board on the issues impacting the delivery of the 62 day referral to treatment cancer performance target and the actions being taken to drive improvements.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	Presented to Systems Resilience Group 20 June 19

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

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

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

Prepared by	Lisa Galligan-Dawson, Deputy Divisional Director Elective Care	Presented by	Andy Ennis, Chief Operating Officer

Bolton
NHS Foundation Trust

Cancer Performance Briefing Paper – June 2019

Purpose of paper

There are a number of national standards relating to Cancer Performance. The key standard is the 62 Day referral to treatment target. The purpose of this paper is to advise the Systems Resilience Group on the issues impacting on delivery of the 62 day target, and the actions being taken to drive improvement.

Background

Bolton NHS Foundation Trust has delivered the quarterly 62 day standard consistently since Q3 13/14. Since September 14 the Trust has also achieved the target within each individual month. The Trust has been the highest / within the top 3 performing Trusts in Greater Manchester & Cheshire (GM&C) consistently for the last 4 years.

The 62 day target is defined as: 'a maximum of 62 days from urgent GP (GMP or GDP) referral for suspected cancer to first definitive treatment (FDT)'. The clock begins on the day the referral is received and stops on the day the patient receives their first definitive treatment. Although this paper is focussed on the 62 day standard it should be noted a number of targets are measured within the 62 days including the 14 day target for first appointment, 31 day decision to treat target, and the 31 day referral to treatment target for paediatric / rare cancers. The 62 day standard is 85%.

Patient pauses / clock re-starts are not permitted within the pathway. Waiting time adjustments may be applied in some very specific circumstances where patients are attending for admitted treatment or if they DNA a first appointment providing this was agreed with the patient. It is widely recognised that some patients will chose to be treated after 62 days. This is built in to the tolerance.

Although the Trust has consistently delivered the 62 day standard, performance over the previous 3 quarters has been showing an overall downward trajectory in performance. (See Appendix 1 & 2)

Key challenges impacting current performance

There are a range of challenges impacting on the Trusts ability to deliver the 62 day performance standard. These can be broken down as follows:

Advances in medicine

More patients are receiving treatment for cancer – both curative and palliative. Most patients are now eligible for some form of treatment. These patients would previously have been recorded as 'for best supportive care'. This is excellent for patient outcomes; but often has a

negative impact on performance due to the additional work up needed for this cohort of patients. Treatment types are also more advanced and often require a longer work up.

Changes to Pathways

Over recent years, many of the cancer pathways have evolved to include additional diagnostics / treatment planning. Previously items like EBUS were used infrequently, but have replaced the bronchoscopy as the diagnostic of choice in the Lung pathway. EGFR, PDL testing are now standard tests for many patients as is PET scan which was previously seen in only a smaller cohort of patients.

With the drive to treat more patients, a number of high risk MDTs and treatment planning meetings have also been introduced to the pathways. The desire to treat more patients has also resulted in a higher number of three (or more) centre pathways. For example, patients may be for surgical intervention but may deteriorate or are not passed fit at anaesthetic assessment, and subsequently go on for oncology treatment, which naturally increases the time to treatment.

It should be noted that the way in which the pathways are delivered across GM could in the future impact the delivery of the 62 day standard. I.e. Dermatology services, complex surgery moving to centralised sites.

Changes to national guidance / policy

In Q2 2018/19 NHSE launched a new allocation policy. Up until this point GM&C had operated their own reallocation policy. The launch of the new national guidance alters the way in which compliance and breaches are allocated to provider Trusts. A previous paper has been circulated on the impact of the new guidance. At present the Trust is benefiting from the new guidance on two centre pathways in terms of performance against the 62 day standard, but this is expected to change in the near future when treating Trusts improve their time to treatment (target is now 24 days).

In April 2019 NHSE launched the updated Cancer Waiting Times Guidance (V10) (CWT) this guidance brings a range of changes which are likely to impact on 62 day performance. Some of these changes will only be operationalized in Q2 19/20. Primarily, this relates to a change in the way that the lung 'optimum pathway' will be recorded. This was the pathway introduced into the Trust in 2017 whereby patients who have an abnormal chest x ray, suspicious of cancer are retained by the Trust for a CT and onward management within Respiratory Medicine when the CT gives a radiological diagnosis or a radiological suspicion of Cancer. At present these are recorded against the consultant upgrade standard. From July 2019 these patients will be recorded against the 62 day core target. Given the challenges within this pathway this could have a significant impact on the delivery of the 62 day standard.

In addition to the changes above, a number of items which were previously classed as treatments or 'enablers' no longer stop the 62 day clock.

V10 of the Cancer Waiting Times Guidance also outlines the requirements of the new Faster Diagnosis standard which is being monitored in shadow from April 2019 and will be recorded nationally from April 2020. Thresholds are expected to be set in Autumn 2019, and further guidance changes are expected in 2020.

From April 2020 compliance with timed pathways for Colorectal, Head and Neck, Prostate and Oesophageal cancers will be monitored. These pathways introduce new diagnostic models and place greater emphasis on the first seen Trusts to make significant improvements in these tumour sites. One such change is the introduction of MRI as the primary first diagnostic in a prostate pathway. Currently the first diagnostic is a TRUS biopsy and in the main only positive patients to proceed to an MRI scan. This new pathway brings with it significant MRI capacity challenges. The full impact of these pathway models is being assessed.

The NHS long term plan (2019) describes a key focus on cancer. The 28 day faster diagnosis, identifying more cancers at a lower stage, and increasing screening are all key factors which will impact on the delivery of the 62 day standards.

Patient wellbeing

With an aging population there are more and more patients living with long term conditions and a range of conditions which affect their ability to undergo investigations and which make treatment planning and delivery more difficult. There is no adjustment applicable for the complexity of patients or when there are other health conditions which need to be treated (for example cardiology issue preventing the commencement of cancer treatment).

Patient choice

There is a consistent challenge associated with patient choice, and there are no adjustments permitted for patient choice. The increased number of patient initiated cancellations, appointments declined and the choice to delay treatment is impacting performance delivery.

Demand

The most significant impact on cancer performance is the significant increase in demand. Since the NICE guidance change in 2015, referrals have been rising significantly. Bolton CCG / FT forecasted year on year growth of approximately 10%. Bolton NHS FT have seen greater increase over the last 2 years overall, with specific areas seeing a significant rise in demand.

Overall, 11349 patients were seen on 2ww suspected cancer pathways (GP referrals) in 17/18. This compares to 13555 in 18/19. However, it is the growth since Q3 18/19 that is the most significant with some tumour sites seeing fluctuations in demand at more than 40% in a month compared to the same period the year previous. (see Appendix 3). It should also be noted that as the current lung pathway identifies the majority of cancers from x-ray, the number of GP 2ww referrals for lung has appropriately reduced (suggesting the pathway is working well). However, when viewing the overall percentage increase in demand it should be recognised that the percentage increase is greater in reality, as this cohort of patients are now no longer captured on the 2ww referral information but are still being managed by the Trust.

It is anticipated that demand will continue to grow. GPs are being encouraged to refer more patients on the suspected cancer pathways with the aim to diagnosing cancer at an earlier stage. Nationally and locally there are also a number of initiatives planned relating to public health and encouraging patients to discuss symptoms with their GP. There are widespread plans to develop the existing screening pathways further, in widening the age range and initiatives to increase

uptake, which need to be managed alongside the symptomatic pathways. The possible introduction of lung screening is also designed to encourage increases in referrals.

It should also be noted that pressures on the services across GM have resulted in some services closing to referrals. Stockport have currently ceased to provide a Breast symptomatic service and Wrightington, Wigan and Leigh have also closed to Breast referrals from out of area. These regional changes along with our organisational reputation may also lead to increases in demand.

Recent conversion rate information suggests that the percentage of patients referred on a 2ww pathway diagnosed with cancer has remained relatively static, indicating that the increased referrals is leading to the diagnosis of more cancers, which will further encourage referral growth.

On data run in May 19, the conversation rate for 18/19 was at 8.6% (with 45 patients still in the diagnostic phase, with cancer neither confirmed nor ruled out). This compares to 8.9% in 17/18.

Overall there has been an additional 161 cancers identified through 2ww referrals in 18/19. It should be noted that lung cancers identified through the 'retained for CT pathway' would also have previously been recorded against the 2ww conversion figures.

There is a significant impact on the specialties receiving the referrals and treating the patients, which in turn is impacting on the waiting times for routine patients.

The increased demand can also be seen with the support services. Cancer Services, CT, MRI, USS, Endoscopy and histopathogy have seen significant rises in demand as they provide services to all the specialties. MR is currently operating at 200% capacity; the PTL currently contains on average 230-250 patients more per week than the previous year.

Given the rise in demand, there is also significant pressure on 'specialist diagnostics' – namely PET, EUS and EBUS. Waiting times for these diagnostics and reporting has significantly increased, and as the diagnostic element falls under the remit of the first seen trust in terms of performance delivery, this is significantly impacting the Trust's performance albeit that the Trust has no direct control over these services.

It should also be noted that there is a further increase in demand on the Cancer Services tracking team as a result of the CWT V10 guidance. The faster diagnosis standard requires a greater number of patients to be tracked until the point in which they are formally removed from suspected cancer pathways, and because of the increased data fields which need to be monitored for national submission both for Faster Diagnosis and for COSD. The design of the CWT guidance changes is labour intensive and there is no ability to automate any of this information collection through either Somerset cancer registry or through the introduction of the EPR.

It is well recognised that the Trust has the leanest cancer tracking team in GM, but with the significant increase in workload it is not possible to absorb this. The latest resource comparison was completed in August 2018 (see appendix 4). There is a plan to refresh this comparison at the end of Q1 19/20.

Actions

A great deal of work has been undertaken already to maintain compliance against the 62 day standard. Towards the end of May 19 corrective action has been undertaken, which includes the Deputy DDO being in attendance for the corporate performance meetings, and the introduction of a task and finish group to address issues within the control of the Trust. An improvement plan has been produced looking at the key opportunities for improvement within each pathway and closer monitoring and visibility of internal standards which have proven effective strategies for delivery of the 62 day standard. Whilst a number of issues are outside the control of the Trust, there are improvements which could be made. It is anticipated that some of the actions which could be taken may have an adverse effect of other delivery standards (i.e. 18 week RTT and DM01) or may have a cost implication.

Additional actions have been taken at GM level to raise awareness of the delays relating to external diagnostics and oncology provision.

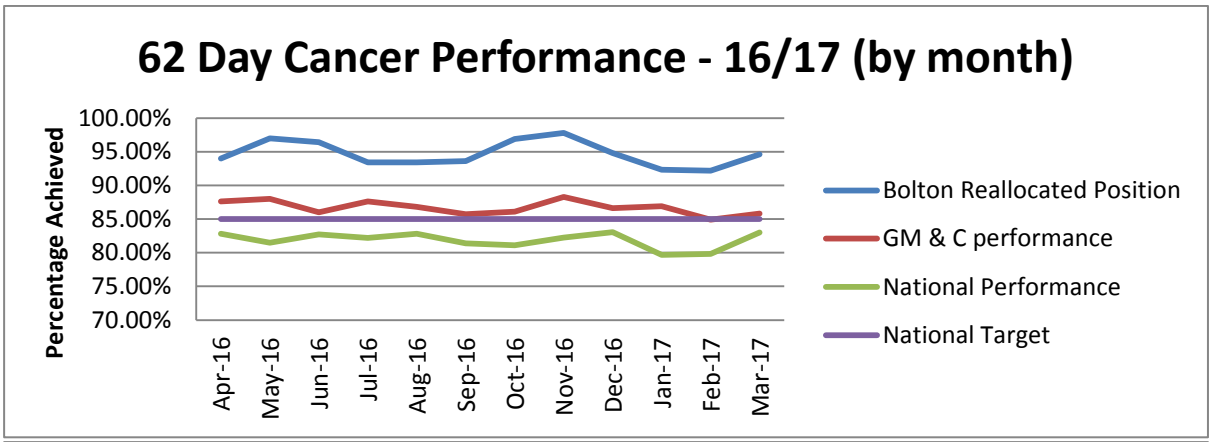
Recommendations

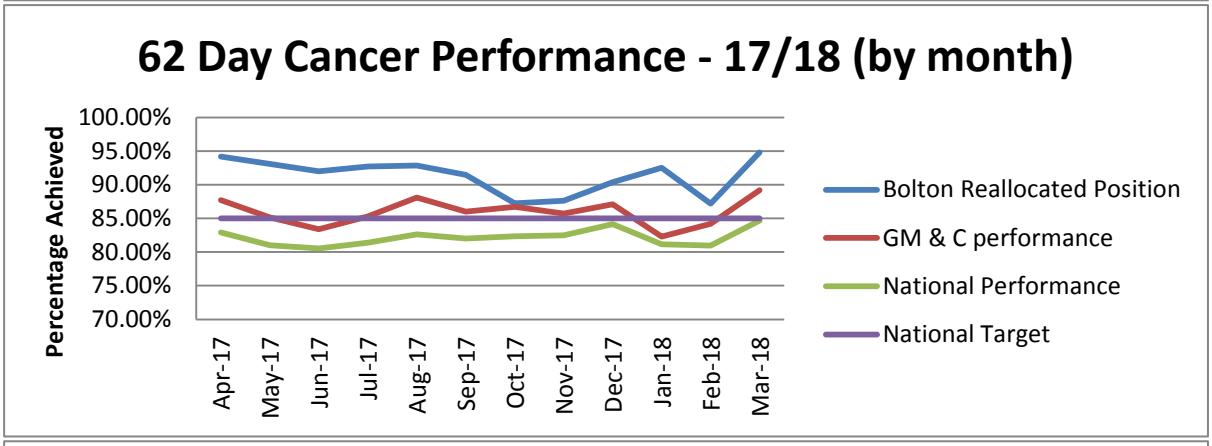
It is proposed that the action plan is supported, and feedback is provided to the Systems Resilience Group on a monthly basis.

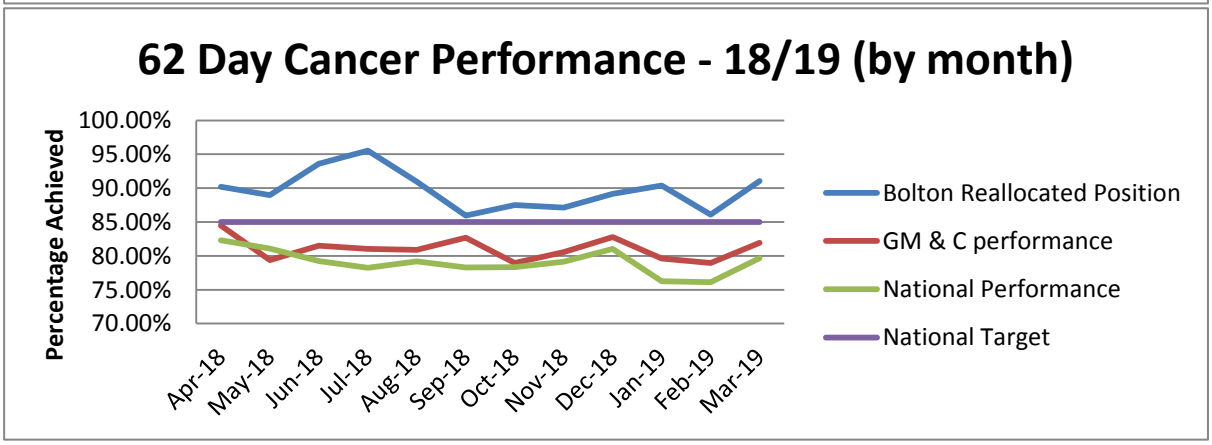
It is proposed that capacity and demand work is used to inform discussions with commissioners in relation to growth, including not only the specialities seeing the increase in referrals but also the diagnostic / support services.

It is proposed that the Trust supports investment into the Cancer Services Tracking Team to enable the continuation of effective patient tracking, which has been integral in delivering the 62 day standard performance and is imperative whilst there are so many additional issues impacting on performance.

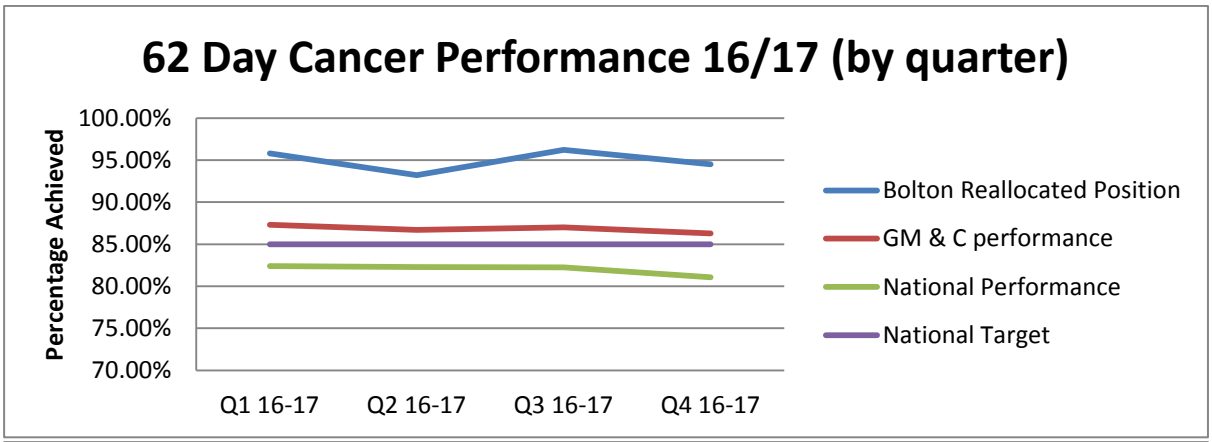
Appendix 1 – Performance by Month

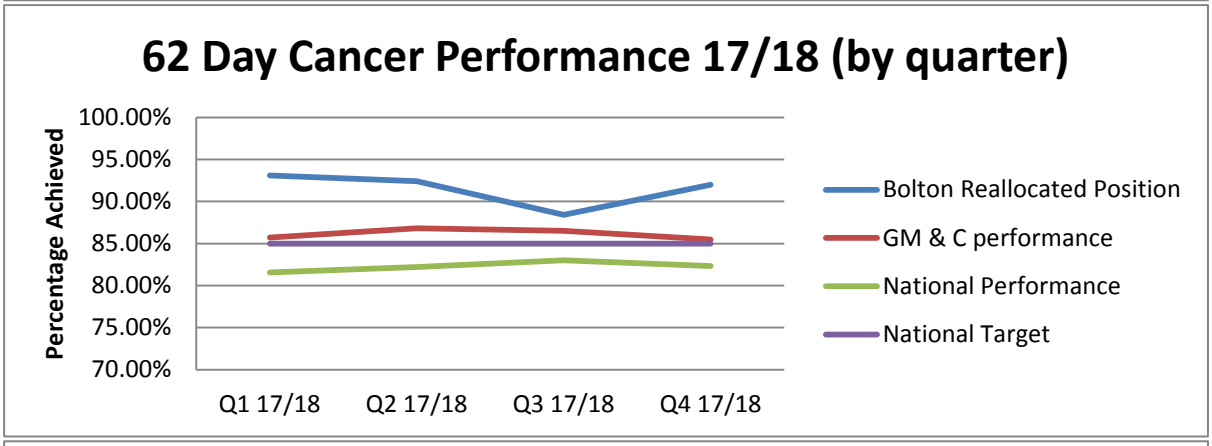


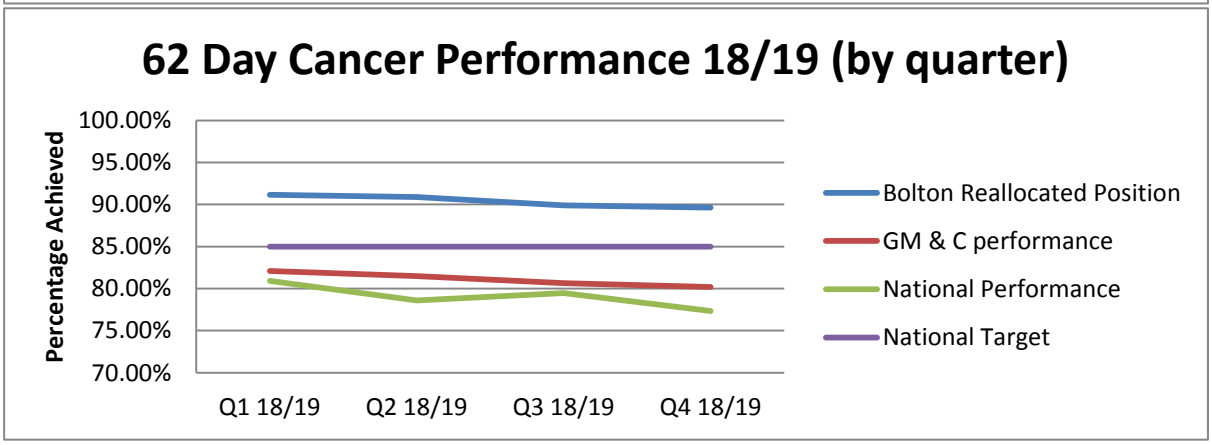




Appendix 2 – Performance by Quarter







Appendix 3

2 week rule - suspected cancer and breast symptomatic combined

	2017/2018			2018/2019			2019/2020			
Month	Referrals	Diff	% Diff	Referrals	Diff	% Diff	Referrals	Diff	% Diff	Total
Apr Total	852	-105	-11.0%	1040	188	22.1%	1155	115	11.1%	3047
May Total	1013	-4	-0.4%	1192	179	17.7%	1241	49	4.1%	3446
Jun Total	1037	31	3.1%	1153	116	11.2%				2190
Jul Total	1023	62	6.5%	1215	192	18.8%				2238
Aug Total	965	15	1.6%	1190	225	23.3%				2155
Sep Total	981	10	1.0%	1107	126	12.8%				2088
Oct Total	1094	132	13.7%	1321	227	20.7%				2415
Nov Total	1097	13	1.2%	1282	185	16.9%				2379
Dec Total	752	-94	-11.1%	1010	258	34.3%				1762
Jan Total	1048	27	2.6%	1285	237	22.6%				2333
Feb Total	957	-23	-2.3%	1213	256	26.8%				2170
Mar Total	1138	-3	-0.3%	1295	157	13.8%				2433
Total	11957	61	0.5%	14303	2346	19.6%				28656

Specialty Growth

		2017/2018			2018/2019			2019/2020			
Month	**Cancer Site**	**Referrals**	**Diff**	**% Diff**	**Referrals**	**Diff**	**% Diff**	**Referrals**	**Diff**	**% Diff**	**Total**
Apr	Breast	137	-12	-8.1%	209	72	52.6%	224	15	7.2%	570
	Breast Symptomatic	177	-22	-11.1%	191	14	7.9%	181	-10	-5.2%	549
	Colorectal	127	-5	-3.8%	140	13	10.2%	187	47	33.6%	454
	Gynaecology	67	-13	-16.3%	69	2	3.0%	102	33	47.8%	238
	Haematology	10	0	0.0%	15	5	50.0%	14	-1	-6.7%	39
	Head and Neck	61	-12	-16.4%	83	22	36.1%	103	20	24.1%	247
	Lung	42	3	7.7%	22	-20	-47.6%	27	5	22.7%	91
	Skin	93	-37	-28.5%	132	39	41.9%	132	0	0.0%	357
	Upper GI	84	4	5.0%	98	14	16.7%	100	2	2.0%	282
	Urology	54	-11	-16.9%	81	27	50.0%	85	4	4.9%	220
Apr Total		**852**	**-105**	**-11.0%**	**1040**	**188**	**22.1%**	**1155**	**115**	**11.1%**	**3047**
May	Breast	172	8	4.9%	227	55	32.0%	258	31	13.7%	657
	Breast Symptomatic	173	-36	-17.2%	196	23	13.3%	172	-24	-12.2%	541
	Colorectal	149	10	7.2%	188	39	26.2%	216	28	14.9%	553
	Gynaecology	71	-12	-14.5%	85	14	19.7%	96	11	12.9%	252
	Haematology	20	13	185.7%	17	-3	-15.0%	12	-5	-29.4%	49
	Head and Neck	71	-3	-4.1%	87	16	22.5%	121	34	39.1%	279
	Lung	51	17	50.0%	39	-12	-23.5%	23	-16	-41.0%	113
	Skin	125	18	16.8%	137	12	9.6%	157	20	14.6%	419
	Upper GI	97	-11	-10.2%	121	24	24.7%	99	-22	-18.2%	317
	Urology	84	-8	-8.7%	95	11	13.1%	87	-8	-8.4%	266
May Total		**1013**	**-4**	**-0.4%**	**1192**	**179**	**17.7%**	**1241**	**49**	**4.1%**	**3446**
Jun	Breast	187	28	17.6%	225	38	20.3%				412
	Breast Symptomatic	173	-50	-22.4%	192	19	11.0%				365
	Colorectal	155	35	29.2%	161	6	3.9%				316
	Gynaecology	96	4	4.3%	87	-9	-9.4%				183
	Haematology	15	6	66.7%	17	2	13.3%				32
	Head and Neck	79	2	2.6%	88	9	11.4%				167
	Lung	29	-20	-40.8%	31	2	6.9%				60
	Skin	122	-6	-4.7%	147	25	20.5%				269
	Upper GI	115	31	36.9%	128	13	11.3%				243
	Urology	66	1	1.5%	77	11	16.7%				143
Jun Total		**1037**	**31**	**3.1%**	**1153**	**116**	**11.2%**				**2190**
Jul	Breast	157	-3	-1.9%	216	59	37.6%				373
	Breast Symptomatic	176	-5	-2.8%	220	44	25.0%				396
	Colorectal	167	40	31.5%	188	21	12.6%				355
	CUP		0	0.0%	1	1	0.0%				1
	Gynaecology	79	-4	-4.8%	98	19	24.1%				177
	Haematology	14	4	40.0%	14	0	0.0%				28
	Head and Neck	65	-9	-12.2%	89	24	36.9%				154
	Lung	35	1	2.9%	18	-17	-48.6%				53
	Skin	153	7	4.8%	162	9	5.9%				315
	Upper GI	106	33	45.2%	137	31	29.2%				243
	Urology	71	-2	-2.7%	72	1	1.4%				143
Jul Total		**1023**	**62**	**6.5%**	**1215**	**192**	**18.8%**				**2238**
Aug	Breast	159	17	12.0%	206	47	29.6%				365
	Breast Symptomatic	146	-22	-13.1%	196	50	34.2%				342
	Colorectal	155	33	27.0%	187	32	20.6%				342
	Gynaecology	76	2	2.7%	84	8	10.5%				160
	Haematology	7	-7	-50.0%	8	1	14.3%				15
	Head and Neck	75	-18	-19.4%	77	2	2.7%				152
	Lung	37	-3	-7.5%	34	-3	-8.1%				71
	Skin	134	-11	-7.6%	157	23	17.2%				291
	Upper GI	92	-7	-7.1%	133	41	44.6%				225
	Urology	84	31	58.5%	108	24	28.6%				192
Aug Total		**965**	**15**	**1.6%**	**1190**	**225**	**23.3%**				**2155**
Sep	Breast	161	31	23.8%	219	58	36.0%				380
	Breast Symptomatic	184	-20	-9.8%	194	10	5.4%				378
	Colorectal	137	18	15.1%	163	26	19.0%				300
	Gynaecology	73	-6	-7.6%	88	15	20.5%				161
	Haematology	14	3	27.3%	11	-3	-21.4%				25
	Head and Neck	73	-2	-2.7%	81	8	11.0%				154
	Lung	39	-2	-4.9%	21	-18	-46.2%				60
	Skin	136	19	16.2%	135	-1	-0.7%				271
	Upper GI	95	-20	-17.4%	118	23	24.2%				213
	Urology	69	-11	-13.8%	77	8	11.6%				146
Sep Total		**981**	**10**	**1.0%**	**1107**	**126**	**12.8%**				**2088**

		2017/2018			2018/2019			2019/2020			
Oct	Breast	179	38	27.0%	281	102	57.0%				460
	Breast Symptomatic	201	17	9.2%	232	31	15.4%				433
	Colorectal	170	22	14.9%	212	42	24.7%				382
	Gynaecology	92	10	12.2%	96	4	4.3%				188
	Haematology	18	6	50.0%	16	-2	-11.1%				34
	Head and Neck	77	6	8.5%	87	10	13.0%				164
	Lung	39	0	0.0%	39	0	0.0%				78
	Skin	123	30	32.3%	141	18	14.6%				264
	Upper GI	113	12	11.9%	123	10	8.8%				236
	Urology	82	-9	-9.9%	94	12	14.6%				176
Oct Total		**1094**	**132**	**13.7%**	**1321**	**227**	**20.7%**				**2415**
Nov	Breast	208	44	26.8%	291	83	39.9%				499
	Breast Symptomatic	216	-20	-8.5%	238	22	10.2%				454
	Colorectal	144	-15	-9.4%	198	54	37.5%				342
	Gynaecology	77	-23	-23.0%	92	15	19.5%				169
	Haematology	23	13	130.0%	18	-5	-21.7%				41
	Head and Neck	81	9	12.5%	82	1	1.2%				163
	Lung	32	-14	-30.4%	27	-5	-15.6%				59
	Skin	124	21	20.4%	119	-5	-4.0%				243
	Upper GI	108	-2	-1.8%	126	18	16.7%				234
	Urology	84	0	0.0%	91	7	8.3%				175
Nov Total		**1097**	**13**	**1.2%**	**1282**	**185**	**16.9%**				**2379**
Dec	Breast	137	6	4.6%	207	70	51.1%				344
	Breast Symptomatic	138	-21	-13.2%	161	23	16.7%				299
	Colorectal	119	5	4.4%	167	48	40.3%				286
	Gynaecology	64	-4	-5.9%	70	6	9.4%				134
	Haematology	4	-14	-77.8%	18	14	350.0%				22
	Head and Neck	45	-21	-31.8%	83	38	84.4%				128
	Lung	18	-24	-57.1%	22	4	22.2%				40
	Skin	80	-10	-11.1%	96	16	20.0%				176
	Upper GI	82	-2	-2.4%	105	23	28.0%				187
	Urology	65	-9	-12.2%	81	16	24.6%				146
Dec Total		**752**	**-94**	**-11.1%**	**1010**	**258**	**34.3%**				**1762**
Jan	Breast	201	22	12.3%	261	60	29.9%				462
	Breast Symptomatic	217	1	0.5%	256	39	18.0%				473
	Colorectal	138	11	8.7%	210	72	52.2%				348
	Gynaecology	87	13	17.6%	103	16	18.4%				190
	Haematology	5	-12	-70.6%	11	6	120.0%				16
	Head and Neck	77	6	8.5%	98	21	27.3%				175
	Lung	35	-19	-35.2%	25	-10	-28.6%				60
	Skin	105	21	25.0%	127	22	21.0%				232
	Upper GI	107	10	10.3%	110	3	2.8%				217
	Urology	76	-26	-25.5%	84	8	10.5%				160
Jan Total		**1048**	**27**	**2.6%**	**1285**	**237**	**22.6%**				**2333**
Feb	Breast	171	-33	-16.2%	255	84	49.1%				426
	Breast Symptomatic	190	-15	-7.3%	237	47	24.7%				427
	Colorectal	139	28	25.2%	185	46	33.1%				324
	Gynaecology	67	-8	-10.7%	103	36	53.7%				170
	Haematology	14	6	75.0%	12	-2	-14.3%				26
	Head and Neck	78	6	8.3%	90	12	15.4%				168
	Lung	30	-18	-37.5%	26	-4	-13.3%				56
	Skin	97	-4	-4.0%	116	19	19.6%				213
	Upper GI	94	2	2.2%	108	14	14.9%				202
	Urology	77	13	20.3%	81	4	5.2%				158
Feb Total		**957**	**-23**	**-2.3%**	**1213**	**256**	**26.8%**				**2170**
Mar	Breast	195	-6	-3.0%	285	90	46.2%				480
	Breast Symptomatic	206	-26	-11.2%	248	42	20.4%				454
	Colorectal	164	7	4.5%	168	4	2.4%				332
	Gynaecology	94	2	2.2%	108	14	14.9%				202
	Haematology	15	3	25.0%	16	1	6.7%				31
	Head and Neck	88	0	0.0%	110	22	25.0%				198
	Lung	39	-11	-22.0%	27	-12	-30.8%				66
	Skin	129	7	5.7%	127	-2	-1.6%				256
	Upper GI	106	5	5.0%	111	5	4.7%				217
	Urology	102	16	18.6%	95	-7	-6.9%				197
Mar Total		**1138**	**-3**	**-0.3%**	**1295**	**157**	**13.8%**				**2433**
Total		**11957**	**61**	**0.5%**	**14303**	**2346**	**19.6%**				**28656**

GM Cancer Resource Review
August 2018

Trust	Performance Management		Deputy Manager / Supervisor		Cancer Trackers / MDT Coordinators		Additional Admin Support		Lead Nurse		Data Quality		Number of referrals Q4 17/18	Number of referrals Q1 18/19	Average number of quarterly referrals per tracker WTE		Number of weekly MDT/ SMDT	Number of MDT /SMDT per tracker WTE	Total PTL numbers weekly (62day patients)	Number on PTL per tracker WTE (approx)
	WTE	Band	WTE	Band	WTE	Band	WTE	Band	WTE	Band	WTE	Band			Q4 (17/18)	Q1 (18/19)				
Bolton NHSFT	0.91	8B	1.0	5*	5.48	4	0.4	2*	1.0	8A	1.6 0.8	3 5	**3141 Total** 2534 2ww 613 BS	**3386 Total** 2807 2ww 579 BS	574	618	14	2.55	1006	184
WWL NHSFT	1.0	8A	1 1	6* 5	6.92	4	0.92 0.2	3 4	1.0*	8A	0.92	4	**3139 Total** 2763 2ww 376 BS	**3515 Total** 3180 2ww 335 BS	454	508	14	2.02	1119	162
Mid Cheshire NHSFT	0.5	8A	1.0	6	5.56	4	0.6	2	0.5	8A	0.8	3	**2724 Total** 2339 2ww 385 BS	**2923 Total** 2577 2ww 346 BS	490	526	9	1.62	978	176
Tameside NHST	1.0	8A	1.0	6	7.46	4	2.0	3	1.0	8B	1.0 0.6	5 3	**2509 Total** 2272 2ww 237 BS	**2743 Total** 2471 2ww 272 BS	336	368	6	0.80	919	123
Stockport NHSFT	1.0	8A	1.0	5	4.0 5.79	4 3	0.6	2	0.8	8A	0.91 1.44	6 3	**3029 Total** 2552 2ww 477 BS	**3145 Total** 2689 2ww 456 BS	309	321	6	0.61	1100	112
East Cheshire NHSFT	0.5	8A	0.8	5	0.9 3.6	4 3	0.5	2	0.5	8A	0.5	5	**1616 Total** 1457 2ww 159 BS	**1771 Total** 1607 2ww 164 BS	359	394	7	1.55	574	128
Pennine Acute NHST	1.0 1.0	8C 7	1.0 1.0	7 6	9.32* 6.36* *	4 3	0.93	2	1.0	8B	- -	- -	**6975 Total** 6447 2ww 528 BS	**7302 Total** 6762 2ww 540 BS	445	466	14	0.89	3480	221
Central Manchester NHSFT	1.0	8B	1.0	6	12.5 2.5	4 3	1.2	3	1.0	8A	1.0	5*	**2844 Total** 2844 2ww 0 BS	**3141 Total** 3141 2ww 0 BS	192	209	14	0.93	1513	101

Trust	Performance Management		Deputy Manager / Supervisor		Cancer Trackers / MDT Coordinators		Additional Admin Support		Lead Nurse		Data Quality		Number of referrals Q2 16/17	Number of referrals Q3 16/17	Average number of quarterly referrals per tracker WTE		Number of weekly MDT/ SMDT	Number of MDT /SMDT per tracker WTE	Total PTL numbers weekly (approx)	Number on PTL per tracker WTE (approx)
	WTE	Band	WTE	Band	WTE	Band	WTE	Band	WTE	Band	WTE	Band			Q4 (17/18)	Q1 (18/19)				
UHSM NHSFT	1	8B	0.87 2.0	7 5	9.8 1.0	4 3	2.25 0.4	3 4	1	8A	0.45	6*	**4576 Total** 3514 2ww 1062 BS	**5048 Total** 4008 2ww 1040 BS	423	467	16	1.48	2170	201
Christie NHSFT	1 2 1 1	8C 8A 6 5	1.0 1.5	7 5	6.53 6.0	4 4	1	3					-	-	-	-	12.5	1.0	1110	89
Salford Royal NHSFT	0.2 1.0	8C 8A	1.0	5	3.0 10.28	3 4	1.8	3	1	8B	1.0	4	**3204 Total** 3204 2ww 0 BS	**3797 Total** 3797 2ww 0 BS	241	285	13	0.98	1447	109

Components of each site vary immensely. Central Manchester, University Hospital of South Manchester, Pennine and Salford Royal are treating hospitals with large diagnostic functions; therefore, receive a vast number of patients from other Trusts, not just their own 2ww referrals.

Wigan Wrightington and Leigh, Mid Cheshire, Tameside, Stockport, Bolton and East Cheshire, are all classed as first seen Trusts.

The Christie operates differently from all the other Trusts in GM and Cheshire. The Christie do not receive 2ww referrals direct, but have the greatest treatment capacity and the number of referrals in from other Trusts.

Whilst each Trust's services and operations will run slightly different, greater comparisons can be made from comparing Trusts which operate similarly (as above) rather than trying to compare all Trusts together.

The above referral and PTL information is based on 62 day pathways only, and does not include 31 day patients. It should be noted that as well as an increase in GP referrals, the number of consultant upgrades has increased across Trusts.

The number on the PTL per tracker and the number of MDTs per co-ordinator has been calculated by adding the total resource for these functions together to be able to compare across the region. Some trusts have combined roles, some have separate roles, but the calculation has been made in this way to allow comparison against the established hours within the team.

Data has been provided directly by each Trust, and has not been validated independently.

Notes provided by individual Trusts:

Stockport NHS FT

Has split roles. Band 3 trackers and band 4 MDT co-ordinators. The resource has been added together in terms of the calculation of PTL numbers management and MDT meetings (as per the review in 2017) to allow like for like review compared to the previous review, and comparison across trusts.
SHH currently treats patients from Tameside, Macclesfield and Mid Cheshire on the urology Surgical Pathways. The 0.91 Band 6 listed under Data Quality is the Cancer Data Manager

Wrightington, Wigan and Leigh NHS FT

B6 is funded currently until December 2018. Lead Nurse currently working 0.6WTE

Bolton NHS FT

Band 5 is currently acting Band 6. 8B Manager is currently working 0.85WTE. 0.4WTE Band 2 is the resource within Medical Records to supply MDT case notes. No Administrative support to MDT / Tracking team.

Pennine Acute NHS FT

Future temporary additional posts to be added to structure. 2.0WTE Band 4 temporary contracts. 1 x 10 months, 1 x 5 months. 3.0 WTE Band 3. 1 x 7 months, 2 x 12 months. Band 7 performance management held within IM&T team

Salford Royal Foundation Trust

2 of the Band 4 establishment start this month. Were vacant for a short period of time previous

University Hospital of South Manchester NHS FT

Data sits within centralised Informatics team

Central Manchester NHS FT

Includes MRI and Trafford sites. Band 5 Data post is currently vacant. 1 Band 4 vacancy within above MDT / Tracking numbers

Christie NHS FT

Does not receive referrals direct from GPs, but undertakes treatment on behalf of all other GM &C Trusts

Tameside NHS FT

Significant increase in the volume of consultant upgrades

Agenda Item No: 14

Meeting	Board of Directors

Date	25th July 2019

Title	Workforce Race Equality Standard (WRES) 2019 Workforce Disability Equality Standard (WDES) 2019			
Executive Summary	1. Our commitment to ensuring Equality Diversity and Inclusion within our workforce is essential to ensure that we deliver safe, caring and excellent services in line with our Trust values. 2. Implementing the Workforce Race Equality Standard and the Workforce Disability Equality Standard is part of our commitment to meeting the Equality Delivery Standards, which are both a required component of the standard NHS contract. Note this is the first year that the WDES is required to be published. 3. The paper sets out that there has been some improvement in the last twelve months surrounding this important agenda though more focused work is required. 4. Board members are advised that in the September, 2019 Board Development session the focus will be on Inclusion and Unconcious Bias training. The Board members will therefore have the opportunity to more deeply explore elements of this paper.			
Previously considered by	Not Applicable			
Next steps/future actions	Discuss	✓	Receive	✓
	Approve	✓	Note	
	For Information		Confidential y/n	N

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

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

Prepared by:	Jane Seddon	Presented by:	James Mawrey

Introduction

1. Our commitment to ensuring Equality, Diversity and Inclusion within our workforce is essential to ensure that we deliver safe, caring and excellent services in line with our Trust values.

2. The importance of inclusion is embedded into the Five Year Forward View (FYFV); NHS Long Term Plan (LTP) and the recently published interim People Plan as well as highlighted quite prominently in the Developing People; Improving Care framework. All of these key documents identify how important it is that inclusion is integral to any and all activities to ensure we provide the best health and care services to the diverse communities we serve.

3. Prerana Issar – Chief People Officer, recently shared the publication – A fair experience for all: which states; to be a model employer, the NHS needs to be an inclusive employer with a diverse workforce at all levels. However, having a diverse workforce at all levels is not the end game; staff also need to feel fully engaged and supported within the workplace. This is critical as it affects upon patient care, patient safety as well as organisational efficiency.

4. There are two key documents that the Trust is required to publish externally. These being: - The Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES).

    - The Workforce Race Equality Standard (WRES) provides a framework for NHS Trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality, and to ensure that employees from black and ethnic minority (BAME) backgrounds receive fair treatment in the workplace and have equal access to career opportunities. The requirement to have signed up to the Workforce Race Equality Standard (WRES) has been included in the NHS standard contract since 2016. It focuses on meeting requirements around ethnicity and hinges on nine race equality Indicators as part of the Equality Delivery System. These indicators are a combination of workforce data and results from the National Staff Survey.

    - The Workforce Disability Equality Standard (WDES) provides a framework for NHS Trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality, and to ensure that disabled employees receive fair treatment in the workplace and have equal access to career opportunities. WDES has been a requirement of the CCG Contract & NHS Contract since 2018/19. The WDES is a set of ten specific measures (metrics) that will enable organisations to compare the employment experiences of disabled and non-disabled staff. It applies to all NHS trusts and foundation trusts from April 2019 and is a key step for NHS organisations to improve equality for the NHS workforce. It compares the reported outcomes and experiences between Disabled and non-disabled staff based on 10 metrics, It highlights at a glance the experiences of Disabled staff.

5. This paper has been produced with the support from the BAME staff network Chair, Inclusion & Diversity Manager, Divisional Management teams, NED Inclusion Champion and Staff Partners.

Performance / Key Findings (WRES)

1. The following improvements have been made since the last reporting year:-

- In the last year, there has been a 0.83% increase in the overall number of BAME staff employed - from 11.61% (2017/18) to 12.4% (2018/19). Worthy of note is that in the last year there has been an increase of 159 Headcount, and of these 40% have been BAME members of staff. These figures are taken as a snapshot on the 31 March 2019.

- The table below shows the distribution of the BAME workforce across the banding levels within the trust, with a variance from the previous reporting period shown in the end row. Deeper workforce analysis shows that for 2017 / 2018 the majority of BAME staff are clinical and clustered at the middle pay bands.

BME	< Band 1	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	VSM	Medical
Non-Clinical	0.04%	0.02%	0.53%	0.33%	0.33%	0.16%	0.05%	0.00%	0.04%	0.02%	0.00%	0.00%	0.02%	0.02%	-
Clinical	0.04%	0.00%	1.12%	0.48%	0.37%	3.88%	1.67%	0.82%	0.11%	0.02%	0.00%	0.00%	0.00%	0.00%	2.38%
Overall	0.07%	0.02%	1.65%	0.81%	0.70%	4.05%	1.72%	0.82%	0.15%	0.04%	0.00%	0.00%	0.02%	0.02%	2.38%
2018 v 2019	-0.01%	-0.02%	0.14%	-0.04%	-0.02%	0.65%	0.12%	0.05%	0.06%	0.00%	0.00%	0.00%	0.02%	0.00%	-0.11%

- Staff Engagement scores for BAME Staff (7.7) working in the Trust where higher than from White Staff (7.3). These engagement scores are higher than other trusts therefore is a positive indicator. We will be able to review these engagement scores on a regular basis following the introduction of the Go Engage tool.

- There has been a reduction in the likelihood of BAME staff entering the disciplinary process (from 1.87 to 1.59) however, this does remain worse than the national average figure of 1.24. A score of 0.8 - 1.25 indicates a non-adverse range. A score greater than 1.25 for BME staff indicates they are more likely to be subject to formal process.

- In the last 12 month less BAME staff have personally experienced discrimination from either their manager, team or colleague (from 20% in 2017/2018 to 18% in 2018/2019).

2. The following deteriorations have been made in WRES performance since the last reporting year:-

- The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has increased from 1.4 in 2017/2018 to 1.53 in 2018/2019. This is now higher than the national average of 1.45. These figures are calculated on a cumulative basis over the 12 months basis.

- The relative likelihood of BAME staff accessing Non-Mandatory training or CPD has reduced from 0.95 to 0.9 in the last 12 months.

- There is significantly more BAME staff that reported a change in the levels of Bullying & Harassment from patients & relatives towards BAME staff - up from 10% to 32% (there was also an increase reported from White staff from 27% to 31%). Every trust in our comparator group in GM saw an increase in this indicator.

Actions taken in 2018 – 2019

1. Since the WRES paper was last presented to the Trust Board the following actions have been undertaken:-
    a. <u>BME Staff Network:</u> The BME staff network has been established which has received very positive engagement, during the third meeting on the 22 May 2019, the appointment of a chairperson was confirmed. A manager's guide explaining the purpose of the BME network has been distributed to encourage managers to support our BME staff to engage in the group and attend meetings.
    b. Cultural awareness sessions have been arranged and promoted. We have received positive feedback from staff attending – LGBT awareness, Trans awareness and the Islam awareness session.
    c. Positive action statements have been added to adverts and training communications. A positive action activity is used to help employers remove barriers and issues to the employment, retention and progression from "under represented" groups, whilst still employing people on merit. We have included an improved positive action statement within our recruitment advertising and added one to all our promotion of development opportunities. An example of a positive action statement used within the trust is:
        i. *This development opportunity is available to all staff, particularly black and minority ethnic employees and/or employees with a health condition or impairment. Reasonable adjustments will be made to enable employees to access development opportunities and reach their full potential at work.*
    d. Ramadan fact sheet and aid memoir has been developed and distributed to all managers explaining the cultural elements and encouraging flexibility for Muslim colleagues during the holy month.
    e. Un-conscious bias training has been developed in conjunction with Enact Solutions a leading EDI specialist firm who use innovative interactive solutions to communicate key messages. The objectives of the half day embracing differences interactive session are:
        - *To recognise that everyone is different and embrace the value of those differences*
        - *To recognise our responsibilities and feel confident in addressing behaviours that don't align with our core values*
        - *To understand how unconscious bias may influence the decisions we make and the interactions we have*
    f. Two BAME Freedom to Speak Up Champion have been appointed.
    g. We have had two employees who have attended the national stepping up programme.
    h. Improvements to the employee relations processes have been introduced which include – early intervention mediation process, personal responsibility framework, effective case management.

Actions to be taken moving forward (WRES)

1. Whilst some improvement has clearly been made, there remains considerable work that needs to be undertaken. This year the WRES action plan has been developed in conjunction with the BAME network.

    The WRES action plan will continue to be grouped into three workstreams:-

    - <u>Workstream 1 - Make recruitment fairer</u>
        i. Un-conscious bias training will be rolled out from September 2019. Colleagues will recall we had planned to roll these our earlier in the

year but there were IT technical challenges with the new programme which have now been resolved.

ii. Designated members of the BAME staff network have agreed that they will act as a guardian of a fair process by inputting into recruitment processes of band 7-9 job vacancies. Training for these network members commences in September 2019.

iii. Recruitment audits commenced in July 2019 and will be undertaken quarterly. These audits involve identifying from TRAC posts that have received BME applicants, posts will be randomly selected to ensure that a robust, fair process has been followed. The first findings of these audits will be presented to the Workforce Assurance Committee in the Quarter 3 report. Escalation will then be provided to Board members via the WAC Chairs report.

iv. The BAME Network will receive support sessions aimed at current BAME staff to help with the application form process and interviewing skills.

- <u>Workstream 2 – Workplace Experience</u>

  i. Significant work has been undertaken with the BAME staff forum and early signs show the staff to be positively engaged and supportive of the group. We are currently establishing a LBGT+ forum which will be followed by a disability staff forum.

  ii. A new exit interview process has been developed which will allow the workforce information team to report workforce experience as informed by employees leaving the Trust.

  iii. The Go Engage tool will provide the trust with data which can be analysed by a number of protected characteristics which will allow the trust to target interventions.

  iv. The Trust's reverse mentoring programme has been developed and training for the programme will commence in the autumn.

  v. A decision tree checklist model will be explored to help managers to decide whether formal disciplinary action is essential or whether alternative actions might be feasible.

  vi. A post action audit process will be explored which will take place on a quarterly basis; this will identify any systemic weaknesses, biases or underlying drivers of adverse treatment for any group. This will feed into an employee relations bi-annual review presented to the Workforce Assurance Committee.

  vii. On a quarterly basis, the Head of Workforce Inclusion & Transformation will review the employee relations cases within each division to discuss potential alternative approaches and potential biases.

  viii. Managers will attend an accredited investigators training programme to ensure a consistent approach for managers when they are conducting investigations.

- <u>Workstream 3 – Support and enable Career Development</u>

  i. The Trust will ensure that they maximise the 'take up' of the Leadership Academy programmes such as the 'Stepping Up Program' and the 'Ready Now' programme. These programmes are leadership development programmes for aspiring BAME colleagues who work within a healthcare setting. They aim to create greater levels of sustainable inclusion within the NHS by addressing the social, organisational and psychological barriers restricting BAME colleagues from progressing.

ii. Linked to the above the Trust will develop an internal 'stepping up' programme. This approach has been used by a couple of other NHS Trusts with great success; specifically one Trust could demonstrate that 75% of colleagues that attended the internal programme were successful in securing a promotion. This programme is in early development stages however, the trust is keen to pilot the programme in the New Year. The programme will be targeted at aspiring middle managers (Band 5-7) in the first instance.
iii. A process to capture all development and CPD is being explored which will help to identify equal opportunities for training and development. A long-term solution is being developed to link to the ESR/OLM project and digital transformation plan.

Performance / Key Findings (WDES)

1. This is the first year that the WDES has been produced and as such, there is no comparator from previous years. Where possible comparators have been given against known national averages – via the NHS Staff Survey. It is recognised that the data is poor across the whole NHS and much work is required to improve declaration rates to enable true visibility of issues related to our disabled workforce.

2. 2.75% of our staff has reported themselves as having a disability (via ESR – HR information system); this is very different to the number who declared themselves as disabled via the NHS Staff Survey (17%). Nationally 3% of staff report that they have a disability in the NHS (via ESR – HR information system), with 18% declaring that they have a disability on the NHS Staff survey.

3. Workforce analysis shows that the majority of Disabled staff are clustered at Bands 1-8a. 38 non-clinical members of staff declared a disability, of these 92% were in bands 1-7 and 8% are in bands 8a+ 112 clinical members of staff declared a disability 95% of these staff are in bands 1-7 and 5% are in bands 8a+.

4. Staff Engagement scores for Disabled Staff (7.1) working in the Trust are lower than for Non-Disabled staff (7.4). The Trust score higher than most GM trusts for disabled staff engagement. Non-Disabled staff feel that they are satisfied that the organisation values their work (Disabled 47%, Non-Disabled 57%).

5. In the last 12 months 10%, more Disabled staff have personally experienced discrimination from either their Patients, team or colleague. This is higher than other Trusts in our comparator group in Greater Manchester.

6. The relative likelihood of Disabled applicants being appointed from shortlisting compared to non-disabled applicants is 1.41. Marginally less disabled staff feel that the Trust provides equal opportunities for career progression (Disabled 85%, Non-Disabled 89%)

Actions taken in the last 12 months related to the WDES

1. We have recently been recognized as a Disability Confident Employer – this means that the Trust has processes in place to ensure that disabled people and those with long term health conditions have the opportunities to fulfill their potential and realise their aspirations. We will now aspire as a Trust to achieve the third level – Disability Confident Leader.

2. Physical – physical adjustments can take place in the form of the environment and to support individuals with physical health conditions. A range of additional support has

been introduced over the last 12 months. MSK is a frequent cause of ill-health for employees often resulting in them becoming disabled. The Trust has an excellent staff physiotherapy service providing fast track service for staff suffering from an MSK condition. The Trust has recently increased the number of appointments available for staff. Since the introduction of the attendance matters team there has been an increase of staff referrals for employees who are off work with an MSK issue, with the physio support helping them to return to work. The attendance matters team have a library of self-help materials covering a wide range of physical health conditions that are shared with staff who may need reading materials. The Trusts new health and well-being portal has a range of support materials ranging from advice developed in conjunction with Macmillan about working/living with cancer to understanding the menopause.

Mental - A range of initiatives and approaches have been introduced at an organisational level over the last 12 months. This has included investing in additional counselling services for our staff to use. As part of the National Mental Health Awareness Week (13th to 19th May 2019) we launched the Employee Assistance Programme (EAP) that provides a 24/7 help and advice telephone line, 24/7 telephone counselling, online cognitive behavioural therapy programme and tools and additional support services. The Trust commissioned an innovative, modular-based 'Caring for Yourself Programme' for staff working in urgent care. The aim of the programme was to equip staff with additional tools and support to improve their resilience ahead of the winter period.

A reasonable adjustment passport has been introduced which allows an employee and their manager to effectively manage and review reasonable adjustments.

Actions to be taken moving forward related to the WDES

1. A key focus this year will be ensuring that the information we hold on our HR systems is accurate. We know from the NHS Staff Survey that a number of our staff are choosing not to declare their disability. As such, the Trust will need to fully understand the reasons for this and then put appropriate measures in place to increase our staff confidence in declaring their disability.

2. Physical Health. A review of the sports and social club will take place to improve the pro-active physical health staff offer from the trust.

3. Mental Health. The Workforce Assurance Committee recently received a report that set out the following actions that will be taken in 2019/2020 related to mental health. As follows:-

    - Signing the 'Time to Change' employer pledge to show the Trust's commitment to changing the way we all think and act about mental health in the workplace.

    - Developing a high-profile awareness campaign and education programme that helps to remove the stigma around mental health.

    - Equipping line managers with the skills, competence and confidence to spot the early signs of mental ill health, to intervene early and support staff with mental health problems.

    - Establishing a network of Mental Health and Wellbeing Champions across the Trust. The champions will complete the RSPH Level 2 qualification in Understanding Health Improvement, which empowers employees to become involved in the overall strategy and to offer support to peers.

Additional information

1. At divisional level, an integrated report has been developed to enable divisions to have an overview of all inclusion strands. The WRES AND WDES are generally reported across the NHS at Trust level, however drilling down the Trust has found that we are able to identify hot spot areas to target interventions.
2. Age: The Trust has an ageing workforce with 52% of the trust workforce over the age of 40. The average age of an employee at the Trust is 43 (male 41, female 43) in line with the national average in the NHS of 43. The Trust needs to be prepared for the fact, just like the community that the Trust serve their workforce will experience ill-health, impairment and disabilities. Retaining staff with lived experiences can be beneficial to Trusts as their understanding can enhance patient care. A lot of these issues will form part of the actions identified through the WDES. Flexible working, including different or set working patterns has been proven to enable older workers to work to a higher pension age. The Trusts staff survey results show that the Trust have made excellent improvements with a positive score of 60% that the Trusts offers opportunities for flexible working compared to the national comparator of 52%. There are still improvements that can be made with the flexible working policy which is currently under review.
3. LGBT+: The rainbow badge campaign was launched during LGBT+ history month and EDI delivered educational presentations at a wide range of forums. Many staff members have made pledges communicating how they will be inclusive for patients and colleagues. You will observe a lot of staff wearing their rainbow pin badges with pride. A webinar has been created and recorded to allow staff to access the learning and make a pledge which will make the campaign more accessible for staff. This was launched on the 17 May - IDAHOBIT - the International Day against Homophobia, Biphobia, Interphobia and Transphobia. This has allowed more people to access the learning and make their pledge; pledges are being received on a daily basis.
4. The LGBT flag is on display outside the main entrance communicating our support for our LGBT community (staff, patients and visitors) and as a wider symbol of inclusion.
5. Gender - To support our commitment to eradicate the gender pay gap within the trust we are exploring the internationally recognised Springboard women's development programme. Research has been conducted and costings identified. We are currently exploring external funding opportunities.

Measurement and Monitoring

1. The Trust will develop improvement targets for inclusion strands that will be monitored by the workforce assurance committee (WAC) and reported to board through the chairs report. These targets will be set at division and trust level.

Trust WRES/WDES annual targets are suggested below:

	WRES Indicator	2017/18	2018/19	2018 – National Data	Target
	Total number of staff	5298	5457	19.1%	0.8% improvement each reporting period
	Proportion of BME staff employed	11.61%	12.44%		
2	Relative likelihood of staff being appointed from shortlisting across all posts.	1.40	1.53	1.45	1.35
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	1.87	1.59	1.24	1.40
4	Relative likelihood of staff accessing non-mandatory training and CPD.	0.95	0.90	1.15	1.0
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 27% BME: 20%	White: 31% BME: 32%	29%	25%
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White: 19% BME: 27%	White: 16% BME: 29%	28%	25%
7	7 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White: 90% BME: 79%	White: 90% BME: 75%	72%	70%
8	8 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White: 5% BME: 20%	White: 5% BME: 18%	15%	15%

WDES Indicator	Trust Wide	Target
	2018/19	
Total number of staff	5457	
Proportion of Disabled staff employed	2.75%	5%
Relative likelihood of staff being appointed from shortlisting across all posts.	1.41	1.35
a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:		
i: Patients/their relatives/Public	D: 34% ND: 24%	30%
ii: Managers	D: 10% ND:11%	10%
iii: Other colleagues	D: 20% ND: 16%	15%
Q13. b) Percentage of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	D: 68% ND: 50%	50%
Q14. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion	D: 85% ND: 89%	89%
Q11. Percentage of Disabled staff compared to non-disabled staff saying they felt pressure to come to work despite not feeling well enough to perform their duties.	D: 27% ND: 19%	25%
Q5. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	D: 47% ND: 57%	50%
Q28. b) Percentage of disabled staff saying their employer has made adequate adjustment(s) to enabled them to carry out their work	74%	78%
The staff engagement score	Disabled: 7.1 Non Disabled: 7.4	7.3

Matters to note related to KPI's

a. Noting that this is the first year NHS organisations have been asked to present their WDES findings then a fuller review of the WDES KPI's will take place next year when the Trust has more benchmark data both internally and externally.
b. Colleagues will note that the WRES annual targets have been proposed. Further discussion will take place with the BAME network as to timescales whereby the Trust will deliver our aspiration of the KPI's being comparable with White colleagues.

2. The Equality action plan (which includes WRES and WDES) will be regularly monitored by the Equality and Diversity Steering Group. The Workforce Assurance Committee (WAC) will provide oversight and reporting to the Board via the normal WAC Chair report. The WRES and WDES data and action plan will be published on the NHS England portal and the Trust's website.

Recommendations

1. The Trust Board is asked to:

    a. Note the details of the Report.

    b. Note the actions that will be taken to improve performance against the key WRES and WDES Indicators. The Trust Board will be updated on the progress being made via the Workforce Assurance Committee Chair's report.

    c. Highlight any specific additional assurance / workforce information required.

    d. Note that in the September, 2019 Trust Board the Board Development will focus on Inclusion and Unconcious bias training. The Board members will therefore have the opportunity to more deeply explore elements of this paper.

NHS Bolton NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD

WRES Indicator	2017/18	2018/19
Total number of staff	5298	5457
Proportion of BME staff employed	11.61%	12.44%
The proportion staff who have self-reported their ethnicity	93.81%	94.04%
Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.		
Relative likelihood of staff being appointed from shortlisting across all posts.	1.4	1.53
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	1.87	1.59
Relative likelihood of staff accessing non-mandatory training and CPD.	0.95	0.9
KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White: 27% BME: 20%	White: 31% BME: 32%
KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White: 19% BME: 27%	White: 16% BME: 29%
7 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White: 90% BME: 79%	White: 90% BME: 75%
8 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White: 5% BME: 20%	White: 5% BME: 18%
Percentage difference between the organisations' Board voting membership and its overall workforce	White: 10.1% BME: -3.9%	White: 1.60% BME: 5.77 %
The Staff engagement score:	White: 7.3 Christian: 7.3 BME: 7.7 Muslim: 8.1	

WORKFORCE DISABILITY EQUALITY STANDARD

WDES Indicator	Trust Wide 2018/19
Total number of staff	5457
Proportion of Disabled staff employed	2.75%
The proportion staff who have self-reported their disability	71.47%
Percentage of staff in each of the AFC paybands or Medical and Dental subgroups and VSM (including executive board members) compared with the % of staff in overall workforce	
Relative likelihood of staff being appointed from shortlisting across all posts.	1.41
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process.	Not available
a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	
i: Patients/their relatives/Public	D: 34% ND: 24%
ii: Managers	D: 10% ND:11%
iii: Other colleagues	D: 20% ND: 16%
Q13. b) Percentage of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	D: 68% ND: 50%
Q14. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion	D: 85% ND: 89%
Q11. Percentage of Disabled staff compared to non-disabled staff saying they felt pressure to come to work despite not feeling well enough to perform their duties.	D: 27% ND: 19%
Q5. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	D: 47% ND: 57%
Q28. b) Percentage of disabled staff saying their employer has made adequate adjustment(s) to enabled them to carry out their work	74%
The staff engagement score	D: 7.1 ND: 7.4

* D = Disabled, ND = Non-Disabled

Agenda Item No 15

Meeting	Board of Directors

Date	25th July 2019

Title	Staffing Paper – Comprehensive Overview
Executive Summary • *Why is this paper going to the Board* • *To summarise the main points and key issues that the Board should focus on including risk, compliance priorities, cost and penalty implications, KPI's, Trends and Projections, conclusions and proposals*	This report provides the Board with a comprehensive update on nurse and midwifery staffing, mainly focusing within the bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	Staffing levels are reviewed on a regular basis via Workforce Assurance Committee

Next steps/future actions *Clearly identify what will follow a Board decision i.e. future KPI's, assurance requirements*	Staffing will continue to be presented on a monthly basis at board through the ward heatmaps. A comprehensive update on progress of activity outlined within this report will be presented to board January 2020.			
	Discuss	✓	Receive	
	Approve	✓	Note	

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

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

Prepared by	Marie Forshaw, Deputy Director of Nursing Contributions from Divisional Nurse Directors, Acute Adult, Elective, Families and Integrated Community Services, Governance Team & Workforce	Presented by	Trish Armstrong-Child, Director of Nursing and Midwifery

NHS
Bolton
NHS Foundation Trust

Board of Directors – 25th July 2019

Comprehensive Staffing Paper Update

1 Purpose

This report provides the Board with a comprehensive update on nurse and midwifery staffing, mainly focusing within the bed base areas within the Trust and includes an overview of the current staffing position and the work that has been taken and continues to be taken to ensure staffing levels are safe and sustainable.

2 Background

Since 2013 the Board has consistently reviewed its current staffing establishment and significant investment has been approved and made into a variety of nursing establishments. The majority of investment has been made within our inpatient areas and has been based on NICE guidance (Inpatient staffing 2014 and Maternity services 2015), professional judgement, the enhanced care project and consideration of quality indicators.

The approach adopted was reinforced by a joint communication from the Care Quality Commission, NHS England, Chief Nursing Officer and NHS Improvement that was sent to Trusts Chief Executives in October 2015. This letter outlined a shared view that providers should approach the need to ensure safe, quality care for patients on a sustained financially stable basis. Whilst reinforcing the need to use guidance and best practice. The importance of professional judgement, taking into account other disciplines contribution to providing direct care was advised. In response to this the organisation has continued to undertake systematic establishment reviews of areas and these will be highlighted later within the paper.

NHS Improvement published further guidance in October 2018 'Developing Workforce Safeguards'. This document has been developed by system leaders to highlight policy that supports organisations to use best practice in effective staff deployment and workforce planning. It offers advice on governance issues related to redesigning roles and responding to unplanned changes in workforce.

The intense focus on staffing levels, nurse recruitment and retention has demonstrated an improved position, but continues to be highlighted as a significant organisational risk on the Trusts Board Assurance Framework (BAF) due to the national position.

3 Current Position

The charts (Table 1, Graph 1) provide a breakdown of our UNIFY fill rate data (January to June 2019 inclusive) that we collect and submit externally on a monthly basis for our inpatient areas. It shows a percentage of the Planned v Actual staffing levels for both the Day and Night shifts split by registered and unregistered.

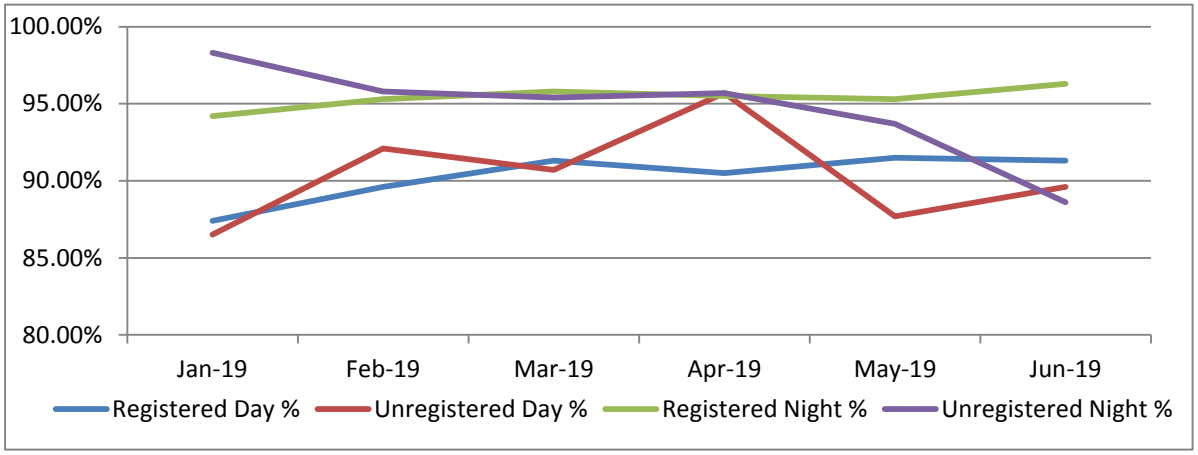
In May 2019, during work being led on Model Hospital by the Deputy Director of Nursing, it was identified that historically we have included assessment areas on the return. However, after reviewing the guidance, it clearly stipulates only inpatient areas should be included. As a result, D1, D2 & CDU have been removed from future returns. In addition, we are currently working on reviewing all the inpatient demand templates to ensure accuracy of reporting to consider all new and emerging roles (such as AP's, TNA's, Nursing Associates, etc).

Table 1

Percentage fill rate – Unify Submission

Month	Registered Day %	Unregistered Day %	Registered Night %	Unregistered Night %
Jan-19	87.40%	86.50%	94.20%	98.30%
Feb-19	89.60%	92.10%	95.30%	95.80%
Mar-19	91.30%	90.70%	95.80%	95.40%
Apr-19	90.50%	95.70%	95.50%	95.70%
May-19	91.50%	87.70%	95.30%	93.70%
Jun-19	91.30%	89.60%	96.30%	88.60%
Average	90.27%	90.38%	95.40%	94.58%

Graph 1
January-June 2019 Fill Rates

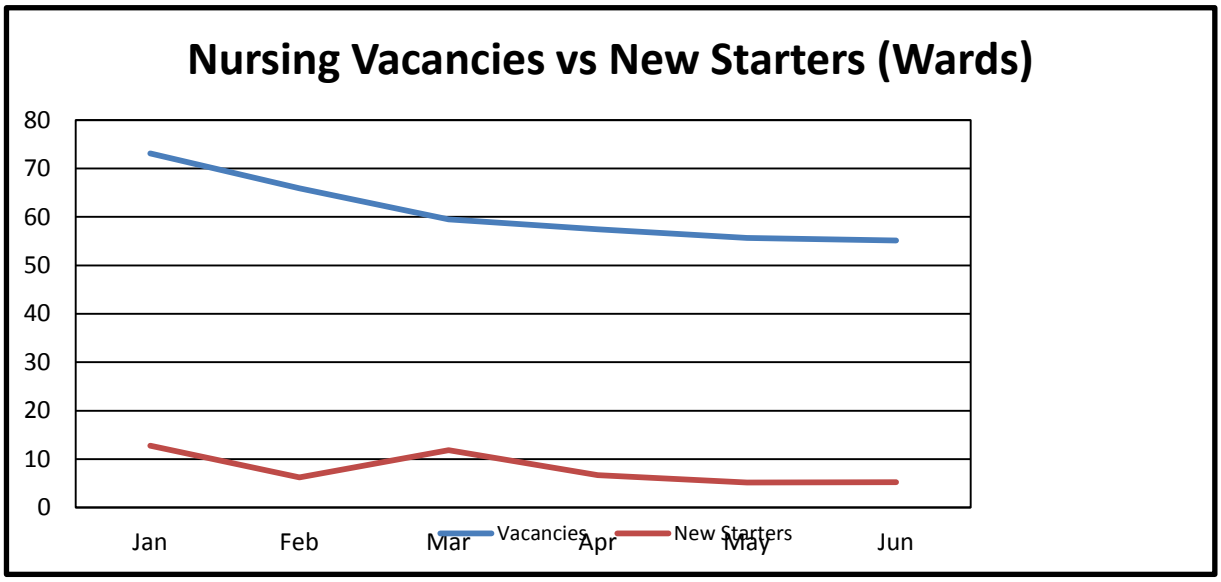


4 Vacancies

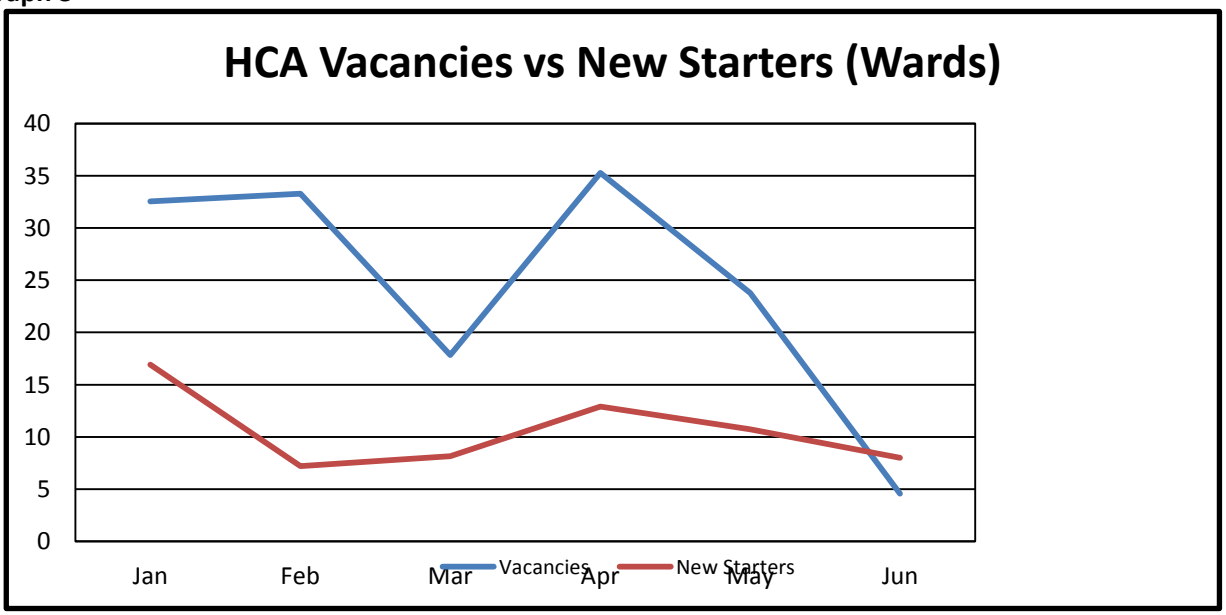
Graph 2 below demonstrates that the Trust has continued to attract nurses and that the overall number of vacancies has reduced significantly over the reporting period.

Graph 3 shows strong performance against recruitment of HCA staff with Trust assessment days supporting a consistent intake of HCA staff and a very positive vacancy level.

Graph 2



Graph 3



5 Recruitment and Retention

Since January 2019 the following recruitment events have been held:

HCA Recruitment Day – 12th February 2019
HCA Recruitment Day – 14th May 2019

Newly Qualified Recruitment Day – 2nd March 2019

We have a planned approach to nursing and HCA recruitment and dates are already in the calendar for the next events which are as follows:

- HCA Recruitment Day – 10th September 2019
- Newly Qualified Recruitment Day – 14th September 2019.

There are a number of ongoing initiatives to support the trust with recruitment and retention. These include:

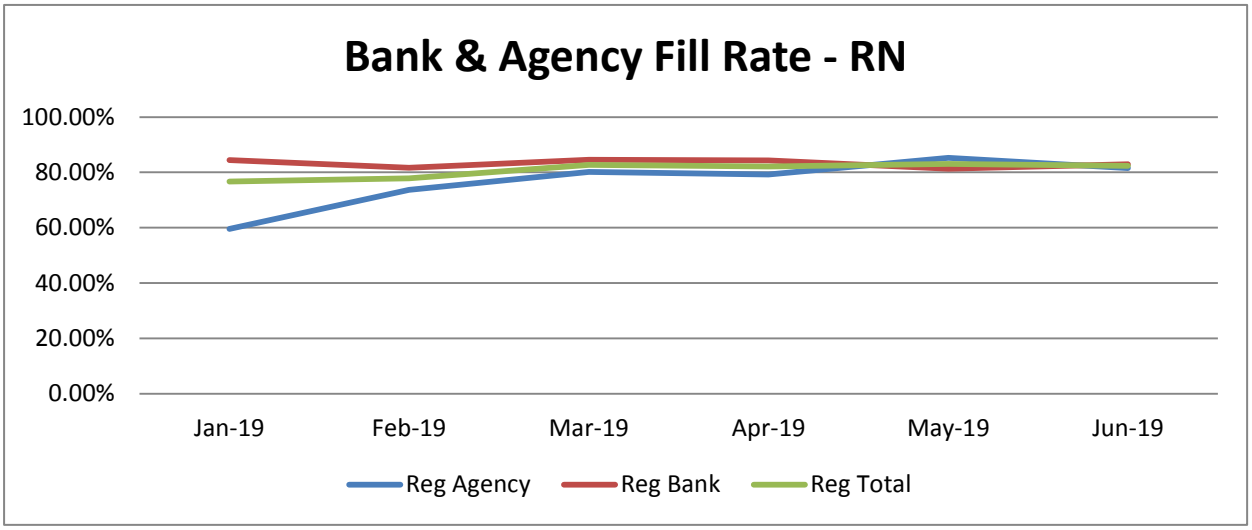
- Weekly meetings held between Divisional Nursing recruitment leads and Employee Service Manager to discuss adverts and progress with all nursing vacancies at offer stage.
- Bespoke adverts created for wards and departments and these are used alongside rolling recruitment campaigns.
- Focused work with the Ward Managers and Matrons on hard to recruit areas with regard to development opportunities available.
- Working with Communications and Human resources to promote the Trust as a great place to work through best use of social media; we have built a strong network of Trust nursing staff who use Social Media to promote the Trust as an employer of choice.
- Implementation of Rotational posts within Adult Acute and Elective Care Divisions.
- The Trust continues to have a very strong focus on ensuring we appoint newly qualified nurses.
- A significant increase in student nursing training places
- The Director of Nursing and the Deputy Director of Nursing meet on a regular basis with nurses in training and on qualification.
- In recognition of the valuable contribution of the HCA workforce the review of the Care Certificate is now complete and is due for roll out.

6 Temporary Staffing

When staffing numbers fall below agreed staffing levels there are systems and processes in place that allows Managers to fill gaps with temporary staffing. The Trust's Temporary Staffing is managed in house within the Human Resource Department. Graphs 4&5 demonstrate our current fill rates against requests.

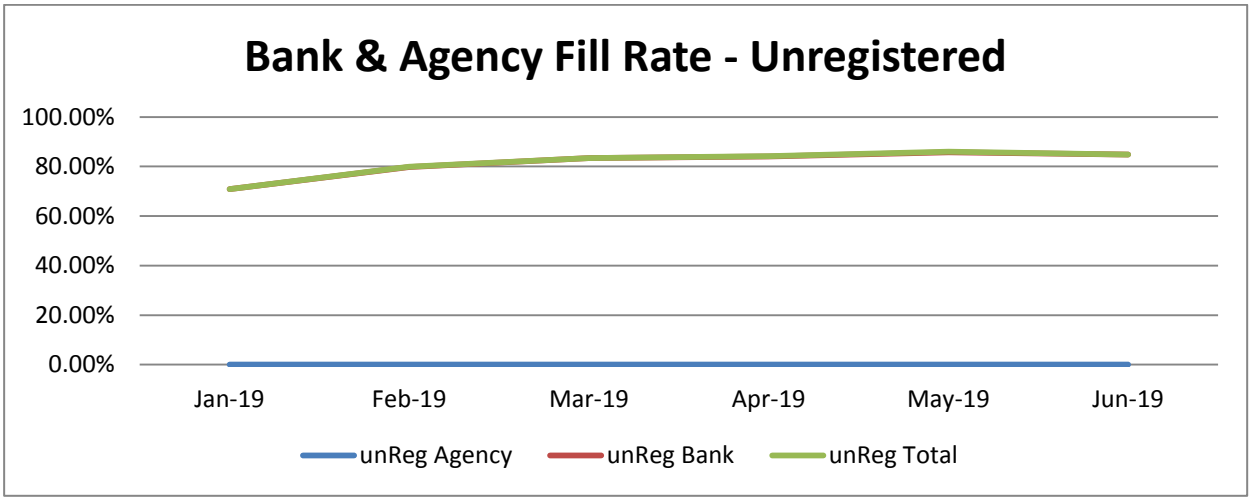
Graph 4

Bank and Agency Fill Rate - RN



Graph 5

Bank and Agency Fill Rate - Unregistered



7 Staffing & Skill Mix Reviews Update by Division

7.1 Acute Adult Division Staffing Establishment Review

The Division continues to review staffing on a six monthly basis. This supports recommendations from national best practice recommendations related to regular review of staffing establishments. The Division uses Model Hospital to support establishment reviews alongside other key metrics including Care Hours Patient per Day (CHPPD) and professional judgement, acuity data including enhanced care requirements and national staffing guidance. This is done in conjunction with clinical staff, finance and business managers. Local staffing profiles are used as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons, use alternative roles and predictive staffing models 2018 - 2020.

Highlights Jan-June 2019

- Lead Matron role in division for recruitment and retention evaluation evidencing increased numbers of newly qualified nurses accepting job offer and commencing employment. Evidence shows keeping in touch Programme is effective and supportive
- Registered nurse (RN) prediction for next intake of newly qualified nurses in September 19 will be below 10wte, however due to contingency bed requirements the division has had between 36 – 55 wte RN vacancies whilst contingency beds were open in Jan – June wte. There has been a month on month reduction in hours required temporary staff using agencies and use of premium cost agency's Jan 19 – May 19 on established wards, however this has been masked by requirements to maintain contingency ward staffing
- In June 19 the division used the least amount of bank and agency nursing, particularly of note for RN evidencing the effects of seasonal planning 2018/19
- The division delivered a successful business case to open Enhanced Respiratory Care bays on D3 and D4 modelled using Nursing Associate roles
- The Trust are the 1st in the country to use the Nurse Associate role in Accident and Emergency as part of Minor Injuries re-modelling (March 19)

Staffing Reviews Undertaken Jan – June 19

- All ward based areas
- Seasonal planning additional contingency capacity
- Accident and Emergency requirements

Re-modelling and Transformation Work streams update

In this period the division has seen the successful opening of additional areas in the Accident and Emergency department in both Minor Injuries, ambulance drop off area and additional resuscitation capacity. There has been a requirement to create additional roles and also use staffing resources differently. Evidence from both quality and safety metrics and operational performance evidence new models of working are effective. Of note, the new role of using Nursing Associates in Minor Injuries is the 1st in the country and successful outcomes include diversion of band 5 RNS to other parts of the department and transfer to nurse led follow-up clinics from the traditional model of Consultant led follow–up clinics.

A programme of work to redesign Frailty pathways focusing on admission avoidance and re-direction of patients for assessment from Accident and Emergency is currently in progress as part of streaming work and development of Acute Medical assessment pathways. A new staffing model to deliver this service is required and will be completed Quarter 3 (Q3) as part of

a business case and findings reported through this paper June-Dec 19 findings. Similarly the development of Acute Medical assessment pathways as part of streaming work is being written in conjunction with Frailty requirements in order to ensure deliver of high quality pathways, whilst ensuring effective use of resources. A staffing model is expected (Q3).

Previous discussion in June – Dec 2018 focused on development of new roles and staffing requirements as part of considering new models of care aligned to the Trust and divisional strategic direction. As part of this, ward A4 will be transferred into the community division in July 2019, however there will be a shared arrangement for staffing and day to day management in Q3 in order to support staff and ensure quality and safety are maintained through transition.

Ward/Department Based Areas

All ward based areas have had a nurse staffing reviews undertaken. Ward based staffing reviews June – Dec 2018 focused on opportunities to undertake tests of change on using clinical staffing resources differently. Operational tests of change related to administration and co-ordination of discharge within wards were in in place on wards B1, B3, D3 and D4. Whilst early indications suggested there are some positive outcomes related to new roles, full evaluation findings could not demonstrate value for money and the role was stopped in April 2019.

Nurse Associates have been introduced on wards D1 and D2 (assessment areas) in Feb 19. Evaluation of this new role will be presented in the next paper.

Initiatives and Innovation

The enhanced respiratory care bay on wards D3 and D4 have been approved in March 19. This means that patients with the highest dependency including those patients requiring advanced respiratory support are cohorted in one area, and staffing resources are used differently. As part of this business case the nurse associate role has been used as part of skill mix requirements for the ward which supports redistribution of specialist skills to the higher acuity areas. As part of future proofing this service, prioritisation of Trainee Nurse associate (TNA) cohorts commencing April 19 and Sept 19 will see placements in respiratory care.

Discussions are also in place with other providers to provide and offer of specialist training for nursing experienced in Dermatology care as part of requirements to future proof services. An update will be provided in the next staffing paper.

Enhanced Care

The number of patients requiring 1-1 support or enhanced care due to either a temporary or permanent cognitive impairment such as a Delirium or Dementia has resulted in a test of change of an Enhanced Care lead to prevent deconditioning, promote mental and physical stimuli, and prioritisation of staffing resources. The evaluation of a secondment post of Enhanced Care Lead (April 18 – April 19) identifies positive correlation between quality, patient and staff experience and effective use of resources. In addition it also evidenced a reduction in the number of additional duties being requested for enhanced care due to cohorting, distraction prescriptions and assessment tools.

As part of ward staffing reviews, a ward based post on B1 has been converted to support a band 2 therapy assistant to support this work.

Recruitment and Retention:

- Jan (19) Commencement of Aspirational talent management and succession planning programme by the Divisional Nurse Director for all grades of staff leading to support of coaching, apprenticeships in leadership at both degree and Masters level and opportunities to lead or co-lead quality projects
- Listening events for, HCA and new nursing staff in preceptorship at 3 monthly intervals
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level

Additional Roles

Nurse Associates and Trainee Nurse Associates

As identified earlier in the paper, the division has used the new role of Nurse Associate innovatively across ED, assessment areas and forward planning within Respiratory Care. Early evaluations suggest new models are effective. Ten Trainee nurse associates will commence training in the division Jan 19-Jan 20. The number of training opportunities are directly linked to both successful business cases in respiratory care and new skill mix requirements across emergency care and assessment areas.

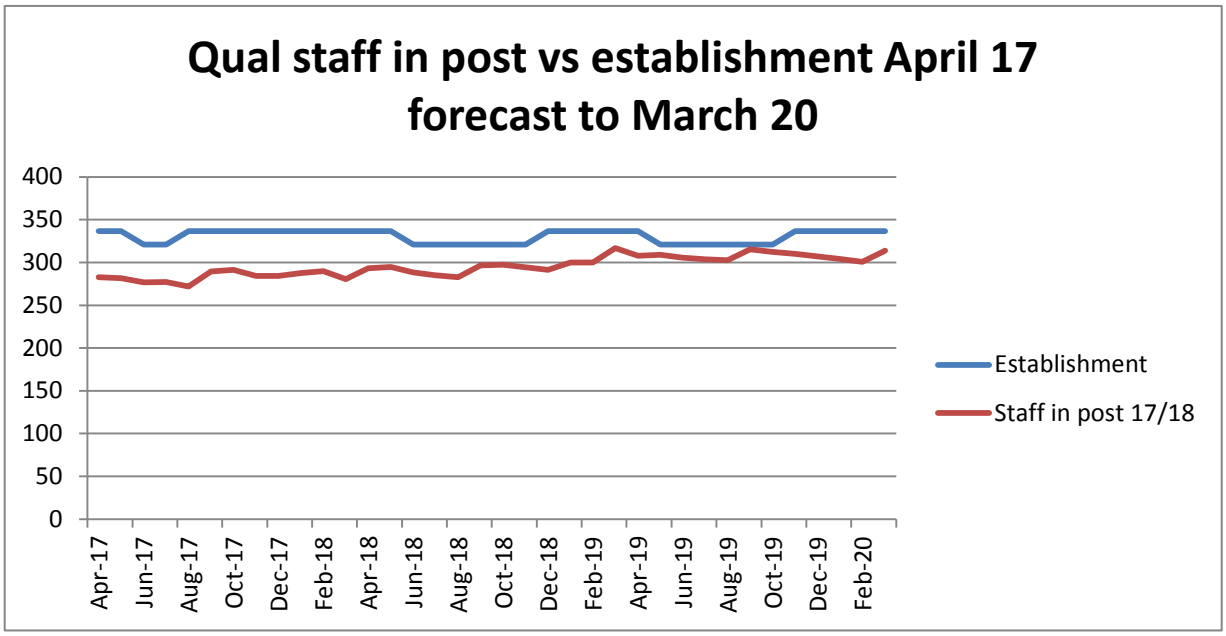
Advanced Practitioners

4 trainee advanced nurse practitioners (ANP) will have commenced training Jan 19 – Sept 19. In Accident and Emergency two posts are aligned to converting Senior medical shifts to Advanced nurse practice shifts on completion of training following identification of hard to recruit to roles. A further two posts are aligned to the Ambulatory Care unit (ACU) as part of skill-mix reviews and hard to recruit to for medical requirements.

Workforce Analysis

Registered Nurse Vacancy Position

The division has had approx. 36 band 5-wte registered nurse gap Jan – June 19. This is due to requirements to staff contingency areas Nov 18-June 19 requiring an additional 15 wte RN positions. This is why the organisation has not yet felt the effect of nurse recruitment. In addition the table below highlights that it is June 19 and Sept 19 where contingency beds are closed and newly qualified nurses are due to start is when the positive impact of Bolton University nurse recruitment (as student nurses qualify) is predicted to have on over-all vacancies by 2019. However this position will be marginalised when additional bed capacity opens in December 2019.



Contingency Area Requirements

There is a requirement for 15.79 wte registered nurses and 20 wte HCA to support extra bed bases as part of winter contingency planning. A successful recruitment plan has been delivered by the Matron responsible for contingency bed planning and additional beds opened in December 2018 as part of a titration of increase of beds Dec 18 – March 19. Going forward the decision has been made to alter the nurse establishment to support the Seasonal Plan 2018/19. The rationale for this is intelligence suggests from staff engagement and sickness information that by using this model we can support staff by offering additional leave at peak childcare times (e.g. Summer) and increase staffing to support additional contingency areas when needed (e.g. Winter). This will also reduce the need for reliance on temporary staff and support continuation of care.

Opening Period

Ward B2 was opened on December 17th 2018 to 26 beds. 6 contingency beds were opened on Ward B2 from November 5th. The ward was closed on June 10th. The original plan was for the ward to close on March 22nd. Trust concerns regarding Emergency Department performance and safety meant the closure was delayed until June 10th.

Temporary staff

There has been a month on month reduction in agency use Jan – June 19 in hours and cost across permanent established wards, however this has been masked due to requirement for contingency ward areas and use of agency staff. Of particular note there has been a significant reduction in the reliance on premium agencies with an expectation it will be rarely required whilst the contingency ward is closed as part of the seasonal plan. In June 19 following closure of the contingency ward there has been a significant reduction in agency hours which was predicted in the seasonal plan. Evaluation of the seasonal plan and impact on agency hours will be reported in the next paper.

7.2 Elective Care Division Staffing Establishment Review

The Division continues to review staffing on a six monthly basis. This supports recommendations from national best practice recommendations related to regular review of staffing establishments. The Division uses Model Hospital to support establishment reviews alongside other key metrics including Care Hours Patient per Day (CHPPD) and professional judgement, acuity data including enhanced care requirements and national staffing guidance. This is done in conjunction with clinical staff, finance and business managers. Local staffing profiles are used as well as education predictions to plan resources appropriately. This has helped us consider benchmarking comparisons, use alternative roles and predictive staffing models 2018 - 2020.

Highlights Jan- June 2019

- In recent peer reviews, the intensive care unit was non-compliant with three core standards for Intensive Care Units in relation to nursing staff. This has been a recurrent for the last 4 years. One of these standards was to have supernumerary shift leader on duty 24 hours a day, 7 days a week. Following a successful business case, the band 7 establishment was increased allowing for supernumerary shift leader for 12 hours (daytime) per day. This is with plans to further increase this to fully meet the standard in the near future. The shift leader will provide cover across the ICU and HDU. Both departments are currently located separately, but plans are underway for them to become co-located. This will further strengthen the supernumerary role.

- All establishments at present were agreed to be correct in relation actual staffing numbers.
- There has been a noticeable impact on F4 as a direct correlation to the wider shared Consultant on call agreements with WWL for Urology. In addition patient acuity has increased due to the number of patients who require invasive artificial airway management. This is currently being monitored on a daily basis and further changes to the establishment may be required once three months of data have been analysed.
- Remodelling and transformation of the specialist nursing workforce identified in the January paper is underway and is scheduled for completion in Jan 2020.

Re- Modelling and Transformation work streams update

Theatres

A complete staffing review for theatres has been completed by the theatre matron and OBM which has resulted in the development of a business case to support an investment in additional staff to enable safe and effective opening of additional emergency theatre capacity in maternity. The current risks relating to theatre are detailed on the divisional risk register and reviewed on a monthly basis. In addition we have been working with the University of Bolton to develop an apprenticeship for ODPs which we will assist in recruitment and retention of theatre staff.

Endoscopy and Bowel Cancer Screening.
Following a successful business case in 2018 to open room four in the endoscopy unit and extend opening times, the unit needed to recruit in excess of 9 WTE band 5 nurses. Despite business case approval, there has been a challenge in recruiting the required number of band 5 nurses, therefore it is necessary to undertake a further skill mix review, this is currently in progress and will be reviewed in the next update.

Ophthalmology
Activity within the Ophthalmology is increasing month on month and in order to respond a full staffing review was undertaken in 2018, resulting in a business case being approved to increase the staffing establishment and to improve the clinical area.

Recruiting experienced ophthalmology nurses has been difficult and availability of staff with the required specialist skills is challenging. Therefore the current workforce has been remodelled and transformed to deliver increased leadership and supervision.

Recruitment and retention
In 2019, the Division has so far welcomed nine Nurses into the Preceptorship programme.

A new Preceptorship rolling' programme had been devised by the corporate team including a 1 week induction followed by a number of sessions delivered by both Corporate and Divisional teams throughout the usual 12 month period.

A series of HCA engagement events is also underway to aid in retaining this large group of support staff.

Additional roles
Nursing Associates and Trainee Nursing Associates
The Division continue to provide training for our Trainee Nursing Associates and earlier this year welcomed the first qualified Nursing Associate into the Out Patient Department.

Workforce analysis
The division continues to recruit to all vacancies and the registered nurse headcount has increased since March 2018. This is a combination of recruiting to vacancy, additional staffing requirements through funded business cases and increase in establishment numbers following detailed staffing reviews.

The rise in numbers can be seen in the following areas:
Ward F4, Endoscopy, Ophthalmology, Breast Care Nursing, Advanced Practice, Nurse Endoscopists, Bowel Cancer Screening and the Day Care unit

Predicted Vacancy

As with other divisions the ability to maintain the pace of recruitment to turnover presents a challenge which results in a continuous vacancy. The vacancy levels documented below include the acute ward areas, and critical care.

Vacancy levels RN	June 19	July 19	August 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20
Actual vacancy (WTE)	2.57	2.57	2.57						
Predicted Mat Leave and LTS (WTE)	19.59	20.12	21.16	9.74	7.46	6.46	6.38	5.46	5.46
Recruitment (WTE)					11				
Turnover (WTE)	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Net Vacancy (WTE)	**25.16**	**25.69**	**26.73**	**12.74**	**+0.54**	**9.46**	**9.38**	**8.46**	**8.46**

Vacancy levels HCA	June 19	July 19	August 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20
Actual vacancy (WTE)	6.17	6.17							
Predicted Mat Leave and LTS (WTE)	11.15	10.15	17.32	18.48	18.70	16.25	16.25	15.64	15.64
Recruitment (WTE)		6.8			5			5	
Turnover (WTE)	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Net Vacancy (WTE)	**20.67**	**12.52**	**20.32**	**21.48**	**16.7**	**19.25**	**19.25**	**13.64**	**18.64**

Working in collaboration with colleagues in finance and HR, the division have committed to reviewing how by recruiting substantively to vacancy, turnover and mat leave, the need for bank and agency can be reduced. As demonstrated, due to the staff turnover and level of maternity leave that is currently known about, we will not get into a position whereby all bank and agency can be eliminated until the division reaches its agreed over recruitment figure.

Contingency Area requirements

As part of contingency planning for winter, the division altered the use of G5 the elective orthopaedic ward and the staffing establishment. This resulted in higher than average temporary staffing use and increased sickness and absence. In addition the division moved staff to Acute Adult to support the opening of B2 and moved staff to support the opening of F6 on a number of occasions. Preparation for next winter is currently underway along with a review of the staffing plan for G5 and additional capacity to minimise the impact of temporary staffing use and sickness and absence.

7.3 Family Care Division Staffing Establishment Review

The Division continues to review staffing on a six monthly basis. This supports recommendations from national best practice recommendations related to regular review of staffing establishments. Establishment reviews are undertaken using a range of metrics including patient acuity (dependency) data, staff skill mix requirements (including multi-disciplinary staff provision), patient safety data and professional judgement. This is done in conjunction with clinical staff, finance and business managers.

Midwifery

This review has taken into consideration NICE recommendations such as NICE recommended Birthrate Plus (BR+) tool for midwifery staffing, and professional judgement.

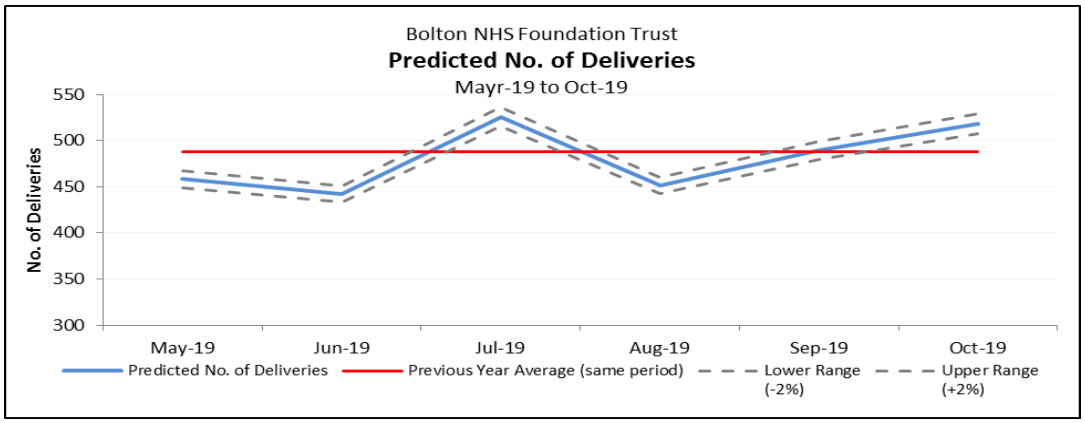
At its simplest Birthrate Plus® can provide any given service with a recommended ratio of clinical midwives to births in order to assure safe staffing levels. This means that taken overall to provide safe high quality maternity services, the NHS in England needs 1 clinical midwife for every 28 births.

Bolton Maternity Birthrate Plus® establishment is currently set at 1:28

Maternity safe staffing is monitored every month the percentage of planned versus actual and ranges from achieving 83% planned on days and 80% on nights. The acuity tool advises where the staff need to be and the helicopter bleep holder ensures the staffing follows the women to the areas where demand is required at that point in time.

A maternity red flag report which captures maternity staffing particularly achieving the supernumerary status of the Delivery Suite Coordinator is monitored 3 times a day. In the last 6 months, the Delivery Suite Coordinator has not achieved supernumerary status on 2 occasions, each for 30 mins duration. On both occasions this was incident reported and the Head of Midwifery was made aware at the time.

M9 Birth Rate + actual Figure (Rolling)	1:28
M9 Birth Rate + actual Figure (In-Month)	1:28.8



Highlights Jan- June 2019:

- An RCM endorsed acuity tool has been implemented on Delivery Suite to monitor activity and patient acuity against midwifery staffing.

- Recruitment and retention has been addressed and there is an open advert on NHS jobs to recruit as necessary, and support has been given from within the Division to 'recruit to turnover' and to cover gaps due to maternity leave.

- Following a successful recruitment campaign, the maternity team look forward to welcoming 14 WTE newly qualified midwives to join the team after graduation in September 2019.

- Flexible employment options are available in accordance with the RCM 'Caring for you Campaign'.

- Efficient deployment of trained staff is maximised on a shift by shift basis overseen by the 'Helicopter bleep holder', with clear escalation processes to enable them to respond to unpredicted service needs and concerns about staffing.

- Helicopter Bleep holder will be implemented 24/7 shortly. The helicopter at night will be supernumerary to have the safety overview of the maternity unit.

- Consistently achieve around 99% 1:1 midwifery care in labour.

- Introduction of a 'Continuity of Carer' team based at Ingleside Midwife Led Unit in January 2019 has enabled personalised maternity care to be provided for the antenatal, intrapartum and postnatal continuum. The 2019 step change target of 20% Continuity of Carer is being achieved.

- PROMPT (Practical obstetric multi-professional training) achieved the CNST safety standard of 90% in June 2019.

- Red flags in relation to midwifery staffing are recorded 3 times daily and taken into consideration with the feedback received by women who use the service.

- All staffing related incidents, outcomes on staff and patients are investigated to ensure action, learning and feedback.

- A staffing review of gynaecology is currently in progress

7.4 Children's Services

Children's Services encompass general and specialist care provision across an age spectrum that extends from neonates to adolescents and young adults. The Family Care Division within Bolton FT meets children and young people's (CYP) medical, surgical, and universal healthcare and development needs via a range of services. In addition, complex care and continuing care is provided by the Integrated Community Paediatric Service (ICPS) with the healthy child programme being delivered across 0-19/25 services.

The importance of identifying and maintaining safe staffing levels and skill-mix across all of these settings is a priority. As the number of young people with complex and long-term health care needs grows, the need for age appropriate care and dedicated facilities designed to meet their specific needs is essential (Children and Young People's Health Outcomes Forum, 2012).

Acute Paediatrics

RCN 2003a and RCN 2011a published Core Standards to be applied in services providing health care for children and young people in acute settings. Additional subsequent guidance produced by the National Quality Board recommends that Trusts must ensure the three components as follows are used in their safe staff processes:

- Evidence based tools (where they exist)
- Professional judgement
- Outcomes

Bolton FT Acute Paediatric service provides nursing care to children and young people in the following inpatient settings -

- Ward E5 – Paediatric Inpatient Unit
- Ward E5 - Day Case Unit including minor elective surgery
- F5 - Short Stay Paediatric Assessment Unit (SSPAU)
- E5 - Paediatric Critical Care Unit (PCCU)

Safe Staffing Guidance

Staffing the above units follows the required standard outlined in the following guidance –

- RCN - Defining staffing levels for children and young people's services (2013),
- High Dependency Care for Children - Time To Move On (RCPCH 2014)
- Standards for the Short Stay Paediatric Assessment Unit (RCPCH 2017).

The RCN recommends the following staffing ratios which are based on the age of the child and acuity of the unit as follows –

- Age 2 years and under - 1:3 (24 hours)
- Age 3 years and over - 1:4 (day)
- Age 3 years and over – 1:5 (nights)

Staffing is based on guidance and the acuity of patients seen in Bolton, with the application of professional judgement on a daily basis taking into account acuity and flow. This maintains safe nursing levels and frequently the unit operates nearer the RCN recommendations. The Bolton ratio however, allows for flexibility and movement in quieter times to balance safe staffing levels to meet seasonal variations. In addition to the above ratios, and as per RCN guidelines, an additional supernumerary nurse supervisor is also rostered for the unit on a shift by shift basis.

Along with this model, the acute paediatric service is supported by a wider team of Advanced Paediatric Nurse Practitioners (APNP's), Nurse Associates (NA), Health Care Assistants (HCA's), Assistant Practitioners (AP's) and play specialists. All of these roles support the delivery of care by providing additional skills and knowledge at the appropriate level to ensure patient safety and high quality care is achieved across all areas.

Figure 1 below outlines the staff ratios for Q1 and Q2 2019/20 for E5 Children's unit, and outlines comparisons with 2018 figures for the same quartiles. The chart also shows the availability of supernumerary shift co-ordinators as outlined in the RCN guidelines.

Figure 1

Month	Jan	Feb	Mar	April	May	June
2018 Nurse to Child Ratio – IP wards – RCN Standards	1:2.7	1:3.7	1:3.4	1:3.2	1:3.2	1:2.6
2019 Nurse to Child Ratio – IP wards – RCN Standards	1:3.2	1:3.3	1:3.5	1:3.3	1:3.0	1:3.3
2018 Supernumerary shift coordinator	97%	92%	80%	80%	100%	100%
2019 Supernumerary shift coordinator	100%	100%	93%	97%	100%	82%

Paediatric Critical Care Unit (PCCU)

The staff ratio to child requirement for the Paediatric Critical Care Unit is 1:2 which is set by the Critical Care Network. Acuity and staffing levels is monitored 4 times a day in order to maintain and sustain a safe and effective high-quality service. PCCU continues to be a challenge to ensure safe staffing during peak times of activity and high acuity. Additional funding from the CCG relieved some of this pressure in winter 2018/19 and we await to see if this will continue for winter 2019/20. This additional funding was vital in ensuring staffing resilience and maintaining patient safety in line with the winter plan.

Paediatric Staffing

Nationally Children's nursing is increasingly challenged due to a lack of suitably trained children's nurses. Bolton FT are working closely with local and GM Higher Education centres to future proof this staff group. Recent NMC validation (June 2019) of the pre-registration children's nursing course at the University of Bolton is a positive step and an opportunity for Bolton FT to be proactively involved in the course and positively impact on future workforce planning.

Paediatrics continues to successfully recruit to vacancies and in 2018/19 additional CCG funding enabled an over establishment of staff to support winter planning. All Trainee Nurse Associates have now taken substantive Nurse Associate posts across the Paediatric Unit.

Neonatal services

Staffing levels on the Neonatal Unit are monitored in accordance with national standards agreed by the British Association of Perinatal Medicine 2011 (BAPM). These standards provide staff to patient ratios based on acuity which are 1:1 for intensive care, 1:2 for high dependency care and 1:4 for special care, as well as a supernumerary shift coordinator (band 7) in charge. These are the gold standards to which all neonatal units aspire. Bolton Neonatal Unit is within the Greater Manchester Neonatal Network which is within the Northwest Neonatal Operational Delivery Network (NWNODN).

The table below displays Bolton BAPM compliance between the periods January – May 2018 compared to 2019. At Bolton we began to record the supernumerary status of the shift coordinator in August 2018.

Month	Jan	Feb	March	Apr	May
2018 BAPM Nurse: Pt ratio	103.9	102.3	99.4	99.8	100.4
2019 BAPM Nurse: Pt ratio	91.5%	91.4%	91.9%	99.7%	92.4%
2019 Supernumerary shift coordinator	93.5%	98%	100%	98%	100%

The neonatal escalation policy provides clarity on the process for managing variation in staffing requirements in order to ensure safe and appropriate care of the infants in our care. The escalation policy instructs that the neonatal unit should close if the BAPM compliance is 80% or less. The table above demonstrates that BAPM compliance from Jan –May 2019 is overall less that of Jan-May2018. This is a reflection of increased activity and acuity and in turn creates increased staffing pressures on the NNU team.

Overall recruitment and vacancy amongst the neonatal nursing team is demonstrating a significant improvement and compares favourably to peers.

The Family Care Division continues to monitor this on a daily basis and the trends are monitored monthly via IPM, in addition to reporting monthly on the Heat map. The Neonatal Operational Delivery Network also monitors and reports on staffing levels.

The Matron holds staffing meetings 3 times per week to review staffing levels, requirements and unit acuity. This is cascaded to senior leaders within the trust in the event of escalation and to provide a comprehensive overview of staffing, acuity, capacity and bank/agency usage.

0-19/25 Services

In January 2019, Bolton FT successfully tendered for the 5-19 service across Bolton, resulting in plans for Bolton FT to provide a full range of services for CYP from 0-19/25. Public Health within Bolton Local Authority has commissioned this new service which is known as Bolton Children's Integrated Health and Wellbeing Service. Bolton NHS FT has secured this 3+1+1-year contract which commenced on the 1st April 2019.

Staff employed within the 5-19 service, previously managed by another NHS Foundation Trust, automatically become employees of Bolton NHS FT on the date of transfer under TUPE on 1st April 2019.

The specification for this new contract identifies the development and delivery of a new service with Key Performance Indicators (KPIs) that can only be met by restructuring the current 0-5s Service and the recently transferred 5-19 (25) service.

The services involved are currently undergoing a formal consultation process which ends on 19th July 2019. .

7.5 Integrated Community Services Division Staffing Establishment Review

The Division continues to review staffing on a six monthly basis. This supports recommendations from national best practice recommendations related to regular review of staffing establishments. The Division uses Model Hospital to support establishment reviews within the community bed base alongside other key metrics including Care Hours Patient per Day (CHPPD), acuity data including enhanced care requirements and national staffing guidance. However, currently there is no guidance available to determine what are considered to be safe staffing levels for domiciliary based community nursing services.

Future workforce planning within the Division will need to take into account the health and social care needs of the people living within the newly established primary care networks and neighbourhoods being mindful of the intention to ensure the neighbourhood offer is multi professional and shared care with both health and social care.
This work will be achieved in conjunction with clinical staff, finance and business managers.

The Integrated Community Services Division is very diverse with over 19 specialties. The registered and unregistered nursing workforce is spread across most of these, however for the purpose of this report the staffing groups have been limited to:

- All community bed based areas
- Community nursing services
- Treatment rooms
- Specialist nursing services

Highlights January to June 2019

- Review of need for more qualified District Nurses – with funding approved for 8 places to start the course in September 2019 (Specialist Practictioner – District Nursing).
- Profile requirements for Trainee Nurse Associates 2018 – 2020
- Recruitment of newly qualified Nursing Associates (4)
- Review of placement of all SPQ-DN in community nursing teams. All teams have two qualified DNs (including the team leader).
  Qualified Nurse Associates have successfully commenced in posts across the Community Nursing Services with a view to further skill mix to employ at least one Qualified Nurse Associate in each Community Team.

- Six registered nurses from the community nursing teams and IMC @ home team started the Non-Medical Prescribing V150 course at Bolton. They have completed at the end of June 2019.
- Four registered nurses commenced the palliative and end of life course at the University of Bolton; they have all now completed this course.
- Within admission avoidance team, there is an ongoing training plan to support the nursing team to complete level seven clinical skills in order to develop the scope of practice of the band 6 nurses within the team.
- Since the last review recruitment to three new Matron posts has been successful in appointing two Matrons for Community Nursing and one Matron for Treatment room services and Specialist Nursing services.

- Preceptee coffee mornings held at the Royal Bolton Hospital by OD &L team and all new staff within the Division are encouraged to attend.
- Completion of Getting it Right First Time (GIRFT) Programme in Diabetes and Endocrinology completed in April 2019.

Divisional Recruitment and Retention:

- Quarterly leadership engagement event
- Weekly leaderships huddles for senior clinical leaders and team leaders
- Commencement of talent management and succession planning considerations for grades 7 and 8a.
- Meet the DND – all new staff within the Division are invited to meet the DND and share their initial experience of the Division and induction.
- Use of the Apprenticeship Levy to provide education opportunities at Masters, Degree and Diploma level
- Staff are offered clinical supervision and coaching

Trainee Nurse Associates and Advanced Clinical Practice

The Division sponsored 4 nursing associates on the pilot program in 2017 – 2019; in January 2019 3 full time qualified Nursing Associates appointed. Two have since left Bolton NHS FT to pursue opportunities elsewhere.

June 2019 - three qualified Nursing Associates (2.4wte) started with both the District Nurse services and the Homeless and Vulnerable Adults team.

Advanced Practitioners

The Division currently has advanced clinical practitioners working within the Admission Avoidance Team and the homeless and vulnerable adult's team. Additionally, there are also six trainees who are due to qualify in September 2019 who have been working within the integrated neighbourhood team and a further two trainees due to qualify in September 2020. The Division had introduced a Frailty Lead – Advanced Practitioner whose remit is to develop and embed a frailty model and provide support to the Divisional ACPs.

Workforce Analysis

Workforce analysis and forecasting

The Division have recently completed their Workforce Plan. Turnover across the Division remains below target, with turnover amongst registered and unregistered staff also remaining low. The detail will be reflected in the next Divisional Workforce Plan.

8 Acuity and Dependency

The organisation uses a variety of tools and methods to match staffing to acuity. It is important that not one tool is considered in isolation but triangulated through a variety of methods available and are outlined below. It is important to note that any tool used to assess is always used in tandem with professional judgement.

Care hours per patient day (CHPPD)

The Chief Nursing Officer advised in June 2018 that the Secretary of State has determined that monthly CHPPD data will be published at trust and ward level on My NHS and NHS Choices from September 2018 .

CHPPD was introduced as a measure for the deployment of nursing, midwifery and healthcare support staff on acute and acute specialist inpatient wards in the February 2016.

This programme is aligned with the 10 commitments of Leading Change, Adding Value (NHS England 2016), specifically commitment nine, to “have the right staff in the right places and at the right time” to achieve the triple aim of better outcomes, better patient and staff experiences, and better use of resources.

CHPPD is now the national principal measure of nursing, midwifery and healthcare support staff deployment on inpatient wards. Alongside clinical quality and safety outcomes measures, CHPPD can be used to identify unwarranted variation and support delivery of high quality, efficient patient care.

CHPPD is a composite of registered nursing staff and health care support worker input hours. Both are recorded separately in this dataset and further additions to the healthcare team (e.g Nursing Associates) will be recorded as a new data point, not amalgamated with others. A site visit s being arranged from NHS Digital to review how the data is being submitted. This will include ensuring roles such as Nursing Associates and Training Nurse Associates are being reported into the correct category.

Table 5

	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
Jan-19	5.3	4.5	9.8
Feb-19	6.8	5.5	12.3
Mar-19	5	5.2	10.2
Apr-19	5.4	5.1	10.5
May-19	5.6	5.9	11.5
Jun-19	5.7	4.9	10.6
Average	5.63	5.18	10.82

Model Hospital

Since the last staffing paper, the Trust has been through a Use of Resources review as part of the CQC Well Led Inspection. Whilst the overall rating was Good, it was noted that our WAU for nursing costs is significantly higher than most Trusts (currently second highest in the country). Initial review is not indicating that are nursing establishments are set higher than other organisations. However, to be able to provide assurance to the board a Task and Finish group, led by the Deputy Director of Nursing is currently in progress an update will be provide in the next report.

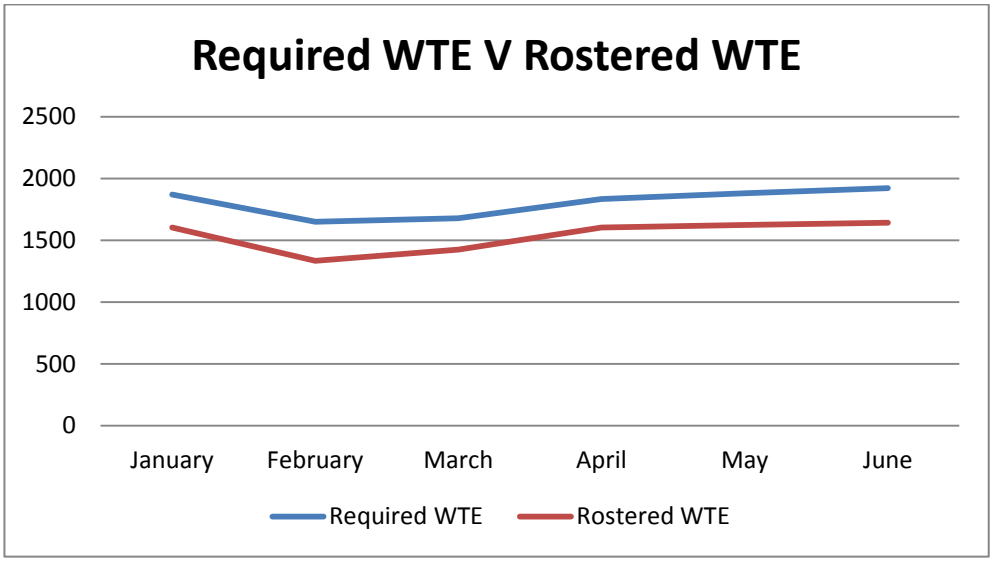
SafeCare

SafeCare allows you to compare staffing levels and skill mix to the actual patient demand. It provides visibility across wards and areas transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards patient safety.

The trust is in the process of working with other Trusts who have successfully implemented the Safercare software and realised the benefits. Once fully implemented and in use the senior nurses & operational teams will have an organisational view of staffing levels & staffing needs. They will enhance our proactivity and informed decision making when considering potential escalation to agency

Graph 6

Required WTE vs Rostered WTE



9 Processes of Governance and Escalation for Safe Staffing

As previously highlighted, nurse staffing remains a significant risk within our wards, departments and community settings. To manage this risk effectively, the organisation has several assurance processes in place to enable appropriate daily oversight and is able to take appropriate action. Outlined below are several embedded processes to ensure tight operational grip.

Following the review of electronic systems, the Matron of the Day visits all Ward areas to discuss patient acuity and dependency, and to review the level of care that patients who need additional supervision require, so that decisions about staff movement between areas is informed by this.

Staffing gaps are highlighted at Corporate Bed Meetings, and support from other Divisions is requested and provided as able.

Incident Reporting

Work has continued across the organisation to encourage staff to feel confident and safe to report any incident or concern regarding staffing or training via the safeguard system. The Trust is in the top 25% of incident reporters nationally, as reported by the NRLS, and anecdotal assessments, based on reporting figures within the organisation, indicate that this position is likely to be hel

d in the next published report. The ability of staff to report incidents, and their understanding of what to report is assessed as part of the Bolton Scheme of Care Accreditation (BoSCA). Staffing incidents are reviewed daily and considered in weekly staffing meetings.

10 Conclusion

Safe staffing levels impact on the ability of nursing and midwifery staff to provide high quality care. As with previous reports, the Trust continues to carry a number of nursing vacancies. This is reflected in the Trust Board Assurance Framework (BAF) and the Division's Risk Registers.

Reviews of staffing numbers and skill mix will continue to be ongoing and any changes will be based on triangulation of acuity, current quality indicators and outcomes and professional judgement, whilst taking into account any available national guidance.

11 Recommendation

The Board is asked to note the report. Support the direction of travel currently being taken particularly in relation to recruitment and ongoing establishment reviews.

Finally, the Board is also asked to recognise and commend the work and efforts of the entire nursing and midwifery workforce who are committed to, and continue to deliver safe and effective care whilst working in a challenging environment.

Integrated Summary Dashboard - June 2019

Bolton NHS Foundation Trust

Executive Summary

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

Understanding the Report

This summary report shows the latest and previous position of selected indicators, as well as a year to date position, and a sparkline showing the trend over the last 12 months.

RAG Status

	Indicator is significantly underperforming against the plan for the relevant period (latest, previous, year to date).
	Indicator is underperforming against the plan for the relevant period (latest, previous, year to date).
	Indicator is performing against the plan (including equal to the plan) for the relevant period (latest, previous, year to date).

Trend

	The direction of travel of the indicator value between the previous and latest period is downwards, and this is undesirable with respect to the plan
	The direction of travel of the indicator value between the previous and latest period is upwards, and this is undesirable with respect to the plan
	The indicator value has not changed between the previous and latest period
	The direction of travel of the indicator value between the previous and latest period is downwards, and this is desirable with respect to the plan
	The direction of travel of the indicator value between the previous and latest period is upwards, and this is desirable with respect to the plan

Bolton NHS Foundation Trust

Quality and Safety

Harm Free Care

Pressure Ulcers
The number of Category 2 pressure ulcers acquired in hospital exceeded the target by two in June. The number of pressure ulcers in the community was under trajectory. There were no lapses in care in the community, and three lapses in care in the hospital, which was one over target.

Falls
Year to date performance during quarter one is on target. Falls with harm have reduced with three cases this quarter compared to seven for the same period last year. No falls with moderate or above harm occurred in June.

The first quarter CQUIN audit for falls was completed in June and is now continuing weekly in the next quarters. Progress will be reported in the quarterly reports to the Quality Assurance Committee.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
6 - Compliance with preventative measure for VTE	>= 95%	95.6%	Jun-19			>= 95%	96.2%	May-19		>= 95%	96.1%		95.4 - 97.8%	
9 - Never Events	= 0	0	Jun-19			= 0	0	May-19		= 0	0		0 - 1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	5.80	Jun-19			<= 5.30	5.68	May-19		<= 5.30	5.31		3.60 - 5.88	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	0	Jun-19			<= 1.6	2	May-19		<= 4.8	3		0 - 5	
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	8.0	Jun-19			<= 6.0	6.0	May-19		<= 18.0	22.0		2.0 - 10.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Jun-19			<= 0.5	0.0	May-19		<= 1.5	0.0		0.0 - 2.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Jun-19			= 0.0	0.0	May-19		= 0.0	0.0		0.0 - 0.0	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	7.0	Jun-19			<= 7.0	12.0	May-19		<= 21.0	27.0		2.0 - 12.0	

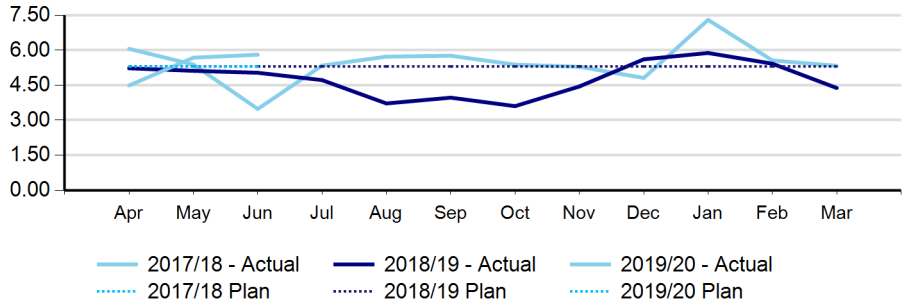
Integrated Summary Dashboard - June 2019

NHS Bolton NHS Foundation Trust

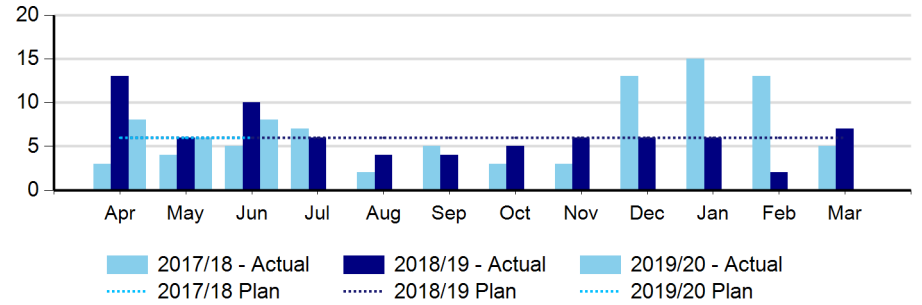
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	1.0	Jun-19			<= 4.0	2.0	May-19		<= 12.0	11.0		1.0 - 8.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	1.0	Jun-19			<= 1.0	0.0	May-19		<= 3.0	1.0		0.0 - 3.0	
21 - Total Pressure Damage due to lapses in care	<= 6	3	Jun-19			<= 6	7	May-19		<= 17	13		2 - 8	
28 - Emergency patients screened for Sepsis (quarterly)	>= 90%	94.3%	Q4 2018/19			>= 90%	92.5%	Q3 2018/19		>= 90%			90.1 - 94.3%	
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	100.0%	Q4 2018/19			>= 90%	91.7%	Q3 2018/19		>= 90%			90.0 - 100.0%	
30 - Clinical Correspondence - Inpatients %<1 working day	>= 80%	79.7%	Jun-19			>= 80%	79.8%	May-19		>= 80%	79.3%		77.7 - 80.9%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 72.5%	52.3%	Jun-19			>= 72.5%	51.9%	May-19		>= 72.5%	51.5%		50.1 - 85.1%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	66.7%	Jun-19			= 100%	87.5%	May-19		= 100%	84.7%		33.3 - 100.0%	
88 - KPI Audits linked to Bolton System of Accreditation (BOSCA)	>= 85%	92.4%	Jun-19			>= 85%	93.2%	May-19		>= 85%	92.9%		91.7 - 94.0%	
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	50.0%	Jun-19			= 100%	100.0%	May-19		= 100%	116.7%		0.0 - 100.0%	

Exceptions

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



15 - Acute Inpatients acquiring pressure damage (category 2)

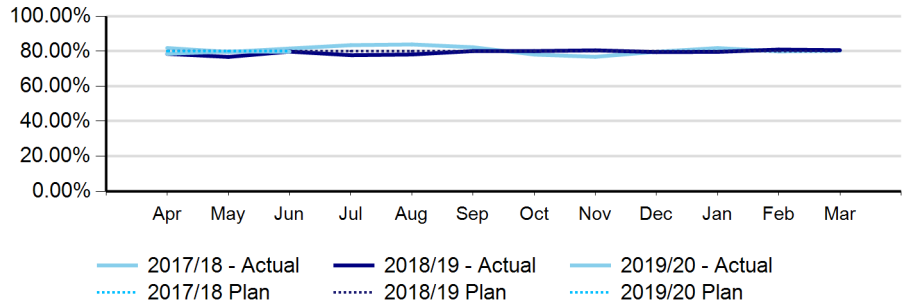


Bolton NHS Foundation Trust

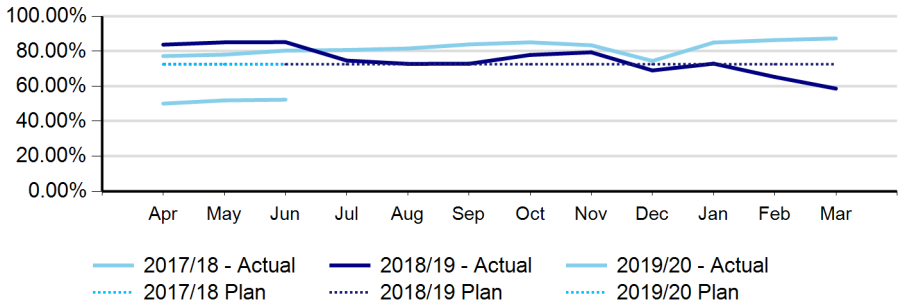
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6.06	5.38	3.48	5.34	5.72	5.76	5.38	5.29	4.81	7.30	5.56	5.33
18/19	5.22	5.11	5.03	4.72	3.72	3.97	3.60	4.45	5.61	5.88	5.42	4.38
19/20	4.49	5.68	5.80									

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3.0	4.0	5.0	7.0	2.0	5.0	3.0	3.0	13.0	15.0	13.0	5.0
18/19	13.0	6.0	10.0	6.0	4.0	4.0	5.0	6.0	6.0	6.0	2.0	7.0
19/20	8.0	6.0	8.0									

30 - Clinical Correspondence - Inpatients %<1 working day



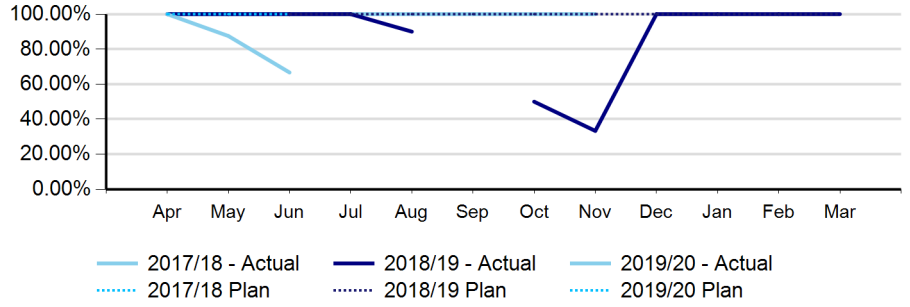
31 - Clinical Correspondence - Outpatients %<5 working days



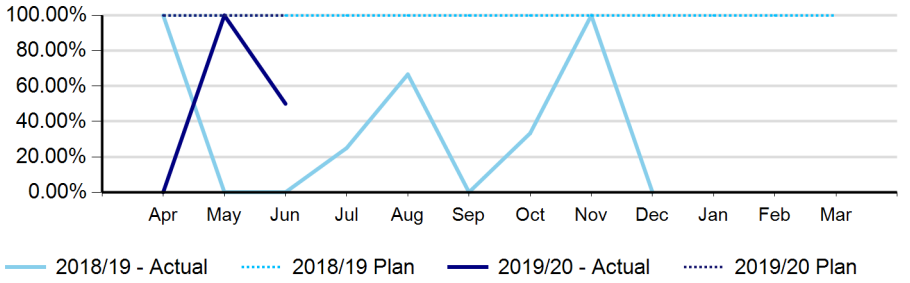
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	81.8%	79.5%	81.5%	83.4%	83.8%	82.2%	78.1%	76.8%	79.7%	81.8%	79.9%	80.2%
18/19	78.4%	76.7%	79.7%	77.7%	78.1%	80.0%	80.0%	80.5%	79.5%	79.6%	80.9%	80.6%
19/20	78.5%	79.8%	79.7%									

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

86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
18/19	100.0%	100.0%	100.0%	100.0%	90.0%		50.0%	33.3%	100.0%	100.0%	100.0%	100.0%
19/20	100.0%	87.5%	66.7%									

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

NHS Bolton NHS Foundation Trust

Infection Prevention and Control

There have been two CDT cases counting towards the year-end objective; a total of 12 cases against the year-end target of no more than 32 cases.

There have been two community onset MRSA bacteraemias which are currently being reviewed by Bolton CCG.

There have been no new CPE cases on ward B3 since 21/04/19 – weekly and admission screening continues.

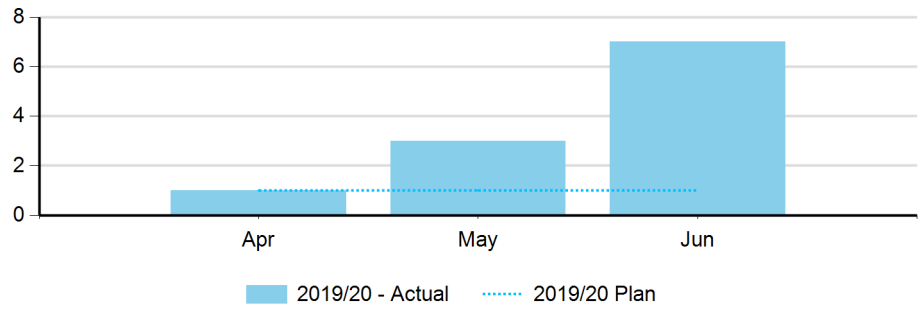
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
215 - Total Hospital Onset C.diff infections	<= 3	1	Jun-19			<= 2	2	May-19		<= 8	7		0 - 4	
346 - Total Community Onset Hospital Associated C.diff infections	<= 1	7	Jun-19			<= 1	3	May-19		<= 3	11		1 - 7	
347 - Total C.diff infections contributing to objective	<= 1	2	Jun-19			<= 2	5	May-19		<= 4	12		2 - 5	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Jun-19			= 0	0	May-19		= 0	0		0 - 1	
218 - Total Trust apportioned E. coli BSI	<= 4	6	Jun-19			<= 4	0	May-19		<= 12	10		0 - 7	
219 - Blood Culture Contaminants (rate)	<= 3%	4.6%	Jun-19			<= 3%	2.8%	May-19		<= 3%	3.7%		2.8 - 6.8%	
199 - Compliance with antibiotic prescribing standards	>= 95%	85.2%	Q3 2018/19			>= 95%	86.0%	Q1 2018/19		>= 95%			85.2 - 85.2%	
304 - Total Trust apportioned MSSA BSIs	<= 1.3	0.0	Jun-19			<= 1.3	0.0	May-19		<= 3.9	1.0		0.0 - 4.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	<= 2	1	Jun-19			<= 1	0	May-19		<= 3	1		0 - 3	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	= 0	0	Jun-19			<= 1	0	May-19		<= 1	0		0 - 1	

Integrated Summary Dashboard - June 2019

Bolton NHS Foundation Trust

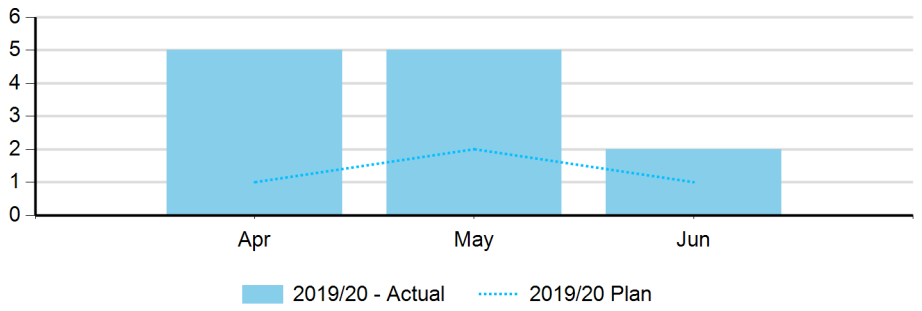
Exceptions

346 - Total Community Onset Hospital Associated C.diff infections



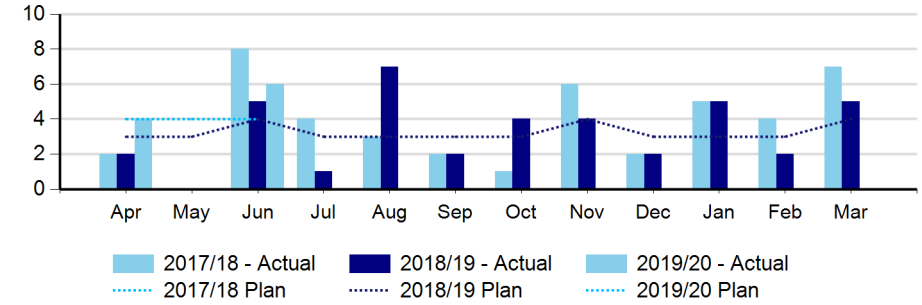
	Apr	May	Jun
19/20	1	3	7

347 - Total C.diff infections contributing to objective



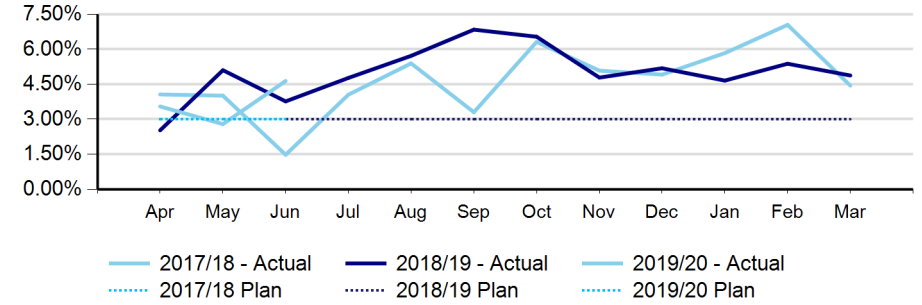
	Apr	May	Jun
19/20	5	5	2

218 - Total Trust apportioned E. coli BSI



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

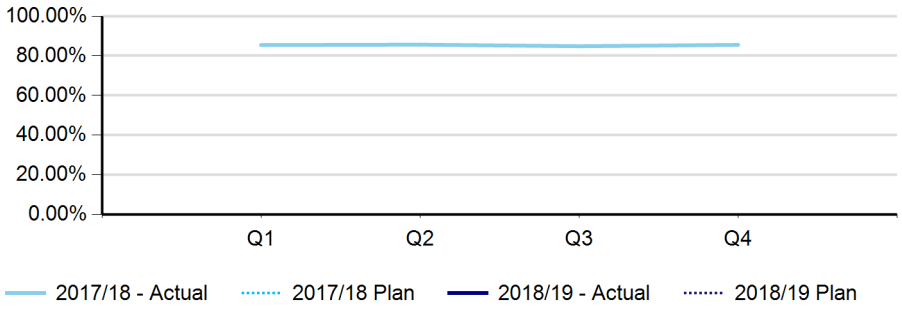
219 - Blood Culture Contaminants (rate)



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

Bolton
NHS Foundation Trust

199 - Compliance with antibiotic prescribing standards



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

Integrated Summary Dashboard - June 2019

Bolton NHS Foundation Trust

Mortality

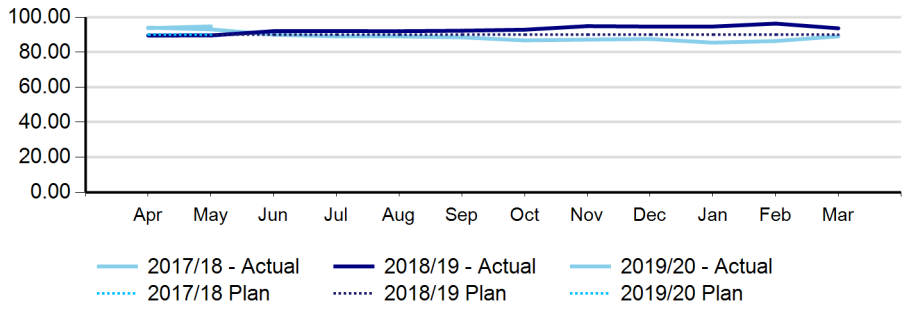
There has been a further decrease in crude mortality in June to 1.7%. Deaths in month have fallen in June 19, which has impacted crude mortality, and shows a reduction from June 18 position.

Standardised Hospital Mortality ratio is updated quarterly in arrears, and we await publication of Q4 18/19.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Jun-19		↑	>= 85%	90.8%	May-19		>= 85%	92.8%		85.1 - 100.0%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	<= 90	94.7	May-19		↑	<= 90	93.7	Apr-19		<= 90	94.7		92.0 - 96.3	
11 - Standardised Hospital Mortality (ratio) (quarterly in arrears)	<= 100.00	119.00	Q3 2018/19		↑	<= 100.00	113.85	Q2 2018/19		<= 100.00			113.85 - 119.00	
12 - Crude Mortality %	<= 2.9%	1.7%	Jun-19		↓	<= 2.9%	2.1%	May-19		<= 2.9%	2.0%		1.7 - 2.7%	

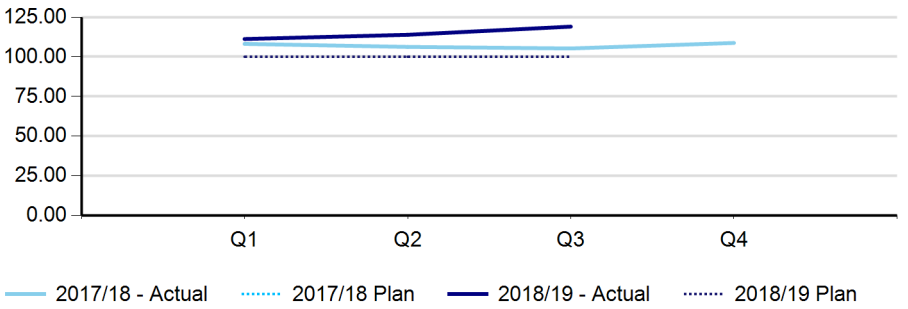
Exceptions

10 - Risk adjusted Mortality (ratio) (2 mths in arrears)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	94.0	93.0	90.0	89.0	89.0	88.4	86.7	87.2	87.5	85.4	86.3	89.0
18/19	89.5	89.5	92.0	92.0	92.0	92.2	92.8	94.9	94.6	94.6	96.3	93.6
19/20	93.7	94.7										

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



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

Bolton NHS Foundation Trust

Patient Experience

A&E FFT - The fall in response rates for June is as a result of a low response rate for Paediatric A&E. Matron for A&E is working with the paediatric A&E team with support from the Patient Experience Manager to look at why previous initiatives have not worked and what other initiatives can be implemented to show an improvement.

Maternity Postnatal FFT
The recommendation rates for postnatal FFT fell slightly in June to below the trajectory. The Matron is currently looking at the themes from this and how the service can be improved as a result.

The Board are asked to note that there was a batch of FFT cards inputted after the cut off deadline by our provider, Healthcare Communications and this slightly affected the response rates for some areas although this did not affect whether they achieved the trajectory with the exception of Podiatry Community who would have achieved their response numbers. A change in process has been implemented with immediate effect to avoid this from happening in future.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
200 - A&E Friends and Family Response Rate	>= 20%	15.1%	Jun-19			>= 20%	18.2%	May-19		>= 20%	16.6%		15.1 - 20.6%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	90.7%	Jun-19			>= 90%	91.1%	May-19		>= 90%	91.2%		88.9 - 91.9%	
80 - Inpatient Friends and Family Response Rate	>= 30%	30.2%	Jun-19			>= 30%	29.5%	May-19		>= 30%	29.2%		25.7 - 33.6%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.9%	Jun-19			>= 90%	96.7%	May-19		>= 90%	97.2%		95.8 - 97.9%	
81 - Maternity Friends and Family Response Rate	>= 15%	28.6%	Jun-19			>= 15%	32.8%	May-19		>= 15%	31.1%		19.0 - 43.6%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	95.9%	Jun-19			>= 90%	95.6%	May-19		>= 90%	95.7%		92.4 - 97.3%	
82 - Antenatal - Friends and Family Response Rate	>= 15%	16.5%	Jun-19			>= 15%	15.2%	May-19		>= 15%	23.0%		1.7 - 43.4%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	100.0%	Jun-19			>= 90%	100.0%	May-19		>= 90%	98.7%		88.9 - 100.0%	
83 - Birth - Friends and Family Response Rate	>= 15%	36.4%	Jun-19			>= 15%	39.3%	May-19		>= 15%	34.9%		24.9 - 50.2%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	94.9%	Jun-19			>= 90%	89.4%	May-19		>= 90%	92.5%		88.5 - 97.6%	

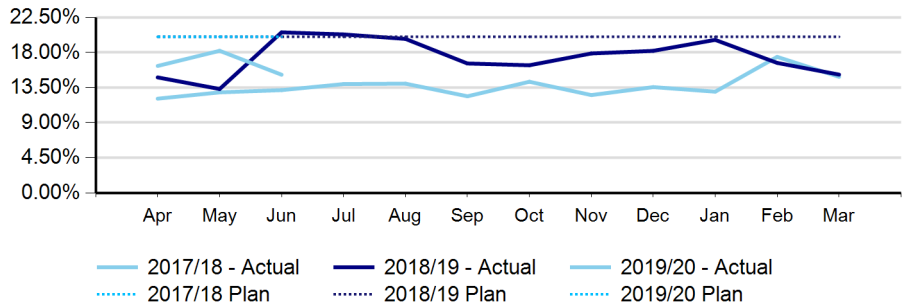
Integrated Summary Dashboard - June 2019

Bolton NHS Foundation Trust

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	22.1%	Jun-19			>= 15%	39.2%	May-19		>= 15%	30.3%		17.7 - 44.5%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	88.8%	Jun-19			>= 90%	95.9%	May-19		>= 90%	92.9%		88.1 - 96.4%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	41.6%	Jun-19			>= 15%	44.0%	May-19		>= 15%	38.2%		28.8 - 75.1%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	98.1%	Jun-19			>= 90%	99.5%	May-19		>= 90%	98.5%		93.2 - 99.5%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Jun-19			= 100%	100.0%	May-19		= 100%	100.0%		100.0 - 100.0%	
90 - Complaints responded to within the period	>= 95%	100.0%	Jun-19			>= 95%	95.2%	May-19		>= 95%	98.4%		88.5 - 100.0%	

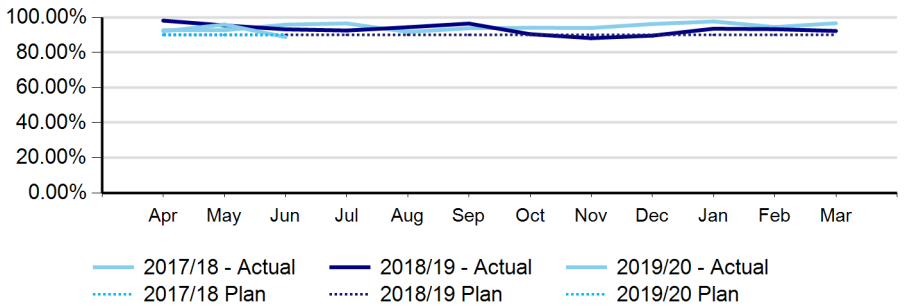
Exceptions

200 - A&E Friends and Family Response Rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	12.1%	12.9%	13.2%	13.9%	14.0%	12.4%	14.2%	12.5%	13.6%	13.0%	17.4%	14.9%
18/19	14.8%	13.3%	20.6%	20.3%	19.7%	16.6%	16.4%	17.9%	18.2%	19.6%	16.7%	15.2%
19/20	16.3%	18.2%	15.1%									

244 - Hospital Postnatal Friends and Family Test - Satisfaction %



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

Bolton NHS Foundation Trust

Maternity

Stillbirths - have decreased in June, there continues to be good practice around 'Saving Babies' Lives'. The division continue to monitor closely.

Booked 12 + 6 – remains static at 87.50% Matron/team leaders continue to audit all late bookers. This month 10.5% were late presenters – booked after 12+6 minus 'scan breaches'.

Births at Bolton Beehive have remained static with all transfers being clinically appropriate. 139 ladies were seen in Beehive this month with 41 births. The unit is on the way to the target of 13-15%.

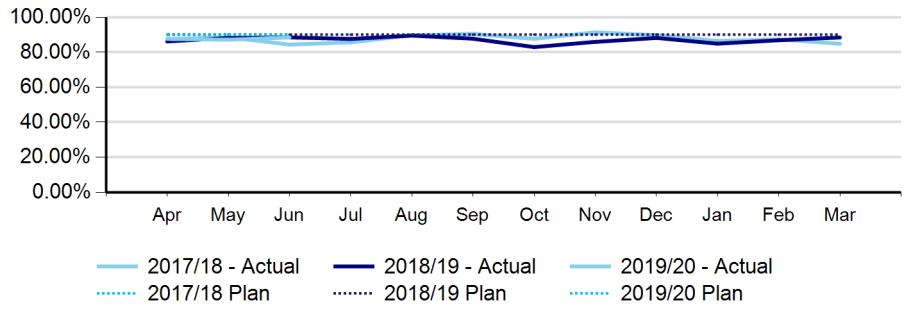
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
322 - Maternity - Stillbirths per 1000 births	<= 3.50	2.14	Jun-19			<= 3.50	7.94	May-19		<= 3.50	5.64		0.00 - 7.94	
23 - Maternity -3rd/4th degree tears	<= 2.5%	1.3%	Jun-19			<= 2.5%	3.3%	May-19		<= 2.5%	2.4%		1.3 - 3.3%	
202 - 1:1 Midwifery care in labour	>= 95.0%	98.2%	Jun-19			>= 95.0%	99.5%	May-19		>= 95.0%	98.8%		97.8 - 99.8%	
203 - Booked 12+6	>= 90.0%	88.4%	Jun-19			>= 90.0%	87.1%	May-19		>= 90.0%	87.7%		82.9 - 89.4%	
204 - Inductions of labour	<= 35%	43.0%	Jun-19			<= 35%	40.5%	May-19		<= 35%	42.7%		37.6 - 45.0%	
208 - Total C section	<= 29.0%	29.7%	Jun-19			<= 29.0%	24.6%	May-19		<= 29.0%	26.9%		24.6 - 31.4%	
210 - Initiation breast feeding	>= 65%	66.74%	Jun-19			>= 65%	70.06%	May-19		>= 65%	68.15%		63.30 - 72.60%	
213 - Maternity complaints	<= 5	3	Jun-19			<= 5	2	May-19		<= 15	8		0 - 8	
319 - Maternal deaths (direct)	= 0	0	Jun-19			= 0	0	May-19		= 0	0		0 - 1	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	8.5%	Jun-19			<= 6%	10.7%	May-19		<= 6%	9.4%		7.6 - 11.4%	

Integrated Summary Dashboard - June 2019

Bolton NHS Foundation Trust

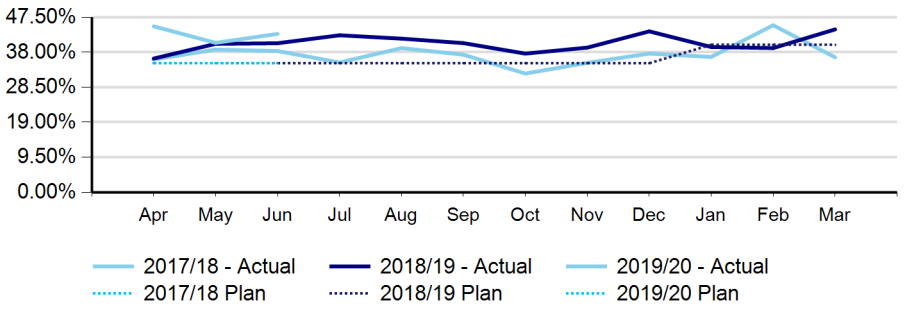
Exceptions

203 - Booked 12+6



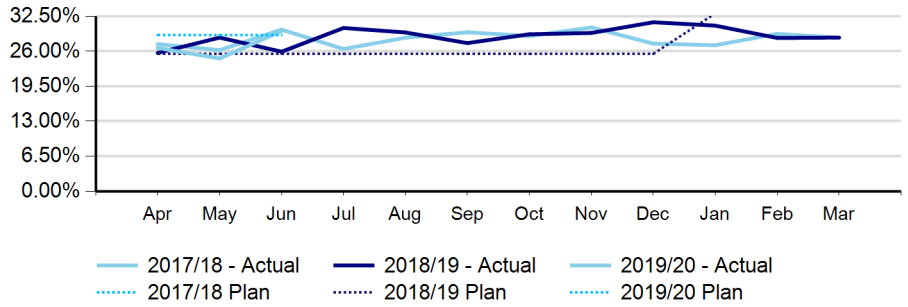
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	87.4%	88.5%	84.3%	85.6%	89.6%	90.4%	87.6%	91.3%	89.7%	86.4%	87.3%	84.8%
18/19	86.1%	88.1%	88.4%	87.5%	89.4%	87.7%	82.9%	85.9%	88.1%	84.8%	86.8%	88.4%
19/20	87.5%	87.1%	88.4%									

204 - Inductions of labour



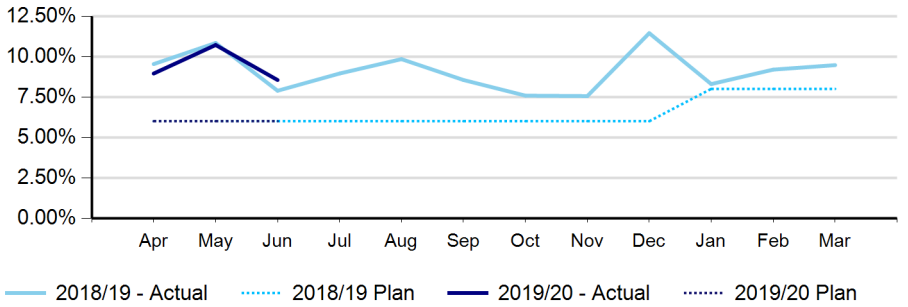
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	36.0%	38.7%	38.3%	35.2%	39.1%	37.3%	32.2%	35.1%	37.6%	36.7%	45.3%	36.6%
18/19	36.3%	40.3%	40.4%	42.6%	41.7%	40.4%	37.6%	39.2%	43.6%	39.4%	39.1%	44.2%
19/20	45.0%	40.5%	43.0%									

208 - Total C section



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

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



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

NHS Bolton NHS Foundation Trust

Operational Performance

Access

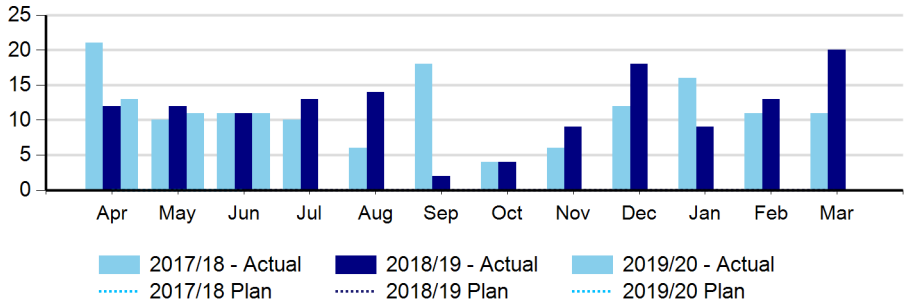
Referral to Treatment time remains a significant risk, it is highly unlikely, unless there was significant investment that the 18 week standard can be achieved this year. The size of the waiting list continues to grow, focus is being placed on reducing this to March 18 levels, but it will be a challenge. Action has been taken to prevent 52 week breaches through, validation, training and waiting list initiatives where needed.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 30	20	Jun-19			<= 31	42	May-19		<= 91	107		15 - 45	
8 - Same sex accommodation breaches	= 0	11	Jun-19			= 0	11	May-19		= 0	35		2 - 20	
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	73.1%	Jun-19			>= 75%	66.7%	May-19		>= 75%	73.0%		55.6 - 90.6%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	85.4%	Jun-19			>= 92%	86.3%	May-19		>= 92%	86.0%		85.4 - 90.3%	
42 - RTT 52 week waits (incomplete pathways)	= 0	7	Jun-19			= 0	6	May-19		= 0	16		1 - 10	
314 - RTT 18 week waiting list	<= 22,812	24,416	Jun-19			<= 22,812	24,259	May-19		<= 22,812	24,416		22,344 - 24,416	
53 - A&E 4 hour target	>= 95%	86.5%	Jun-19			>= 95%	85.3%	May-19		>= 95%	85.4%		78.9 - 91.3%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0%	4%	Jun-19			= 0%	4%	May-19		= 0%	4%		4 - 10%	
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	1.53%	Jun-19			= 0.00%	1.05%	May-19		= 0.00%	1.31%		0.35 - 3.50%	
72 - Diagnostic Waits >6 weeks %	<= 1%	0.9%	Jun-19			<= 1%	1.0%	May-19		<= 1%	1.0%		0.4 - 3.2%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	100.0%	Jun-19			= 100%	40.0%	May-19		= 100%	77.2%		0.0 - 100.0%	

Bolton NHS Foundation Trust

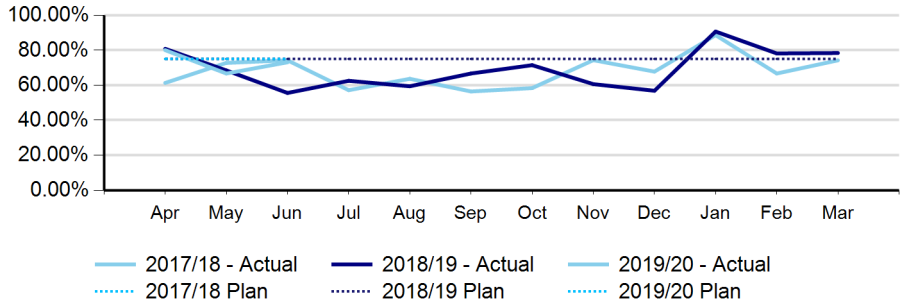
Exceptions

8 - Same sex accommodation breaches



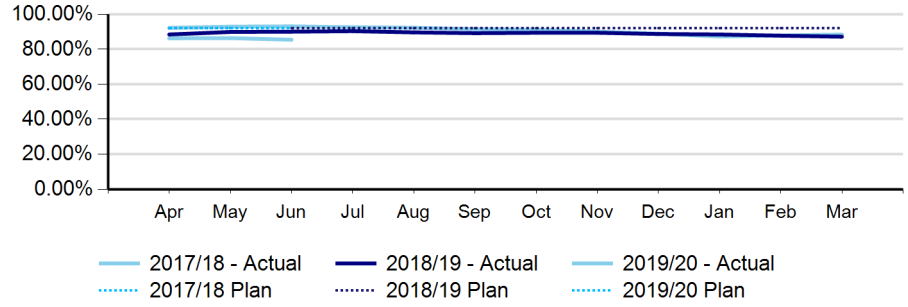
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	21	10	11	10	6	18	4	6	12	16	11	11
18/19	12	12	11	13	14	2	4	9	18	9	13	20
19/20	13	11	11									

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



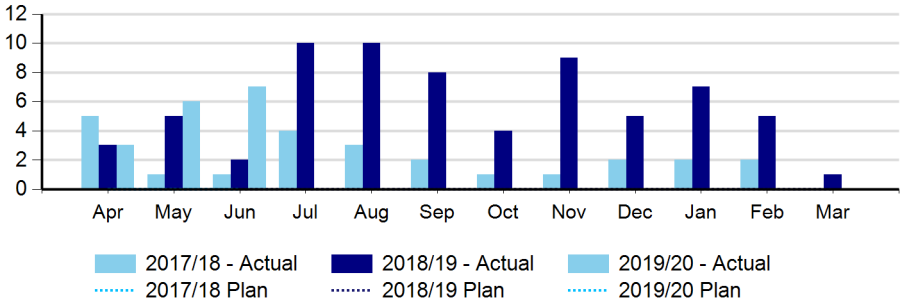
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	61.3%	72.7%	74.2%	57.1%	63.6%	56.4%	58.3%	74.3%	67.7%	88.6%	66.7%	74.2%
18/19	80.8%	68.4%	55.6%	62.5%	59.4%	66.7%	71.4%	60.6%	56.8%	90.6%	78.1%	78.4%
19/20	80.0%	66.7%	73.1%									

41 - RTT Incomplete pathways within 18 weeks %



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	92.1%	92.9%	93.0%	92.5%	92.2%	91.4%	91.1%	90.0%	88.8%	87.2%	87.8%	88.3%
18/19	88.4%	89.8%	90.0%	90.3%	89.6%	89.1%	89.4%	89.4%	88.7%	88.4%	87.7%	87.1%
19/20	86.2%	86.3%	85.4%									

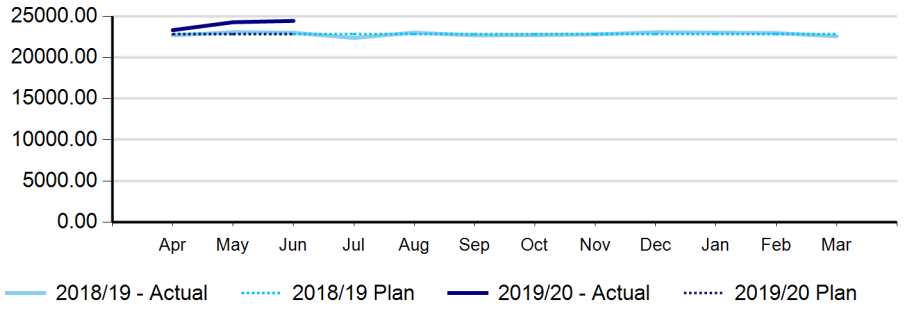
42 - RTT 52 week waits (incomplete pathways)



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

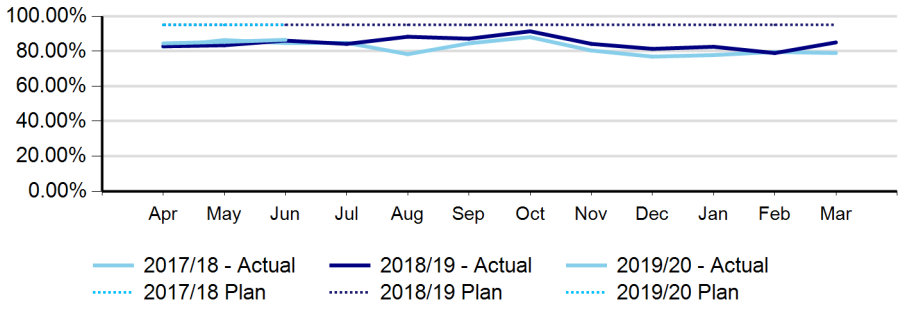
Bolton NHS Foundation Trust

314 - RTT 18 week waiting list



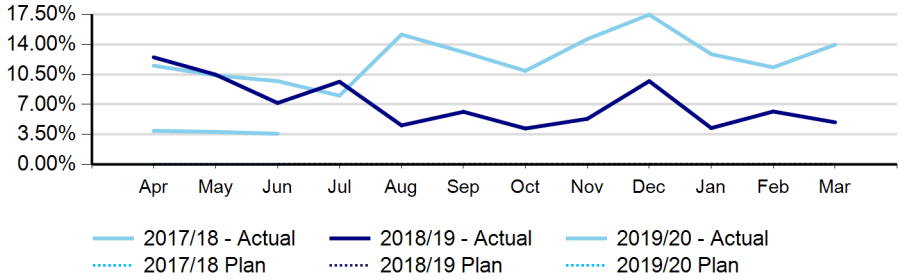
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	22,675	23,052	22,985	22,344	23,003	22,663	22,691	22,783	23,050	23,004	22,949	22,554
19/20	23,298	24,259	24,416									

53 - A&E 4 hour target



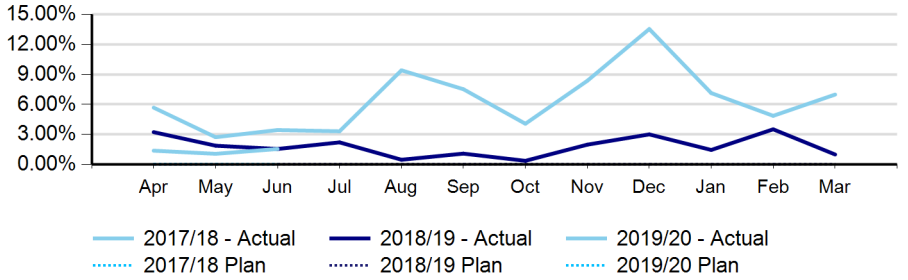
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	82.5%	86.3%	84.6%	84.7%	78.3%	84.5%	88.0%	80.4%	76.9%	77.8%	79.5%	78.9%
18/19	82.7%	83.4%	86.0%	84.1%	88.2%	87.1%	91.3%	84.2%	81.3%	82.5%	78.9%	85.0%
19/20	84.4%	85.3%	86.5%									

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



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

71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	5.67%	2.71%	3.43%	3.30%	9.40%	7.51%	4.06%	8.36%	13.54%	7.13%	4.85%	6.98%
18/19	3.22%	1.86%	1.53%	2.19%	0.45%	1.07%	0.35%	1.97%	2.99%	1.44%	3.50%	0.98%
19/20	1.36%	1.05%	1.53%									

NHS Bolton NHS Foundation Trust

Productivity

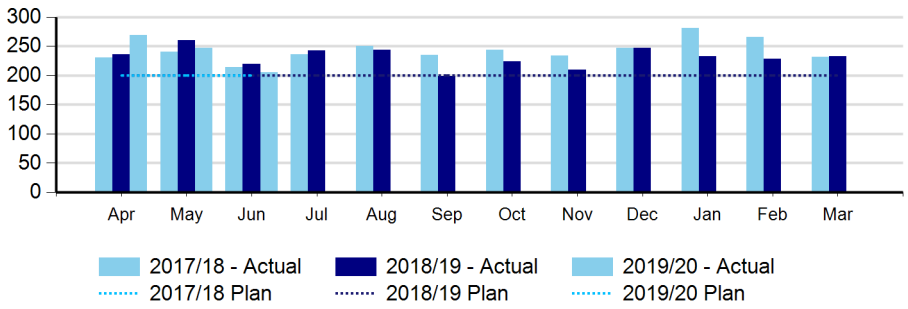
The number of patients with a length of stay is statistically more significant than the number over 21 days as a factor in 4 hour standard performance. Work is heavily weighted to focus on this area, with some success. We continue to work with ECIP to reduce LOS further, including reducing he medically optimised.
As part of the efficiency drive we will though qtr 3 and 4 be seeking to maximise day case work and reduce cancellations on the day.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
56 - Stranded patients	<= 200	205	Jun-19			<= 200	247	May-19		<= 200	205		199 - 269	
307 - Stranded Patients - LOS 21 days and over	<= 69	74	Jun-19			<= 69	85	May-19		<= 69	74		68 - 100	
57 - Discharges by Midday	>= 30%	30.0%	Jun-19			>= 30%	30.0%	May-19		>= 30%	29.6%		26.2 - 33.1%	
58 - Discharges by 4pm	>= 70%	68.5%	Jun-19			>= 70%	69.2%	May-19		>= 70%	67.3%		63.4 - 70.0%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	12.1%	May-19			<= 13.5%	11.1%	Apr-19		<= 13.5%	11.6%		10.8 - 12.9%	
60 - Daycase Rates	>= 80%	88.9%	Jun-19			>= 80%	89.8%	May-19		>= 80%	89.4%		87.1 - 90.6%	
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.4%	Jun-19			<= 1%	1.7%	May-19		<= 1%	1.8%		1.4 - 2.4%	
62 - Cancelled operations re-booked within 28 days	= 100%	97.1%	Jun-19			= 100%	85.4%	May-19		= 100%	82.9%		63.6 - 100.0%	
318 - Delayed Transfers Of Care (Trust Total)	<= 3.3%	1.9%	Jun-19			<= 3.3%	2.6%	May-19		<= 3.3%	2.4%		1.1 - 3.0%	
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.27	Jun-19			<= 2.00	2.36	May-19		<= 2.00	2.51		2.06 - 2.90	
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.65	Jun-19			<= 3.70	4.63	May-19		<= 3.70	4.61		4.09 - 4.67	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	88.9%	May-19			>= 80%	95.0%	Apr-19		>= 80%	92.1%		75.0 - 95.0%	

Bolton NHS Foundation Trust

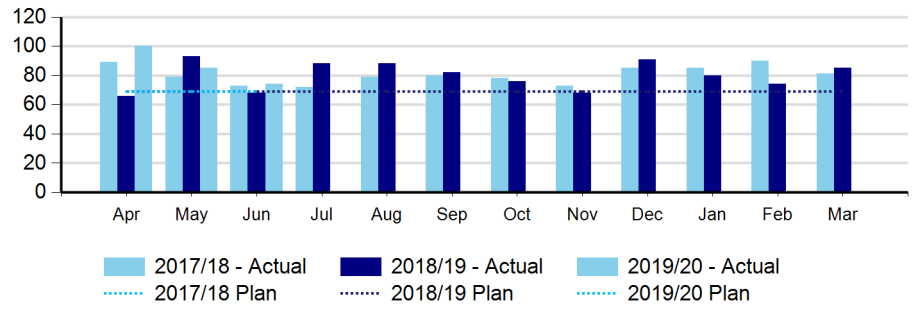
Exceptions

56 - Stranded patients



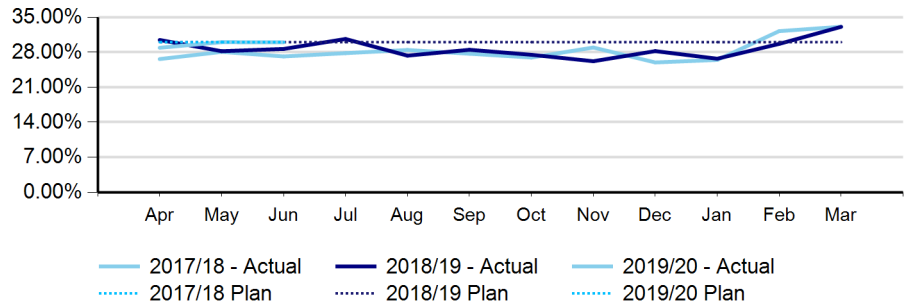
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	230	240	214	236	250	235	244	234	247	281	265	232
18/19	236	260	219	242	243	199	224	210	247	233	228	233
19/20	269	247	205									

307 - Stranded Patients - LOS 21 days and over



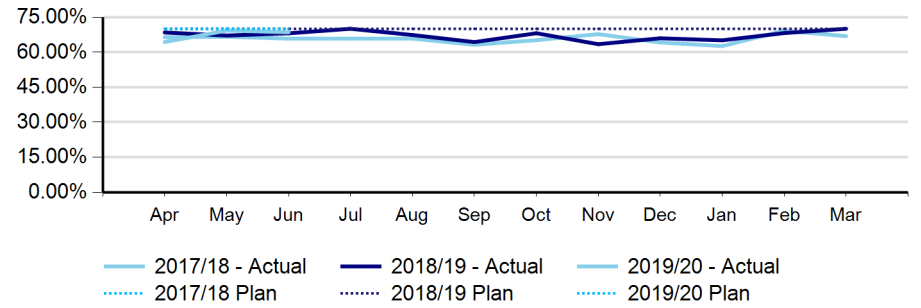
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	89	79	73	72	79	80	78	73	85	85	90	81
18/19	66	93	68	88	88	82	76	68	91	80	74	85
19/20	100	85	74									

57 - Discharges by Midday



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	26.6%	28.1%	27.1%	27.8%	28.4%	27.7%	26.9%	28.9%	25.9%	26.4%	32.2%	33.1%
18/19	30.4%	28.2%	28.6%	30.6%	27.3%	28.5%	27.5%	26.2%	28.2%	26.7%	29.7%	33.1%
19/20	28.9%	30.0%	30.0%									

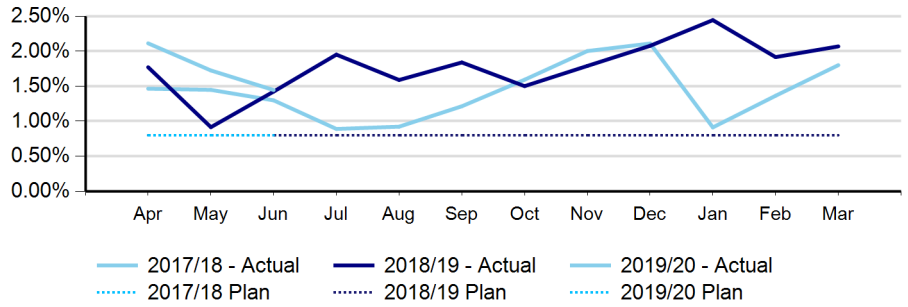
58 - Discharges by 4pm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	66.4%	66.6%	65.8%	65.8%	65.8%	63.2%	65.1%	67.7%	64.1%	62.6%	69.2%	66.9%
18/19	68.4%	67.1%	68.1%	70.0%	67.3%	64.3%	68.1%	63.4%	65.9%	65.1%	68.2%	70.0%
19/20	64.3%	69.2%	68.5%									

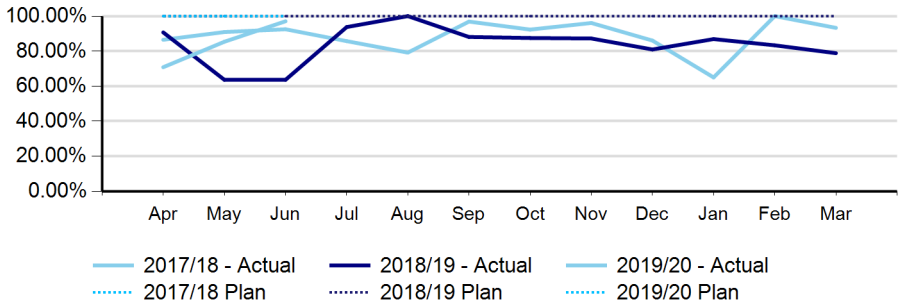
Bolton NHS Foundation Trust

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



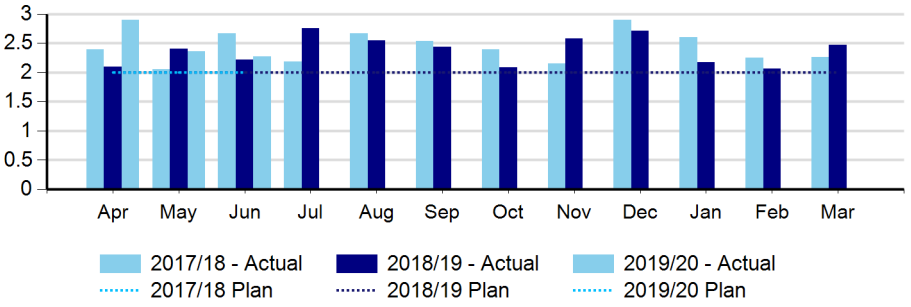
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1.5%	1.4%	1.3%	0.9%	0.9%	1.2%	1.6%	2.0%	2.1%	0.9%	1.4%	1.8%
18/19	1.8%	0.9%	1.4%	2.0%	1.6%	1.8%	1.5%	1.8%	2.1%	2.4%	1.9%	2.1%
19/20	2.1%	1.7%	1.4%									

62 - Cancelled operations re-booked within 28 days



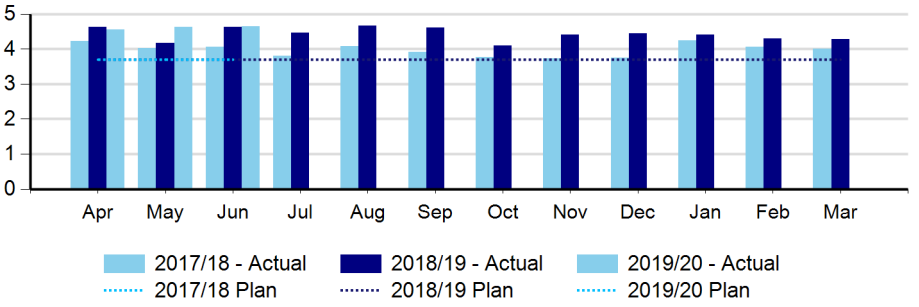
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86.5%	90.9%	92.5%	85.7%	79.2%	96.9%	92.3%	96.1%	86.0%	65.0%	100.0%	93.3%
18/19	90.7%	63.6%	63.6%	93.8%	100.0%	88.1%	87.5%	87.2%	81.0%	86.9%	83.3%	78.8%
19/20	70.8%	85.4%	97.1%									

65 - Elective Length of Stay (Discharges in month)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2.39	2.05	2.66	2.18	2.66	2.53	2.39	2.15	2.90	2.60	2.25	2.26
18/19	2.10	2.40	2.22	2.75	2.54	2.44	2.08	2.58	2.71	2.17	2.06	2.47
19/20	2.90	2.36	2.27									

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	4.23	4.02	4.05	3.80	4.07	3.91	3.76	3.72	3.75	4.25	4.06	4.00
18/19	4.62	4.17	4.62	4.47	4.67	4.60	4.09	4.41	4.44	4.40	4.29	4.28
19/20	4.56	4.63	4.65									

Bolton NHS Foundation Trust

Cancer

The Trust has achieved the 62 day standard for month 2, but it is at a lower rate than expected, June position is expected to fail. The Board will be aware that it is expected that the odd month may fail, but because of the lower than usual performance in April and May, there is a risk that the quarter will also fail. The key reasons for this pressure are, the number of referrals to cancer pathways is up by 20%, this has put pressure on diagnostic capacity across GM, and especially PET scanning. Work has been undertaken in GM and capacity is being addressed, and further work is looking inot how pathways can be shortened.

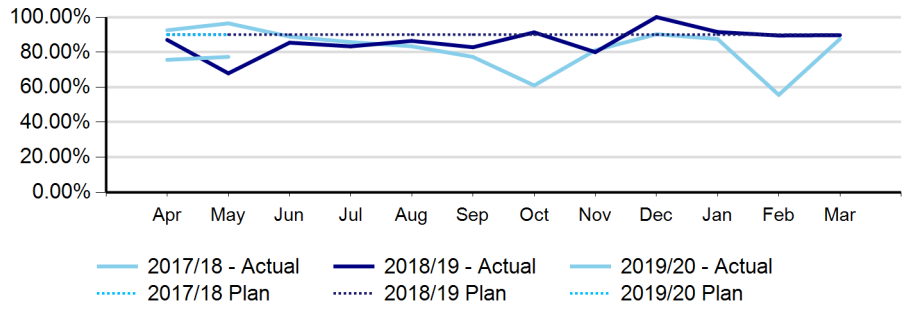
Breast services remain under pressure but as can be seen the performance is improving.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
46 - 62 day standard % (1 mth in arrears)	>= 85%	85.0%	May-19			>= 85%	88.5%	Apr-19		>= 85%	86.9%		85.0 - 95.4%	
47 - 62 day screening % (1 mth in arrears)	>= 90%	77.3%	May-19			>= 90%	75.6%	Apr-19		>= 90%	76.5%		75.6 - 100.0%	
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	99.0%	May-19			>= 96%	99.0%	Apr-19		>= 96%	99.0%		98.1 - 100.0%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	May-19			>= 94%	100.0%	Apr-19		>= 94%	100.0%		87.5 - 100.0%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%	100.0%	May-19			>= 98%	100.0%	Apr-19		>= 98%	100.0%		100.0 - 100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	96.9%	May-19			>= 93%	98.0%	Apr-19		>= 93%	97.4%		93.8 - 98.7%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	50.3%	May-19			>= 93%	27.1%	Apr-19		>= 93%	37.5%		27.1 - 95.0%	

Bolton NHS Foundation Trust

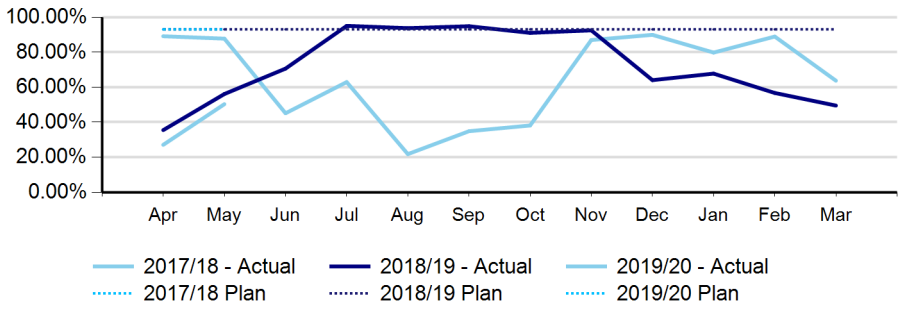
Exceptions

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



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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	89.1%	87.7%	45.1%	62.9%	21.8%	34.9%	38.1%	86.9%	89.9%	79.8%	88.9%	63.7%
18/19	35.5%	56.1%	70.6%	95.0%	93.7%	94.8%	91.0%	92.4%	64.0%	67.7%	56.7%	49.5%
19/20	27.1%	50.3%										

Bolton NHS Foundation Trust

Community

The total number of people deflected from ED attendance/admission by the Admission Avoidance Team and Home First Team remains above plan, the next steps are pathways into a frailty service. The total intermediate tier length of stay remains below threshold and on a reducing trend.

The numbers of people in hospital beds who are medically optimised, and the numbers of days occupied by these people, has reduced in June but remains above plan. The Trust is an early adopter site for the new Discharge Patient Tracking List and Long Length of Stay review process and this has been introduced in July.

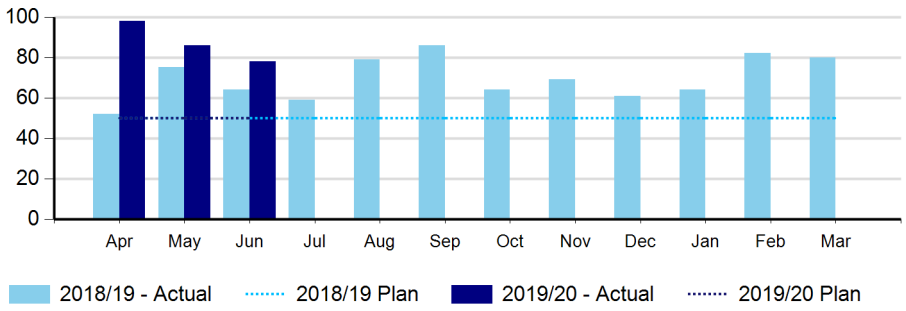
Raising awareness of the delays to community beds is resulting in some changes to the delays, although it is too early to assume this is a trend.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
334 - Total Deflections from ED	>= 400	492	Jun-19			>= 400	518	May-19		>= 1,200	1,547		300 - 537	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	4.80	Jun-19			<= 6.00	5.38	May-19		<= 6.00	4.80		3.86 - 6.75	
230 - Medically Optimised Numbers	<= 50	78	Jun-19			<= 50	86	May-19		<= 150	262		59 - 98	
231 - Medically Optimised Days	<= 209	479	Jun-19			<= 209	683	May-19		<= 627	1,715		388 - 790	

Bolton NHS Foundation Trust

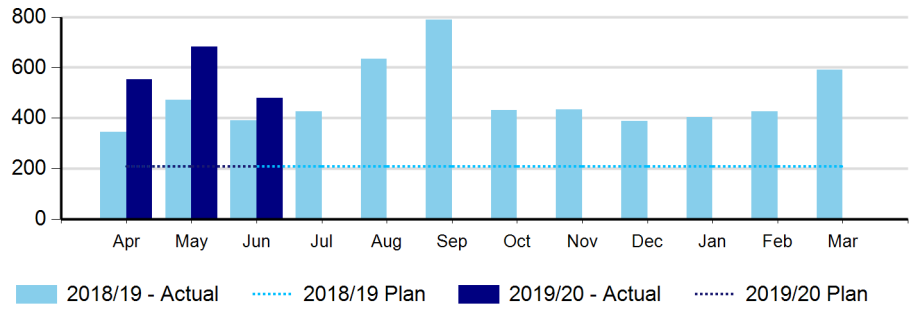
Exceptions

230 - Medically Optimised Numbers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	52	75	64	59	79	86	64	69	61	64	82	80
19/20	98	86	78									

231 - Medically Optimised Days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	344	472	391	426	634	790	430	434	388	403	425	591
19/20	553	683	479									

Bolton NHS Foundation Trust

Workforce

Sickness, Vacancy and Turnover

The sickness rate is higher than target and high than last month. Long term sickness continues to be the driver for this high sickness rates, with short term absence pressures remaining at the expected tolerance levels. Given the plethora of actions that are taking place to seek to reduce sickness management, the Workforce Assurance Committee (WAC) have asked for a focused paper at the next meeting on why these actions are not reducing absence to the tolerance levels anticipated – a more detailed update will follow in the following WAC Chair report.

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

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
117 - Sickness absence level - Trust	<= 4.20%	5.05%	Jun-19			<= 4.20%	4.93%	May-19		<= 4.20%	4.84%		4.55 - 5.45%	
120 - Vacancy level - Trust	<= 6%	5.94%	Jun-19			<= 6%	4.69%	May-19		<= 6%	5.80%		2.61 - 6.78%	
121 - Turnover	<= 9.90%	10.10%	Jun-19			<= 9.90%	9.93%	May-19		<= 9.90%	9.95%		9.16 - 10.65%	

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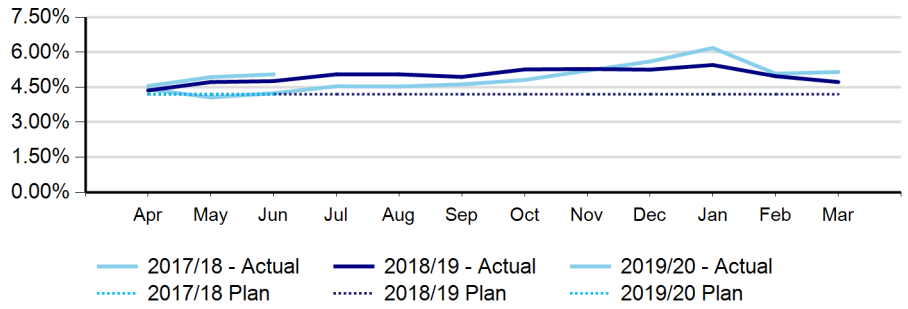
NHS Foundation Trust

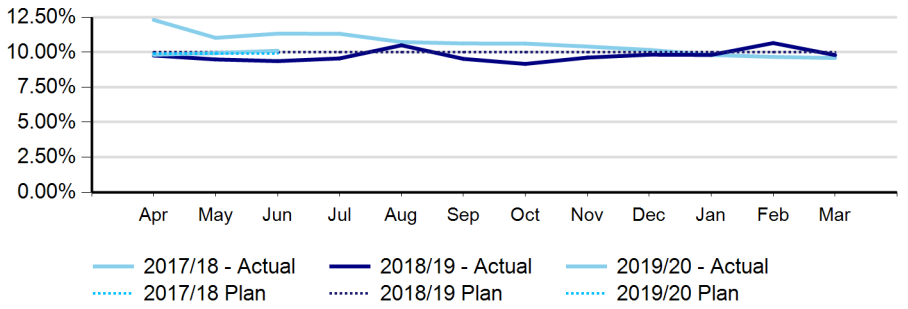
Exceptions

117 - Sickness absence level - Trust



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

121 - Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	12.30%	11.02%	11.32%	11.31%	10.72%	10.62%	10.61%	10.40%	10.16%	9.80%	9.66%	9.58%
18/19	9.76%	9.48%	9.36%	9.55%	10.49%	9.52%	9.16%	9.61%	9.82%	9.80%	10.65%	9.79%
19/20	9.81%	9.93%	10.10%									

NHS Bolton NHS Foundation Trust

Organisational Development

The Organisational Development indicators remain strong, and colleagues will note the upward trends across the majority of the metrics. It has been noted that the staff engagement KPI's may benefit from a further review. This matter had intended to be considered at the July Workforce Assurance Committee but given the inclusion focus that took place at this meeting it will be cosndered at the next meeting when there will be a focus on the findings of the feedback from the GoEngage programme.

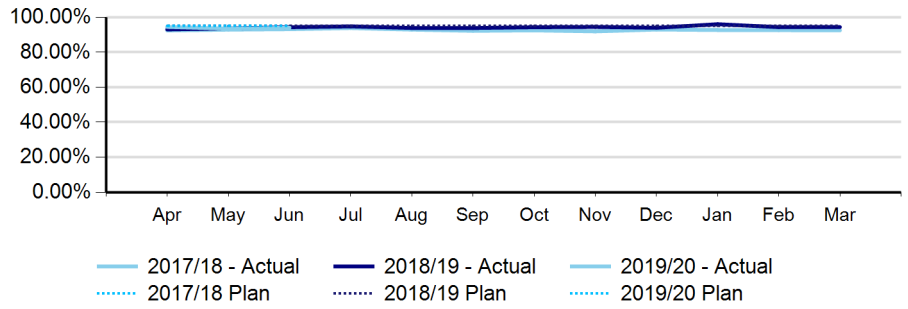
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
37 - Staff completing Statutory Training	>= 95%	94.0%	Jun-19			>= 95%	93.4%	May-19		>= 95%	93.9%		93.4 - 96.0%	
38 - Staff completing Mandatory Training	>= 85%	92.1%	Jun-19			>= 85%	91.8%	May-19		>= 85%	92.0%		85.9 - 93.1%	
39 - Staff completing Safeguarding Training	>= 95%	96.18%	Jun-19			>= 95%	95.55%	May-19		>= 95%	95.81%		94.73 - 96.18%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	84.7%	Jun-19			>= 85%	84.3%	May-19		>= 85%	84.4%		83.4 - 89.4%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	68.0%	Q4 2018/19			>= 66%	70.0%	Q3 2018/19		>= 66%			68.0 - 70.0%	
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	82.0%	Q4 2018/19			>= 80%	75.0%	Q3 2018/19		>= 80%			75.0 - 83.0%	

Integrated Summary Dashboard - June 2019

Bolton NHS Foundation Trust

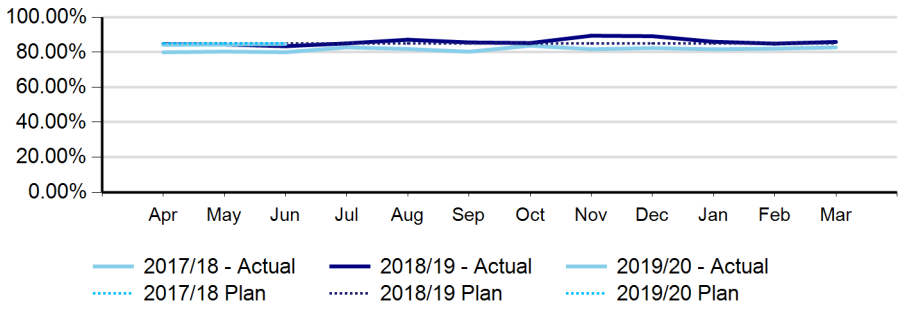
Exceptions

37 - Staff completing Statutory Training



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

101 - Increased numbers of staff undertaking an appraisal



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

Bolton NHS Foundation Trust

Agency

Colleagues will note the in-month Agency spend remains below the Trust's forecast. As would be expected the two areas of greatest spend being nursing and medical. Of note there has been a positive reduction in the nursing agency spend. The Trust benchmarks favourable on agency spend when compared to peer organisations for percentage agency spend versus overall pay, that said the Workforce Assurance Committee is sighted on the multiple actions that are being taken to drive down agency spend to the lowest possible level.

	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
198 - Trust Annual ceiling for agency spend (£m)	<= 0.67	0.59	Jun-19			<= 0.71	0.71	May-19		<= 2.10	1.98		0.56 - 0.90	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.36	0.22	Jun-19			<= 0.31	0.28	May-19		<= 0.98	0.79		0.22 - 0.33	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.33	0.28	Jun-19			<= 0.33	0.31	May-19		<= 0.98	0.89		0.19 - 0.50	

NHS Bolton NHS Foundation Trust

Finance

Finance

The June YTD performance against the control total is a deficit of £5.3m, £2.4m worse than the plan. The variance is mainly as a result on the under delivery of ICIP, income performance and control of costs.

PSF/MRET of £1.1m has been earned year to date compared to a plan of £1.1m. The PSF element is subject to achievement of the finance plan in Quarter 1 or the ICS (GM) achieving its control total. As such this has been accrued on the basis of the system delivering overall.

Overall, the Trust has made a deficit after PSF/MRET and Impairments of £4.3m year to date compared to a plan of £1.8m.

At this time the Trust is reporting that it will achieve the plan, but there are significant risks associated with this, particularly in the light of Q1 performance. The risk range for the forecast is from £9.7m surplus (plan) to a £22.2m deficit; with the most probable being £7.7m deficit. Recovery plan actions have been developed, but it will require external system help to achieve the plan.

The Trust capital plan for the year is £15.0m. The spend for Q1 YTD was £0.7m which is £0.4m off plan.

In June there was a net cash inflow of £1.2m with a closing cash balance of £12.5m, which is £2.7m above plan.

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

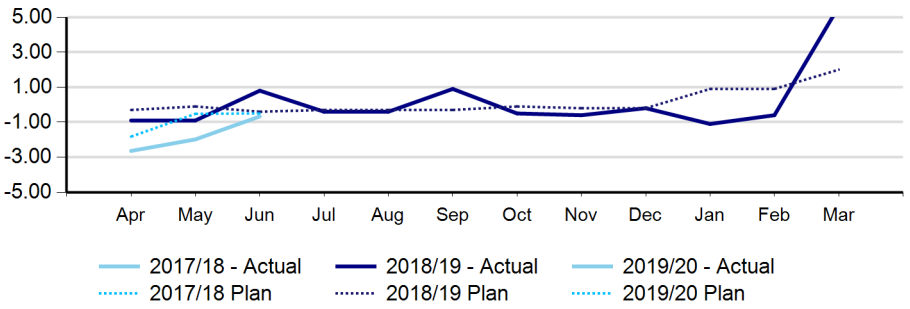
	Latest					Previous				Year to Date			Last 12 Months	
Outcome Measure	Plan	Actual	Period	RAG		Plan	Actual	Period	RAG	Plan	Actual	RAG	Range	Trend
220 - Control Total (£ millions)	>= -0.5	-0.7	Jun-19			>= -0.5	-2.0	May-19		>= -2.8	-5.3		-2.6 - 5.6	
221 - Provider Sustainability Fund (£ millions)	>= 0.01	-0.01	Jun-19			>= -0.01	-0.01	May-19		>= -0.01	-0.03		-0.01 - 1.30	
222 - Capital (£ millions)	>= 0.8	0.3	Jun-19			>= 0.2	0.2	May-19		>= 1.5	0.7		0.2 - 4.2	
223 - Cash (£ millions)	>= 9.8	12.5	Jun-19			>= 11.3	11.3	May-19		>= 9.8	12.5		6.0 - 19.1	
224 - Use of Resources	>= 3	3	Jun-19			>= 3	3	May-19		>= 3	3		2 - 3	

Integrated Summary Dashboard - June 2019

Bolton NHS Foundation Trust

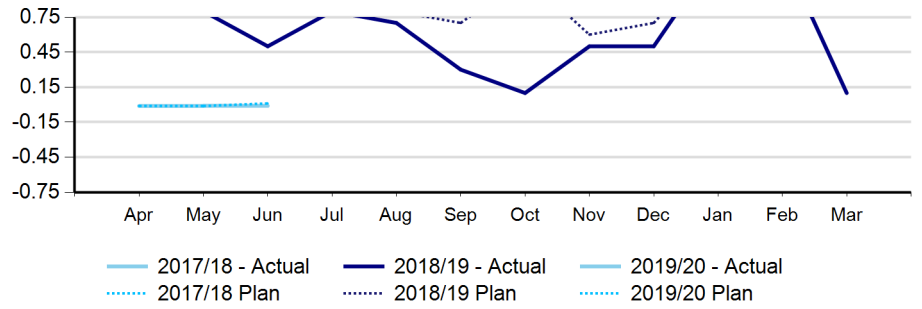
Exceptions

220 - Control Total (£ millions)



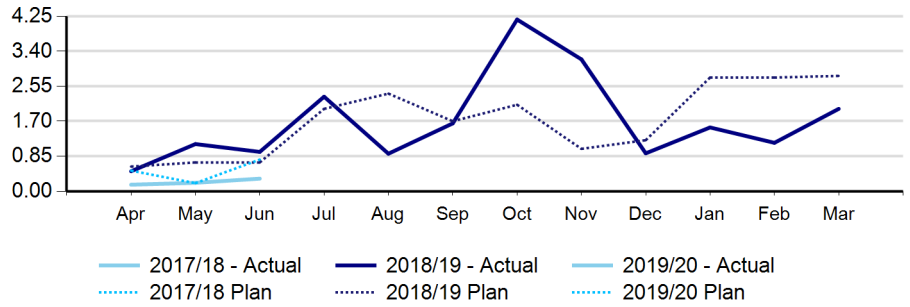
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18												2.3
18/19	-0.9	-0.9	0.8	-0.4	-0.4	0.9	-0.5	-0.6	-0.2	-1.1	-0.6	5.6
19/20	-2.6	-2.0	-0.7									

221 - Provider Sustainability Fund (£ millions)



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

222 - Capital (£ millions)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18												2.9
18/19	0.5	1.1	1.0	2.3	0.9	1.6	4.2	3.2	0.9	1.5	1.2	2.0
19/20	0.2	0.2	0.3									

NHS Improvement

Model Hospital

Bolton NHS Foundation Trust

Finance & Use of Resources

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

Report Date: 18 July 2019
Generated by: Emma Cunliffe
The Model Hospital website: https://model.nhs.uk

Single Oversight Framework

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

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

Peer group: 'My Region'

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

Financial Sustainability	Data period	Trust value	Performance band description
Capital service capacity - value	May 2019	-1.85	In quartile 1 - Lowest 25% (blue)
• Capital service capacity - SOF Score	May 2019	4	
Liquidity (days) - value	May 2019	12.45	In quartile 4 - Highest 25% (blue)
• Liquidity (days) - SOF Score	May 2019	1	

Financial Efficiency	Data period	Trust value	Performance band description
Income and expenditure (I&E) margin - value	May 2019	-7.10%	In quartile 2 - Mid-Low 25% (blue)
• Income and expenditure (I&E) margin - SOF score	May 2019	4	

Financial Controls	Data period	Trust value	Performance band description
Distance from financial plan - value	May 2019	-4.20%	In quartile 1 - Lowest 25% (blue)
• Distance from financial plan - SOF score	May 2019	4	
Distance from agency spend cap - value	May 2019	34.00%	In quartile 3 - Mid-High 25% (blue)
• Distance from agency spend cap - score	May 2019	3	

Use of Resources Framework

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

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

Peer group: 'My Region'

Clinical Services	Data period	Trust value	Performance band description	Peer median	National median
Pre-procedure elective bed days	Q4 2018/19	0.14	In quartile 3 - Mid-High 25% (amber / red)	0.14	0.12
Pre-procedure non-elective bed days	Q4 2018/19	1.36	In quartile 4 - Highest 25% (red)	0.80	0.66
Did not attend (DNA) rate	Q4 2018/19	8.97%	In quartile 4 - Highest 25% (red)	7.70%	6.96%
Emergency Readmission 30 days	Q4 2018/19	8.09%	In quartile 3 - Mid-High 25% (amber / red)	7.54%	7.73%

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

People	Data period	Trust value	Performance band description	Peer median	National median
Staff retention rate	31/12/2018	86.9%	In quartile 3 - Mid-High 25% (amber / green)	86.8%	85.6%
Sickness absence rate	30/11/2018	5.52%	In quartile 4 - Highest 25% (red)	5.11%	4.35%
Total pay cost per WAU	2017/18	£2,434	In quartile 4 - Highest 25% (red)	£2,351	£2,180
Substantive Medical staff cost per WAU	2017/18	£412	In quartile 1 - Lowest 25% (green)	£459	£533
Substantive Nursing staff cost per WAU	2017/18	£967	In quartile 4 - Highest 25% (red)	£826	£710
Substantive AHP staff cost per WAU	2017/18	£184	In quartile 4 - Highest 25% (red)	£148	£130

Corporate services, procurement, and estates and facilities	Data period	Trust value	Performance band description	Peer median	National median
Total non-pay cost per WAU	2017/18	£1,058	In quartile 1 - Lowest 25% (green)	£1,222	£1,307
Finance function cost per £100m turnover (comparison within sector)	2017/18	£741.21k	In quartile 3 - Mid-High 25% (amber / red)	£619.28k	£676.48k
HR function cost per £100m turnover (comparison within sector)	2017/18	£827.23k	In quartile 2 - Mid-Low 25% (amber / green)	£966.04k	£898.02k

Corporate services, procurement, and estates and facilities	Data period	Trust value	Performance band description	Peer median	National median
Estates & Facilities Cost (£ per m2)	2017/18	£292	In quartile 1 - Lowest 25% (green)	£293	£342
Procurement League Table: Process Efficiency and Price Performance Score (scaled 0 to 100)	Q3 2018/19	69	In quartile 3 - Mid-High 25% (amber / green)	77	66

Finance	Data period	Trust value	Performance band description
Capital service capacity - value	May 2019	-1.85	In quartile 1 - Lowest 25% (blue)
Liquidity (days) - value	May 2019	12.45	In quartile 4 - Highest 25% (blue)
Distance from agency spend cap - value	May 2019	34.00%	In quartile 3 - Mid-High 25% (blue)
Income and expenditure (I&E) margin - value	May 2019	-7.10%	In quartile 2 - Mid-Low 25% (blue)
Distance from financial plan - value	May 2019	-4.20%	In quartile 1 - Lowest 25% (blue)

About the peer group referenced in this report

Peer group

Your trust is benchmarked against the peer group My Region

Trusts in your NHS England and NHS Improvement region

Peer group members

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

Colour meanings

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

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

Board Assurance Heat Map - Hospital - June 2019

	INDICATOR	Target	Darley Court	AED-Adults	AED-Paeds	B1 (Frailty Unit)	A4	B2	B3	B4	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	H3 (Stroke Unit)
			Acute Division																		
Beds	Total Beds		30			23	22	0	21	0	25	26	26	27	10	14	26	22	26	27	24
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	G>=100%, A>80% <99.9%, R = <80%=R, >80% <94.9%=A, >95%	95.0%	90.0%	Non Return	100.0%	100.0%		100.0%		95.0%	100.0%	100.0%	80.0%	95.0%	100.0%	90.0%	100.0%	95.0%	100.0%	95.0%
	IPC Rapid Improvement Tool %		100.0%	86.0%	90.0%	96.0%	96.0%		92.0%		78.0%	96.0%	96.0%	79.0%	96.0%	92.0%	Non Return	88.0%	96.0%	96.0%	88.0%
	Mattress Audit Compliance %	Yes=G, No Return=White	100.0%			97%	100%		100%		100%	100%	100%	100%	100%	100%	99%	100%	98%	99%	100%
	C - Diff	0	0	0	0	0	0		0		1	0	0	0	0	0	0	0	0	0	0
	New MSSA BSIs	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0
	New E.Coli BSIs	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0
	MRSA acquisitions	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0
Harm Free Care	Safety Express Programme Harm Free Care (%)	95%	96.6%			95.7%	100.0%		100.0%		100.0%	92.3%	100.0%	92.6%	100.0%	100.0%	100.0%	100.0%	96.2%	96.0%	100.0%
	All Inpatient Falls (Safeguard)	0	8	2	0	4	0	0.0%	6	0.0%	3	4	11	5	0	1	7	10	4	5	4
	Harms related to falls (moderate and above)	0	0	0	0	0	0	0.0%	0	0.0%	0	0	0	0	0	0	0	0	0	0	0
	VTE Assessment Compliance	95%				0.0%	Non Return		0.0%		90.9%	100.0%	96.6%	55.6%	100.0%	96.7%	95.4%	94.6%	100.0%	84.6%	95.5%
	Monthly New pressure Ulcers (Grade 2)	0	1	0	0	0	0		1		0	0	1	1	0	0	0	0	1	2	0
	Monthly New pressure Ulcers (Grade 3)	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0
	Monthly New pressure Ulcers (Grade 4)	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0
	PU due to lapses in care	0	0	0	0	0	0		1		0	0	1	1	0	0	0	0	0	0	0
Audit	Monthly KPI Audit %	R=<80%,A>80%<94.9%,G>=95%	98.8%	95.4%	87.8%	83.6%	96.4%		90.6%		91.6%	94.3%	96.0%	88.6%	99.2%	84.4%	96.5%	96.9%	93.0%	84.7%	93.8%
	Bolton System of Care Accreditation (BoSCA)	R=<50%,B=>50%<74.9%,S=>75%<89.9%,G=>90%	92.3%	71.7%		80.5%	76.3%				77.0%	79.4%	76.0%	79.3%	91.7%	81.2%	75.3%	81.9%	92.9%	90.0%	90.2%
Patient Experience	Friends and Family Response Rate	**30%**	100.0%	17.3%	7.4%	31.5%	52.7%		50.0%		84.1%	43.4%	52.4%	11.7%	68.0%	29.5%	22.2%	17.6%	18.3%	55.4%	71.0%
	Friends and Family Recommended Rate	**97%**	100.0%	89.4%	99.4%	100.0%	94.9%		100.0%		100.0%	100.0%	95.3%	100.0%	98.0%	89.3%	90.5%	92.3%	93.3%	97.2%	100.0%
	Number of complaints received	**0**	0	3	0	0	0	1	0		0	0	0	0	0	0	0	0	0	0	0
Governance	SIs in Month	**0**	0	0	0	0	0		1		0	0	0	0	0	0	1	0	0	0	0
	Total Incidents	**0**	23	47	5	23	8	1	34		14	28	33	36	8	20	85	68	29	19	17
	Harms related to Incidents (Moderate and above)	**0**	0	0	0	0	0		0		2	2	0	0	0	0	1	0	0	0	0
Staff Development	Appraisals	85%	98.3%	90.8%		55.6%	97.1%		86.3%		85.7%	97.7%	83.8%	52.5%	73.3%	90.0%	75.5%	87.2%	90.0%	90.0%	51.2%
	Statutory Training	95%	96.11%	95.40%		92.96%	89.60%		85.9%		84.92%	94.44%	88.06%	86.83%	92.54%	95.83%	86.18%	90.15%	93.55%	87.50%	90.58%
	Mandatory Training	85%	94.7%	96.02%		83.2%	89.5%		88.1%		86.7%	93.7%	89.0%	82.4%	95.3%	93.0%	82.3%	88.8%	93.3%	83.9%	88.3%
Staffing & Workforce	% Qualified Staff (Day)					85.0%	101.3%				89.0%	94.9%	78.0%	88.4%	96.6%	-	-	-	96.9%	111.1%	ports\Workin
	% Qualified Staff (Night)					98.4%	108.6%		104.0%		97.9%	98.2%	99.8%	100.0%	100.0%	-	-	-	100.1%	99.1%	100.0%
	% un-Qualified Staff (Day)					77.5%	103.6%		92.8%		91.1%	99.9%	102.9%	101.6%	122.5%	-	-	-	99.8%	104.8%	99.3%
	% un-Qualified Staff (Night)					77.5%	105.3%		103.6%		94.1%	128.2%	111.4%	91.7%	98.3%	-	-	-	75.9%	98.8%	103.6%
	Budgeted Nurse: Bed Ratio (WTE)		5.10	-5.08	-	0.62	2.49		0.62		2.55	-0.34	4.67	4.50	1.18	0.41	-1.76	-4.86	-1.73	0.00	2.13
	Current Budgeted WTE (From Ledger)		43.38	139.12	-	38.03	32.83		43.34	41.23	33.71	41.23	42.69	40.69	26.93	19.97	50.82	40.30	40.01	39.97	36.15
	Actual WTE In-Post (From Ledger)		38.28	137.20	-	34.41	30.34		37.92	38.57	31.16	38.57	38.02	32.19	25.75	19.56	44.58	36.16	33.74	36.17	32.02
	Actual Worked (From Ledger)		44.81	144.03	-	39.43	36.48		45.24	43.82	38.35	43.82	45.77	43.06	25.39	21.94	51.32	44.33	41.02	44.96	37.16
	Sickness (%) (May)	R = >4.75, A = 4.2 - 4.75, G = <4.2	0.76%	1.67%		5.14%	4.76%		16.54%		12.83%	0.39%	6.39%	3.12%	6.06%	4.98%	9.46%	4.79%	1.22%	14.37%	7.27%
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)		5.10	-5.08	-	0.62	2.49		0.62		2.55	-0.34	4.67	4.50	1.18	0.41	-1.76	-4.86	-1.73	0.00	2.13
	Pending Appointment		0	7		3	0		4.8		0	3	0	4	0	0	8	9	8	3.8	2
	Substantive Staff Turnover Headcount (rolling average 12 months)	10%	16.6%	7.2%		23.2%	16.1%		7.8%		15.9%	8.9%	17.9%	23.3%	0.0%	20.4%	3.8%	12.9%	22.3%	4.6%	12.4%

	INDICATOR	HDU	ICU	E3	E4	F3	F4	G3/TSU	G4/TSU	G5	DCU (daycare)	EU (daycare)	H2 (daycare)	UU (daycare)	E5 (Paed HDU and Obs)	F5	M1 and Assessment	EPU	M2	CDS	M3 (Birth Suite)	Ingleside	M4/M5	NICU	Total
		Elective Division													Families Division										
Beds	Total Beds	10	8	25	25	25	22	24	24	16	25	9	11	4	31	7	17	6	26	15	5	4	44	38	770
Infection Prevention Control	Hand Washing Compliance % (Self Assessed)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	70.0%	100.0%	90.0%	100.0%	80.0%		90.0%		100.0%	100.0%	100.0%		100.0%	95.0%	96.5%
	IPC Rapid Improvement Tool %	100.0%	100.0%	96.0%	100.0%	88.0%	96.0%	91.0%	83.0%	87.0%	86.0%	100.0%	100.0%	96.0%	96.0%		100.0%		100.0%	96.0%	95.0%		96.0%	95.0%	94.1%
	Mattress Audit Compliance %	100%	100%	100%	100%	100%	100%	100%	100%	81%					Non Return		100%		100%	100.0%	98%		100%	100%	99.1%
	C - Diff	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
	New MSSA BSIs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	New E.Coli BSIs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MRSA acquisitions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harm Free Care	Safety Express Programme Harm Free Care (%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%		100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	98.7%
	All Inpatient Falls (Safeguard)	1	0	4	0	2	0	2	2	2	0	1	0	0	0	0	0	0	0	0	0	0	1	0	89
	Harms related to falls (moderate and above)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	VTE Assessment Compliance	100.0%	100.0%	96.6%	95.7%	91.3%	99.1%	96.1%	96.92%	95.3%	98.3%	97.0%	88.2%	97.6%			98.7%	98.5%	97.6%	100.0%	72.9%	57.1%	94.4%		95.6%
	Monthly New pressure Ulcers (Grade 2)	0	0	0	0	0	1	1	0	0	0	0	0	0	0		0		0	0	0	0	0	0	9
	Monthly New pressure Ulcers (Grade 3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0
	Monthly New pressure Ulcers (Grade 4)	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0
	PU due to lapses in care	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	3
Audit	Monthly KPI Audit %	99.7%	100.0%	95.7%	96.4%	92.8%	93.5%	100.0%	95.3%	98.9%	91.5%	100.0%	98.7%	99.7%	95.0%		86.8%		97.8%	97.9%	99.2%		99.7%	92.4%	94.8%
	Bolton System of Care Accreditation (BoSCA)	90.7%	93.9%	75.1%	90.4%	90.4%	82.8%	90.4%	92.5%	93.7%				75.6%	90.1%		75.3%		91.9%	88.0%	83.4%		90.4%	85.9%	84.9%
Patient Experience	Friends and Family Response Rate	50.0%	70.0%	58.2%	31.6%	24.3%	29.5%	51.1%	84.8%	35.6%	31.0%	24.7%	31.7%	13.5%	14.4%	0.0%	21.8%		16.5%	22.9%	50.0%		22.1%	65.8%	30.2%
	Friends and Family Recommended Rate	100.0%	100.0%	100.0%	97.3%	95.7%	100.0%	97.8%	9696.4%	100.0%	95.6%	97.7%	97.6%	100.0%	97.4%	N/A	100.0%		100.0%	94.1%	100.0%		88.8%	100.0%	97.9%
	Number of complaints received	0	0	1	0	0	0	0	0	1	0	0	0	0	0		0	0	1	0	0		0	0	7
Governance	SIs in Month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	Total Incidents	12	21	16	22	26	18	36	19	14	28	16	2	5	20	4	12	6	7	65	6	7	26	91	977
	Harms related to Incidents (Moderate and above)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	6
Staff Development	Appraisals	92.9%	93.7%	81.8%	94.3%	92.5%	93.8%	100.0%	97.8%	94.7%	88.2%	93.4%	67.4%	100.0%	61.0%		85.7%		83.0%				81.9%		85.1%
	Statutory Training	97.55%	99.32%	89.14%	94.62%	95.17%	93.30%	95.00%	94.30%	96.18%	92.73%	94.06%	92.37%	96.83%	97.0%		94.92%		90.4%				96.26%		92.7%
	Mandatory Training	98.9%	98.9%	85.4%	95.0%	94.2%	94.1%	96.6%	96.5%	98.7%	96.3%	95.4%	90.8%	97.1%	96.4%		84.0%		88.3%				93.7%		91.8%
Staffing & Workforce	% Qualified Staff (Day)	93.2%	94.9%	91.5%	95.6%	-	97.9%	80.7%	91.1%	77.1%					83.8%		88.1%		91.3%	79.0%	59.1%		85.5%	97.7%	
	% Qualified Staff (Night)	96.5%	95.0%	99.1%	100.0%	-	105.4%	100.4%	91.4%	100.4%					80.9%		101.9%		91.1%	82.9%	39.2%		81.4%	99.4%	95.1%
	% un-Qualified Staff (Day)	70.8%	99.6%	98.3%	83.8%	-	88.3%	84.1%	51.8%	109.5%					87.3%		86.7%		67.9%	78.0%	80.9%		95.6%		
	% un-Qualified Staff (Night)	42.0%	39.3%	105.8%	89.5%	-	132.1%	65.4%	100.0%	108.8%					103.6%		139.6%		91.0%	85.6%	76.7%		95.2%		
	Budgeted Nurse: Bed Ratio (WTE)	-1.67	-1.66	4.96	-0.65	-0.22	-1.07	-3.50	5.88	-2.81	-3.58	4.94	-5.27	1.10	-3.05		-	-	-	-	-		-	-	3.90
	Current Budgeted WTE (From Ledger)	39.58	55.02	35.52	30.21	37.79	30.21	44.49	44.49	18.07	27.45	52.39	46.30	15.88	67.65		25.72						106.59		1,427.76
	Actual WTE In-Post (From Ledger)	37.57	56.68	28.56	30.86	34.09	29.28	46.99	35.61	13.88	29.03	46.45	44.28	14.78	70.70		22.81						100.51		1326.72
	Actual Worked (From Ledger)	35.85	54.93	35.48	35.62	40.28	35.91	53.92	44.89	15.51	29.43	49.91	43.59	14.97	70.67		26.25						99.60		1477.74
	Sickness (%) (May)	3.22%	4.52%	2.70%	8.36%	4.46%	11.78%	10.88%	3.64%	4.90%	9.69%	7.58%	13.57%	1.05%	5.93%		7.47%						4.05%		6.4%
	Current Budgeted Vacancies (WTE) - (Budgeted wte -actual wte in post -Pending appt)	-1.67	-1.66	4.96	-0.65	-0.22	-1.07	-3.50	5.88	-2.81	-3.58	4.94	-5.27	1.10	-3.05		0.91						3.08		10.55
	Pending Appointment	3.7	0.0	2	0	3.92	2	1	3	7	2	1	7.29	0	0		2						3		90.49
	Substantive Staff Turnover Headcount (rolling average 12 months)	0.0%	10.5%	3.0%	17.6%	7.3%	3.0%	7.7%	8.9%	4.9%	8.3%	12.1%	3.8%	0.0%	10.2%		17.5%						11.4%		10.6%

Bolton NHS Foundation Trust

Board Assurance Heat Map - District Nursing Domiciliary - June 2019

INDICATORS	Avondale and Chorley old Road	Breightmet & Little Lever	Crompton merged with Egerton & Dunscar	Farnworth	Great Lever and Central	Horwich	Pikes Lane (Deane)	Pikes Lane (St Helen's Road)	Waters Meeting	Westhoughton	Evening Service	Total
Safety Express Programme Harm Free Care (%)	100.00%	100.00%	95.31%	100.00%	96.55%	98.00%	95.24%	100.00%	100.00%	97.67%		
Total Monthly New pressure Ulcers (Grade 2+)(Lapse in Care + No Lapse in Care)	4	1	1	0	0	0	0	2	0	0		8
Total Monthly New pressure Ulcers (Grade 2+) *(No Lapse in Care only)*	4	1	1	0	0	0	0	2	0	0		8
Number of Home Visits (from Lorenzo) **	73	5	30	78	110	132	165	197	0	47	1887	2724
Monthly KPI Audit % (Revised Buddy Assessed Audit)	98.00%	99.30%	96.61%	93.45%	98.66%	97.19%	97.35%	98.43%	97.51%	82.43%	90.00%	
BoSCA - Bolton Safe Care Accreditation	95.74%	94.15%	94.17%	85.67%	98.18%	91.42%	96.15%	94.74%	91.74%	91.62%	84.43%	
Current Budgeted WTE	11.64	13.72	16.00	18.24	7.11	13.15	17.13		17.26	11.09	19.96	145.30
Actual WTE In-Post	11.04	14.60	17.50	18.60	7.11	13.60	16.53		14.41	9.80	18.07	141.26
Actual WTE Worked	10.10	14.62	17.67	18.34	7.11	13.83	15.99		15.97	10.02	19.11	142.74
Pending Appointment												
Current Budgeted Vacancies (WTE)	0.20		0.53				1.00		2.00	1.49		5.22
Sickness (%) May 2019	9.64%	0.41%	0.00%	10.27%	0.48%	4.41%	11.82%		2.09%	0.81%	3.70%	5.37%
Substantive Staff Turnover Headcount (rolling average 12 months)	7.59%	5.38%	12.90%	15.25%	0.00%	0.00%	4.74%		18.65%	10.17%	9.25%	9.16%
12 month Appraisal	90.9%	94.1%	66.7%	66.7%	100.0%	81.3%	94.4%		77.8%	63.6%	96.90%	82.5%
12 month Statutory Training	96.97%	96.08%	92.11%	83.33%	100.00%	95.83%	90.63%		97.22%	100.00%	92.16%	93.21%
Number of complaints received	0	0	0	0	0	0	0	0	0	0	0	0
Total Incidents reported on Safeguard (see end total column)	10	0	0	7	10	8	5	11	0	4	1	56

Agenda Item No: 17

Meeting	Board of Directors

Date	25 July 2019

Title	2018/19 Annual Report of the Finance & Investment Committee

Executive Summary	This paper provides a review for the Board of the activities of the Finance and Investment Committee relating to the objectives set for 2018/19. The paper also proposes objectives for 2019/20 in the light of the Committee's terms of reference and in the context of the annual workplan.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	Finance & Investment Committee

Next steps/future actions	The Board is asked to note the Committee's 2018/19 annual report, objectives and 2019/20 work plan.			
	Discuss		Receive	✓
	Approve		Note	✓
	For Information		Confidential y/n	

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

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

Prepared by	Rachel Hurst Deputy Director of Finance	Presented by	Alan Stuttard Chair of the Finance & Investment Committee

2018/19 ANNUAL REPORT

Introduction

The purpose of this paper is to review for the Board the activities of the Finance and Investment Committee in regard of the objectives set by the Board for 2018/19 and to propose objectives for 2019/20 in the light of the Committee's terms of reference.

2018/19 Performance

The Committee's objectives for 2018/19 were to provide the Board with assurance on:

1. Delivery of the 2018/19 operational financial plan
2. Development of the 2019/20 operational financial plan
3. Development of a revised five year financial plan, in light of Devolution Manchester
4. Implementation of the investment in estates
5. Implementation of the investment in IT
6. Implementation of the financial aspects of the Northwest Sector partnership and the single service following the "Healthier Together" decision making business case
7. Development of Bolton Integrated Care Organisation
8. Development of the Business Case for £100m redevelopment of the Hospital Site
9. The implementation of the Trust's procurement strategy
10. Any other significant financial transactions / issues as per the terms of reference

The Committee reviewed its performance against each of the objectives it has been set and RAG rated performance as follows:

Objective	RAG rating
1. Delivery of the 2018/19 operational financial plan	Green
2.Development of the 2019/20 operational financial plan	Green
3. Development of a revised five year financial plan, in light of Devolution Manchester	Amber
4. Implementation of the investment in estates	Green
5. Implementation of the investment in IT	Green
6. Implementation of the financial aspects of the Northwest Sector partnership and the single service following the "Healthier Together" decision making business case	Green
7. Development of Bolton Integrated Care Organisation	Green
8. Development of the Business Case for £100m redevelopment of the Hospital Site	Amber
9.The implementation of the Trust's procurement strategy	Green
10.Any other significant financial transactions / Issues as per the terms of reference	Green

Objective 3. Development of a revised five year financial plan, in light of Devolution Manchester is shown as amber due to limited number of updates and specific requirement for review of any proposals that impact on the FT financial powers. However, a five year financial forecast has been included in the new strategy and will be reviewed by the Committee and the Board.

Objective 7. Development of the Business Case for £100m redevelopment of the Hospital Site is shown as amber due to the fact that the strategic case is under review. The Strategic Estates Board is reviewing the plans for the whole site.

The following table shows the objectives agreed by the Board and the activities undertaken by the committee to fulfil them:

Objective	**Action**
1. Delivery of the 2018/19 operational financial plan	The Board approved an extremely challenging financial plan which required a £15.5m income and cost improvement target to be achieved to deliver the control total of £1.6m giving a planned surplus of £12.7m including PSF with a use of resources rating of 1 and a cash balance of £10.0m The committee received and challenged monthly reports from the Executive which identified progress against the plan, highlighted risks and mitigating actions. In addition to the reports provided by the Finance Director to the Board the Committee Chair gave monthly reports to Trust Board on the range of risks and the key mitigating actions and the level of assurance the committee had. A control total of £1.7m (above target) was achieved. Total PSF achieved was £16.112m. With impairments of £11.488m, the overall surplus was £6.326m. The use of resources rating was a 1 and the cash balance was £19.1m.
2. Development of the 2019/20 operational financial plan	The committee received and challenged monthly updates from the Executive through the process of developing the plan. In addition to the reports provided by the Finance Director to the Board the Committee Chair gave reports on emerging risks and mitigations and the level of assurance that the committee had. The committee recommended approval of the 2019/20 plan in March 2019. This plan was subsequently agreed by the Board.

3. Development of a revised five year financial plan, in light of Devolution Manchester	The committee received updates from the Executive on developments of the Greater Manchester Devolution. A five year plan has been produced for the strategy and will be reviewed by the Committee and the Board.
4. Implementation of investment in estates	The committee received and challenged updates from the Strategic Estates Board
5. Implementation of investment in IT	The committee received and challenged updates from the Digital Transformation Board as part of the review of the capital programme.
6. The financial aspects of the Northwest Sector partnership and the single service following the "Healthier Together" decision making process	The committee received updates from the Executive.
7. Development of Bolton Integrated Care Organisation	The committee received updates from the Executive.
8. The Development of the Business Case for £100m redevelopment of the Hospital Site	A new Strategic Estates Board has been set up, chaired by the Chief Executive. The estates strategy and hospital site plan is being reviewed by iFM. Individual business cases have been brought to the committee for approval as appropriate.
9. The implementation of the Trust's procurement strategy	The committee received regular procurement key performance indicator reports.
10. Any other significant financial transactions / Issues as per the terms of reference	The committee reviewed and critically challenged the following additional material items through the year: • CRIG decisions • Authorisation of high value contracts • Consideration of waivers (prior to approval by the Audit Committee) • Tenders - 0-19 service - Greater Manchester Diabetic Eye Screening • Collaborative Image Sharing Project Outline • Outpatient Pharmacy • Tax Avoidance Issues in the NHS • Benchmarking • GM Financial issues, eg system protection of PSF

Annual Terms of Reference Review

The committee reviewed its terms of reference in June 2019. This is a separate agenda item proposing membership changes.

Objectives for 2019/20

In light of the terms of reference it is proposed that the committee's objectives for 2019/20 should be to give the Board assurance on:

1. Delivery of the 2019/20 operational financial plan
2. Oversee the development and implementation of ICIP
3. Review and monitor financial performance of iFM as a subsidiary of the Trust
4. Development of the 2020/21 operational financial plan
5. Development of a revised five year financial strategy
6. Business case review and approval of the financial aspects of GM and NW Sector service reconfiguration
7. Oversee the work of the Strategic Estates Board
8. Implementation of the Trust's procurement strategy and delivery
9. Receive updates on Model Hospital and Use of Resources (UOR)
10. Receive assurance on FFF accreditation
11. Any other significant financial transactions / issues as per the terms of reference

Work Plan

A proposed work plan to deliver the objectives set out above is attached as appendix one along with a record of agenda items since July 2017 at appendix two.

Recommendation

The Finance and Investment Committee is asked to agree to submit the Committee's 2018/19 annual report, objectives and work plan to the Board for approval.

Appendices

1. 2019/20 Work Plan
2. Agenda items log

Appendix 1

Bolton NHS Foundation Trust - Finance & Investment Committee - Draft 2019/20 Work Plan

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.0	**Delivery of the 2019/20 operational financial plan**												
1.1	Finance Report	■	■	■	■	■	■	■	■	■	■	■	■
1.2	IFM Bolton Contract Review Board	■	■	■	■	■	■	■	■	■	■	■	■
1.3	Finance Department Business Plan					■					■		
1.4	Chair Reports - Strategic Estates Board	■		■		■		■		■		■	
1.5	Chair Reports - CRIG	■	■	■	■	■	■	■	■	■	■	■	■
1.6	Chair Reports - DTB	■	■	■	■	■	■	■	■	■	■	■	■
1.7	Accounts Going Concern Submission	■											
1.8	Update on the Trust's banking arrangements					■							
1.9	Tenders - for evaluation / approval if required	■	■	■	■	■	■	■	■	■	■	■	■
1.10	Insurance							■					
1.11	Authorisation/Review of high value supplier payments												■
1.12	Costing		■			■			■			■	
2.0	**Oversee the development and implementation of ICIP**												
2.1	ICIP assurance/progress report	■	■	■	■	■	■	■	■	■	■	■	■
2.2	Review of efficiency opportunities and progress				■			■			■		
3.0	**Development of the 2020/21 operational financial plan**												
3.1	Review of budget setting principles						■						
3.2	Draft financial plan for the following year										■		■
3.3	Approach to contracting									■	■	■	■
3.4	Financial plan initial submission										■		
3.5	Final operating plan submission												■
4.0	**Development of a revised five year financial strategy**												
2.1	Update based on Trust Strategy				■								
5.0	**Business case review and approval of the financial aspects of GM and NW Sector service reconfiguration**												
2.1	Business Cases - as required	■	■	■	■	■	■	■	■	■	■	■	■
2.2	GM/NW Sector financial aspects - as required	■	■	■	■	■	■	■	■	■	■	■	■
6.0	**Oversee the work of the Strategic Estates Board**												
6.1	Business Cases - as required	■	■	■	■	■	■	■	■	■	■	■	■
7.0	**Implementation of the Trust's procurement strategy and delivery**												
7.1	Procurement quarterly update	■			■			■			■		
8.0	**Receive updates on Model Hospital and Use of Resources (UOR)**												
8.1	Quarterly updates on Model Hospital				■			■			■		
8.2	UOR: Assessment Framework - Finance				■								
9.0	**Receive assurance on FFF accreditation**												
9.1	Annual update on finance staff development and FFF accreditation		■										■
10.0	**Significant financial transactions review**												
10.1	Receive due diligence and financial aspects of BCMS - as required						■						
11.0	**Reporting to Board**												
11.1	Objectives and work plan			■									
11.2	Annual terms of reference review			■									
11.3	2018/19 annual report			■									
11.4	Chair's asssurance report	■	■	■	■	■	■	■	■	■	■	■	■

Updated: 29/05/19	Lead	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Sep-18	Oct-18	Nov-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Financial Plan Implementation																						
Finance Report	AC																					
Fundamental Review	N/A																					
Tactical Financial Plan	AW																					
Draft Financial Plan for following year	AC																					
Integrated Performance Framework - Finance	N/A																					
Monthly Forecasting Process	N/A																					
Approach to Planning	?																					
Financial Planning Update	AC																					
Financial Plan Initial Submission	AC																					
Tariff Impact Assessment	RH																					
Finance Department Business Plan	RH																					
Final Operating Plan Submission	AW																					
Accounts Going Concern Submission	CH																					
ICIPs																						
Strategic Approach to ICIP Delivery	AW																					
ICIPs	JB																					
ICIP 19/20 Board Presentation	PMO/AW																					
ICIP Assurance/Progress Report	MH																					
BFT/CCG Joint Savings Report	N/A																					
Identifying Efficiency Opportunities	MH																					
NHS Efficiency Map	MH																					
Review of Progress re Lord Carter Recommendations	N/A																					
NHSI Self-Assessment Checklists	MH																					
Trust Learning from the Financial Improvement Programme FY18 (FIP2)	N/A																					
Use of Resources																						
Single Oversight Framework - Finance and Use of Resources	AW																					
Use of Resources: Assessment Framework - Finance	AW																					
Use of Resources Assessment	AW																					
Use of Resources: CQC Report and Future Monitoring	JB																					
Cash and Loans/Banking																						
Cash and Loans	CH																					
Update on the Trust's Banking Arrangements	CH																					
Cash Management	CH																					
Capital																						
Capital Programme Update	AW																					
Capital Plan - current year	AW																					
Capital Plan - following year	AW																					
Review of the Capital Approval Process	AW																					
iFM Bolton																						
iFM Finance Report	LW																					
iFM Contract Review Board - MD Report	AW																					
iFM Bolton Summary Progress Report	AW																					
Outpatient Pharmacy Summary Briefing Paper	N/A																					
iFM Bolton Wave 1 and 2 Post Implementation Review	N/A																					
Procurement																						
Procurement Quarterly Update (KPI Report prior to Jan 19)	LT/NK																					
Procurement Process - High Value Contracts	CH																					
Procurement Strategy Implementation	LT/NK																					
Report from NHS NW Procurement Development	N/A																					
Waivers	NK																					
Significant Transactions Review																						
Tender Update	SM																					
Authorisation/Review of High Value Supplier Payments	CH																					
Provision of IT Services to Bolton CCG	AW																					
GM																						
Report on developments	N/A	V	V	V	V	V	V	V	V	V	V	V	V	V	V	V						
Locality Financial Report	N/A																					
Integrated Care System Single Control Total	N/A																					
Other																						
Annual Report of the F&I Committee	AW																					
Annual Terms of Reference Review	AW																					
Permanent Injury Benefit	N/A																					
Tax avoidance issues in the NHS	N/A																					
Impact of 3 year pay deal	N/A																					
Agency	N/A																					
Planning Guidance	AW																					
Reference Costs	RH																					
Costing Submission - pre-submission	RH																					
FFF Accreditation	RH																					
Valuation Techniques	CH																					
Insurance	CH																					
HMRC Contracted Out Services Review	CH																					
GM Integrated Care System Financial Framework	AW																					
Financial Update on Making the Estate Fit for the Future	AW																					
Investment in the Corporate Services Delivery Vehicle	AW																					
Audit Report - A&E	AW																					
Monitoring and Responding to Service Tender Opportunities: Guidance Document	SM																					
Chair Reports																						
Strategic Estates Board (meets bi-monthly from Mar -19)	AW																					
CRIG	AW																					
Digital Transformation Board	AW																		V			
Business Cases																						
iFM Bolton Outpatient Pharmacy	N/A																					
iFM Bolton Non-Pay Transfer	N/A																					
Unified Comms	N/A																					
A&E	N/A																					
Endoscopy	N/A																					
Elior	N/A																					
Postgraduate Education Facility / BCMS	N/A														V	V						
LED Lighting Retrofit Programme	N/A																					

Agenda Item No: 18

Meeting	Board of Directors

Date	25th July 2019

Title	Finance & Investment Committee Terms of Reference

Executive Summary	The attached Terms of Reference for the Finance and Investment Committee have been updated, with key changes being:- • To review and monitor financial performance of iFM Bolton as a subsdiary of the Trust. • Revised membership.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	Finance & Investment Committee

Next steps/future actions	The Board is asked to approve the Terms of Reference for the Finance and Investment Committee.				
	Discuss	✓	Receive		
	Approve	✓	Note		
	For Information		Confidential y/n		

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

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

Prepared by	Rachel Hurst Deputy Director of Finance	Presented by	Alan Stuttard Chair of the Finance & Investment Committee

Finance and Investment Committee – Terms of Reference

1. Authority

The Group Finance and Investment Committee (F&IC) is authorised by the Board of Directors (Board) to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any decision taken by the committee to obtain outside legal or other independent professional advice will always be highlighted in the Chair's report.

2. Reporting Arrangements

The Committee will be accountable to the Board.

The minutes of committee meetings shall be formally recorded by the Secretary. The Chair of the committee will issue a Chair's report to the Board and shall draw to the attention of the Board any issues that require disclosure to the full Board, or require action by the Trust Executive.

The Committee will refer to other Board governance committees, matters considered by the committee deemed relevant for their attention. The Committee will consider matters referred to it by other governance committees.

The annual work plan of the Committee may be reviewed by the Group Audit Committee at any given time.

3. Main Duties and Responsibilities

i. To provide assurance to the Board

ii. To approve and make any decisions as set out in the Scheme of Reservation and Delegation (SORD)

iii. To review and monitor financial performance of IFM as a subsidiary of the Trust

iv. Details are set out below:

- To oversee Financial Risk Assessment and Financial Risk Management.
- To review and/or approve the Annual, Medium and Long Term Financial Plans (revenue and capital plans) and in particular the Assumptions, Risks, Issues and Dependencies (ARIaD) underpinning the estimates. Recommend adoption of the plans to the Board.
- To review and/or approve group revenue income and expenditure and the capital programme for recommendation to the Board.
- To review and/or approve the essential elements of the contracts with commissioners of patient activity and other services and recommend adoption of the contracts.
- Review and/or approve Divisional plans/recovery plans and exception reports as required by the Divisional Financial Management Framework.
- Review and/or approve decisions made by the Strategic Estates Board which is established as a sub committee of the F&IC.

- Review and/or approve decisions made by the Digital Transformation Board which is established as a sub committee of the F&IC.
- Monitor income and expenditure against planned levels seeking explanations from Divisions/Directorates for any significant adverse variances.
- Monitor performance against savings plans seeking explanations from Divisions/Directorates for any significant adverse variances.
- Monitor expenditure against capital budgets on behalf of the Board and approve cost increases and appropriate corrective action in respect of significant variances from plan.
- Approve the use of Measured Term Contracts for capital schemes over £50k and monitor overall expenditure.
- Approve progress to tender for schemes costing over £0.5 million.
- Monitor cash flow ensuring that significant variances from plan are explained and action taken where appropriate.
- Approve and oversee the Treasury Management Policy and banking arrangements making decisions on significant investments of cash balances.
- Approve arrangements for borrowing/loans following approval of the loan by the Board.
- Authorisation/review of high value supplier payments
- Consider the implications of longer term strategy (including financial strategy) for the Trust given the NHS commissioning arrangements, resources available and the local health economy position.
- Review and/or approve comparative cost statements or other benchmarked information to assess the relative efficiency of the Trust and to make recommendations to the Board for improvements. The committee may seek clarification on any financial matter by requesting reports on any item of expenditure.
- Review and/or approve Business Cases for developments or changes in service for schemes where the financial values require Board of Directors' approval and make recommendations to the Board. Ensure that the business case process is followed and embedded throughout the Trust. Monitor progress against developments in service and major capital schemes.
- Evaluate tenders for major external service contracts where the financial values involved require Board approval, ensure that the specified service meets the Trust requirements and make recommendations to the Board.
- Approve any special payments not covered by the Scheme of Delegation.
- To review and/or approve Strategic and Operational Plans and in particular key assumptions, risks, issues and dependencies. Recommend adoption of the plans to the Board.

On behalf of the Board the committee shall:

- Approve the Trust's procurement strategy
- Monitor the delivery of the procurement strategy
- Obtain external assurance that the procurement strategy remains fit for purpose

4. **Membership**

- Three Non Executive Directors
- Chief Executive
- Director of Finance
- Deputy Director(s) of Finance (non voting)
- Chief Operating Officer
- IFM Director of Finance (in attendance)

5. **Chair**

The committee is chaired by a non executive director as appointed by the Trust chair. In the absence of the committee chair another non executive will chair.

6. **Frequency of Meetings**

Monthly

7. **Quorum**

At least three members, one of whom must be Director of Finance (or Deputy Director of Finance – if deputising), one of whom must be a Non Executive Director and one an Executive Director.

8. **Attendance**

If a member fails to attend two consecutive meetings the Chair of the committee will speak to the individual. The Chair will also be required to act if they feel that lack of attendance has not enabled adequate discussion or decision making.

9. **Decisions**

The Committee is a decision making committee. Decisions by the Committee must accord with the requirements of the Standing Orders and the Scheme of Delegation – General Principles and be reported to the next available Board of Directors meeting via the minutes of the Finance Committee.

10. **Agenda and Papers**

An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive no later than 4 working days before the meeting.

11. **Standard Agenda Items**

- Financial Performance Report.

12. **Organisation**

The Committee will be supported by the PA (Secretary) to the Finance Director, whose duties in this respect will include:

- Agreement of the agenda with the Chairman and Director of Finance and attendees and collation of papers

- Taking the minutes and keeping a record of matters arising and issues to be carried forwards

Minutes of the meeting will be approved by the committee members.

13. **Monitoring Effectiveness**

The Committee will undertake an annual review of its performance against its annual work plan which will go to the Board for review.

14. **Review of Terms of Reference**

These Terms of Reference will be reviewed at least annually.

Agenda Item No: 19

Meeting	Trust Board

Date	July 2019

Title	Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme
Executive Summary	To qualify for the CNST Discount Incentive Scheme Trusts offering Maternity Services are required to complete and submit to Board a completed template which demonstrates progress made to implement the 10 Maternity Safety Actions and the evidence used to support this. The Trust was successful in the Year 1 applications and the incentive scheme is being run for a second year. Successful compliance with the 10 Safety Actions could ensure the Trust receives up to £800k rebate for 19/20. This report documents the final submission details and evidence. It is recommended that the committee:- a) Review the contents of this report. b) Review and note Evidence to support claim at Appendix A. c) Approve sign off (Appendix B).
Previously considered by	This report was also submitted to CGQA in June for initial review and QAC in June and July.
Next steps/future actions	Once Board Sign off has been received the report will be submitted to NHS Resolution prior to the deadline of 12 noon Thursday 15th August 2019. It is important to note that non submission will be treated as a nil response and no incentive payment will be made.

Discuss	✓	Receive	✓
Approve	✓	Note	
For Information		Confidential y/n	N

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

Quality, Safety and Patient Experience	✓	To be well governed	✓
Valued Provider		To be financially viable and sustainable	

Great place to work		To be fit for the future	✓

Prepared by	Marie Higgin, OBM – Obs, Gynae & Neonates	Presented at Quality and Assurance Committee by	Marie Higgin, OBM – Obs, Gynae & Neonates Valerie Clare, DND and HoM

1. Background

1.1 In 2018/19 NHS Resolution (NHSR) supported a CNST discount incentive scheme which was available to all Trusts offering Maternity services which was entirely discretionary and subject to available funds.

1.2 Bolton NHS Foundation trust met the standards required and submitted the application form within the requested timescale with supporting evidence.

1.3 As a result the Trust received a total of £540k refund on the CNST contribution and a further £280k of the unallocated funds.

1.4 NHSR has agreed to run the incentive scheme for a second year which would allow the Trust to receive £800k for 19/20.

1.5 The Trust is, once again, required to assess themselves against the 10 Maternity Safety Actions. These are the same questions as year one but the supporting evidence and criteria has been enhanced.

1.6 To qualify for the scheme Bolton FT are required to complete and submit to Board a completed template along with the evidence used to support the claim. Evidence to be used is supplied as Appendix A.

1.7 It is important to note that NHSR have stated they do not wish to receive the evidence provided as Appendix A and will only accept the self-certified template (Appendix B). Therefore all evidence will be supplied to the Quality Assurance committee and Board only.

1.8 The application is both self-certified and will be externally validated.

1.9 It is an expectation that Boards will self-certify declarations following consideration of the evidence provided herein (this responsibility has been remitted to the Quality Assurance Committee to consider the evidence in detail).

1.10 There are specific timescales for applications which are summarised below for reference.

Step	Date
Completed Board Reports with Board Sign off submitted to NHS Resolution	Noon on 15th Aug 19
Trusts notified of results	By End of Sept 19
Appeal applications	14th August 19
NHS Resolution to confirm and pay discounts	By End of Nov 19

2. Purpose

2.1 The purpose of this paper is to provide the Committee/Board with information on the CNST application for year 2.

2.2 The Final submission is due by 12 noon on 15th August 2019.

2.2 Bolton NHS Foundation Trust is committed to implementing all 10 Action points and compliance is demonstrated in detail within this report.

3. Summary of Trust's progress

3.1 Bolton NHS Foundation Trust Maternity services includes;

- Bolton NHS Foundation Trust, Main Site & Community
- Ingleside, Salford

3.1 Progress and evidence against each action point is documented in Section 4 and a summary is provided in Table 1 below:-

3.2 We are confident that we will be compliant with all 10 safety action points and evidence has been supplied to support this.

Table 1: Progress and evidence against each action point:-

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

4. Evidence of Bolton NHS Foundation Trusts achievement of the 10 Safety actions

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
Req. standard	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.	Yes
	b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.	Yes
	c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.	Yes
	d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.	Yes
Evidence Requested	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met. **Evidence supplied:** Appendix A1 – Integrated performance report (Qtr 3) Appendix A1.2 – Q3 integrated governance report summary. Appendix A1.3 – Integrated performance report (Qtr 4)	

2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
Req. Standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).	Yes
Evidence requested	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details). **Evidence supplied:-** With regards to the submission of the January MSDS data for CNST scoring it was submitted on time. We have received the scoring back from NHS Digital (attached) and we met the minimum required. We have received a confirmation email to advise of the successful submission and the final validation report is awaited. Appendix A2 – CNST Criteria January submission Appendix A2.1 – CNST Criteria June submission confirmation email.	

3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
Req. Standard	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. *The new service delivery model has been agreed and pathways are developed.*	Yes
	b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.	Yes
	c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN)	Yes

	reviews.	
	d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN.	Yes
Evidence requested	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads. Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS. **Evidence supplied:-** Appendix A3 – Copy of ATAIN Action plan Appendix A3.1 – Email confirmation of receipt Appendix A3.1 – Email confirmation of receipt (May 19) Appendix A3.2 – Copy of WQF agenda Appendix A3.3 – Copy of Clinical Governance and Quality Assurance Agenda Appendix A3.4 – CGQA Agenda Appendix A3.5 - IV Therapy agenda to support ATAIN	

4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes

Req. Standard	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.	Yes
	b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. ***We meet all these standards therefore no action plan needed. Accreditation details is provided within the evidence folder***	NA
Evidence requested	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk ***A clarifying question was submitted to ask whether the action plan should be supplied to RCOG or provide evidence of submission of the action plan to HEENW as the survey was done by the GMC and Deanery, not the RCOG. As we have not received a response at the time of writing of this report we have submitted the action plan to the deanery (Health Education England North West, HEENW) and the RCOG. However this will be overseen by HEENW and a copy has been supplied as evidence to the Committee/Board.*** b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards. ***We meet all these standards therefore no action plan needed. Accreditation details are provided within the evidence folder*** **Evidence supplied:-** Appendix 4.1 – Copy of Obs and Gynae outliers report Appendix 4.2 – Copy of Action plan to address lost educational opportunities Appendix 4.3 – Copy of the Questions Drill Down	

	Appendix 4.4 – Workforce committee where GMC results discussed Oct 18 Appendix 4.4/5 – Copy of Agenda and minutes of Workforce Assurance committee May 19- -– *Not supplied with this report but will be available for the final submission in July.* Appendix 4.6 – Obs/Anaesthetics staffing paper Appendix 4.7 - Copy of accreditation for theatres	

5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
Req. Standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.	Yes
	b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service	Yes
	c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)	Yes
	d) A bi-annual report that covers staffing/safety issues is submitted to the board	Yes
Evidence Requested	A bi-annual report that includes evidence to support a-c being met. This should include: •A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. •Details of planned versus actual midwifery staffing levels. •An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls	

	Evidence supplied:- Appendix A5.1 – Copy of birth Rate + report (Mar 19) Appendix A5.2 – Copy of birth predictor tool Appendix A5.3 – Copy of bookings and delivery report Appendix A5.4 – Copy of Maternity Statistics report Appendix A5.5 – Midwifery staffing review paper (Jan 19) Appendix A5.6 – Copy of BoD minutes where C5.5 was discussed (Jan 19) Appendix A5.7 – Copy of Maternity Dashboard showing monitoring of 121 care Appendix A5.8 – Helicopter Bleep SOP Appendix A5.9 - Maternity Bleep Escalation Appendix A5.10 – Copy of Helicopter data sheet	

6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
Req. Standard	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	Yes
Evidence Requested	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s). **Evidence supplied:-** Appendix A6.1 – Copy of presentation to the Board (Feb 19) Appendix A6.2 – Copy of Board Minutes (Feb 19)	

7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes

Req. Standard	User involvement has an impact on the development and/or improvement of maternity services.	Yes
Evidence Requested	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women. **Evidence supplied:-** Appendix 7 – Facebook advertisement of MVP event Appendix 7.1 – Copy of Joint action plan to create a Single point of access Appendix 7.2 – Copy of Monthly Divisional Board agenda with standard item for Patient story Appendix 7.3 15 Steps Appendix 7.4 15 Steps at Ingleside Appendix 7.5 Joint working in pictures Appendix 7.6 Companion policy MVP Appendix 7.7 Pt Experience, Inclusion & Partnership committee agenda Appendix 7.8 – MVP letter – feedback Elective C sections Appendix 7.9 – MVP listening event from March 18 Appendix 7.10 – MVP minutes Appendix 7.11 - PEIC Maternity Survey June 2019 Action Plan	

8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
Req. Standard	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year. Figures at time of producing report:- Midwives – 100% compliant Support staff 100% compliant	Yes

	Obstetrics – 95% compliant Theatre Staff – 100% compliant. Anaesthetics – 94% complaint.	
Evidence Requested	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar. **Evidence supplied:-** Compliance rates for groups shown above	

9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
Req. Standard	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)	Yes
	b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues ***Board level safety champion undertakes a weekly walk around with senior nurses and midwives*** ***The Director of Nursing reports to the board monthly on any concerns within maternity and neonates.*** ***The senior leadership team have implemented monthly listening events within the Family Care Division and can evidence 'You said, we did'.***	Yes
	c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	Yes
Evidence Requested	•Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three • Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally • Evidence of attendance at one or more National Learning Set or the annual national learning event • Evidence of engagement with relevant networks and the collaborative LLS	

	• Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff • Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns **Evidence supplied:-** Trish Armstrong-Childs is the Executive Safety Champion and meetings are regularly scheduled. Within these meetings issues are discussed and addressed. Trish has also recently attended the National learning event in March and we have provided email confirmations. She has also supported the Division during the Perfect week and this is shared in the evidence below. Formal feedback via the SCORE survey and provided this as evidence of engagement with Staff. Appendix A9.1 – Copy of Safety champion meeting Agenda (Feb 19) Appendix A9.2 – Copy of SCORE survey action plan Appendix A9.3 – Copy of MatNeo Presentation Appendix A9.4 – Copy of MatNeo Staff poster Appendix A9.5 – Copy of MatNeo Poster Appendix A9.6 – Copy of HATs poster Appendix A9.7 – Email confirmation of attendance at a National Learning Event. Appendix A9.8 – Copy of poster from Perfect week Tea at ten Appendix A9.9 – Copy of poster for Golden Hour Appendix A9.10 – Copy of MatNeo action plan Appendix A9.11 – Copy of Perfect week poster Appendix A9.12 – Evidence of national nomination for patient safety award Appendix A9.13 – Letter from HEE re MatNeo work	

10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes
Req. Standard	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.	Yes

Evidence Required	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team. ***We are complaint with this criteria***	

5. Next Steps

5.1 This report has been submitted to Board for formal sign off (Appendix B).

5.2 Once Board Sign off has been received the report will be submitted to NHS Resolution prior to the deadline of 12 noon Thursday 15th August 2019. It is important to note that non submission will be treated as a nil response and no incentive payment will be made.

6. Recommendations

6.1 It is recommended that the Committee/Board

a) Review and note the contents of this report.

b) Review and note Evidence to support claim at Appendix A.

d) Provide approval for formal sign off at Appendix B.

7. Appendices

Appendix A List of evidence to support submission.

Appendix B Sign off document from NHSR.

Appendix A: Evidence to support submission

EVIDENCE SUPPLIED			
Ref	Action Point	Name of document	Purpose
Appendix A.1	1	**A1** – Integrated performance report (Qtr 3) **A1.2** – Q3 integrated governance report summary. **A1.3** – Integrated performance report (Qtr 4) – *Not supplied with this report but will be available for the final submission in July.*	To demonstrate board reporting of the required standards
Appendix A.2	2	**A2** – CNST Criteria January submission **A2.1** – CNST Criteria June submission confirmation email.	To evidence submission to of the MSDS
Appendix A.3	3	**A3** – Copy of ATAIN Action plan **A3.1/2** Email confirmations of receipt **A3.3** – Copy of WQF agenda **A3.4** – Copy of Clinical Governance and Quality Assurance Agenda **A3.5** IV antibiotics Agenda to support ATAIN	To provide evidence of the Avoiding Term Admissions to Neonates actions plan and that this has been shared with the appropriate stakeholders.
Appendix A.4	4	**A4.1** – Copy of Obs and Gynae outliers report **A4.2** – Copy of Action plan to address lost educational opportunities **A4.3** – Copy of the Questions Drill Down **A4.4** – Workforce committee where GMC results discussed Oct 18 **A4.4/5** – Copy of Agenda and minutes of Workforce committee May 19- -– *Not supplied with this report but will be available for the final submission in July.* **A4.6** – Obs/Anaesthetics staffing paper	Evidence of effective medical workforce planning

		A4.7 – Copy of the accreditation for theatres	
Appendix A.5	5	**A5.1** – Copy of birth Rate + report (Mar 19) **A5.2** – Copy of birth predictor tool **A5.3** – Copy of bookings and delivery report **A5.4** – Copy of Maternity Statistics report **A5.5** – Midwifery staffing review paper (Jan 19) **A5.6** – Copy of BoD minutes where C5.5 was discussed (Jan 19) **A5.7** – Copy of Maternity Dashboard showing monitoring of 121 care **A5.8** – Helicopter Bleep SOP **A5.9** - Maternity Bleep Escalation **A5.10** – Copy of Helicopter data sheet	Evidence of effective midwifery workforce planning
Appendix A.6	6	**A6.1** – Copy of presentation to the Board (Feb 19) **A6.2** – Copy of Board Minutes (Fab 19) - Not supplied with this report but will be available for the final submission in July.	Evidence of presentation to Board on the Saving Babies Lives Bundle
Appendix A.7	7	**A7** – Facebook advertisement of MVP event **A7.1** – Copy of Joint action plan to create a Single point of access **A7.2** – Copy of Monthly Divisional Board agenda with standard item for Patient story **A7.3** 15 Steps **A7.4** 15 Steps at Ingleside **A7.5** Joint working in pictures **A7.6** Companion policy MVP **A7.7** Pt Experience, Inclusion & Partnership committee agenda **A7.8** – MVP letter – feedback Elective C sections **A7.9** – MVP listening event from March 19	Evidence of feedback mechanisms and working with the Maternity Voices Partnership

		A7.10 – MVP minutes **A7.11** - PEIC Maternity Survey June 2019 Action Plan	
Appendix A.8	8	**A8** – Compliance rates for groups have been documented ***within the main document***	To provide the updated compliance rates
Appendix A.9	9	**A9.1** – Copy of Safety champion meeting Agenda (Feb 19) **A9.2** – Copy of SCORE survey action plan **A9.3** – Copy of MatNeo Presentation **A9.4** – Copy of MatNeo Staff poster **A9.5** – Copy of MatNeo Poster **A9.6** – Copy of HATs poster **A9.7** – Email confirmation of attendance at a National Learning Event. **A9.8** – Copy of poster from Perfect week Tea at ten **A9.9** – Copy of poster for Golden Hour **A9.10** – Copy of MatNeo action plan **A9.11** – Copy of Perfect week poster **A9.12** – Evidence of national nomination for patient safety award **A9.13** – Letter from HEE re MatNeo work	To evidence trust safety champion meetings and exec / staff involvement.
Appendix A.10		Fully compliant	

Appendix B – Sign off document from NHSR

NHS Resolution

Maternity incentive scheme – year two

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

Contents

Introduction

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

This document provides guidance on the safety actions for year two of the maternity incentive scheme.

Maternity incentive scheme year two: conditions

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form (see Appendix 1) to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions
- The Board declaration form must be signed and dated by the trust chief executive to confirm that:
    - The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
    - The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

Evidence for submission

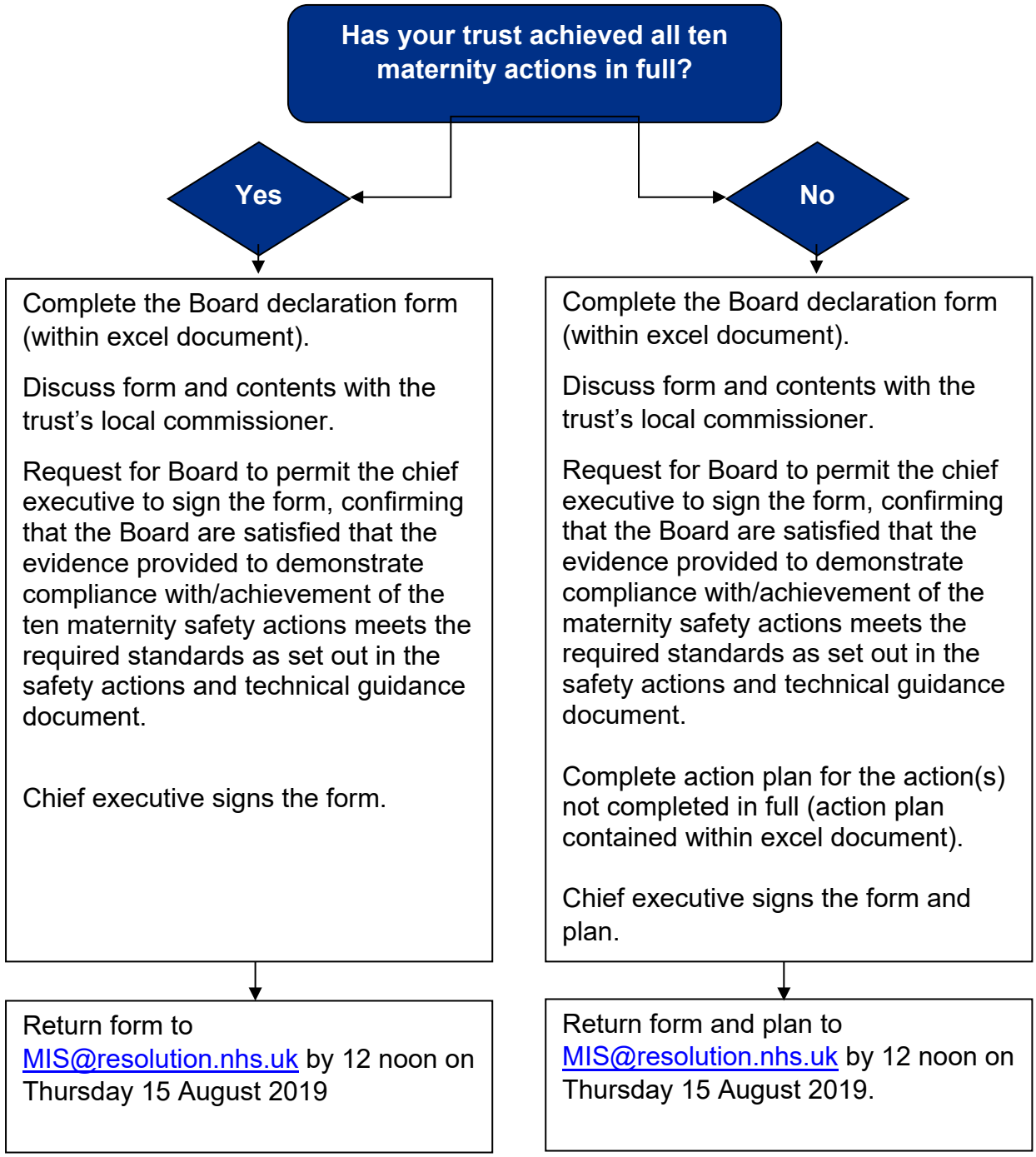
- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the trust Board only, and will not be reviewed by NHS Resolution.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)
- Trust submissions will also be sense checked with the Care Quality Commission (CQC).

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date.
- The Board declaration form must be sent to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019. An electronic acknowledgement of trust submissions will be provided within 48 hours.
- Submissions and any comments/corrections received after 12 noon on Thursday 15 August 2019 will not be considered
- Trusts will be notified of results by the end of September 2019.
- Appeals must be submitted in writing by the trust chief executive and sent to NHS Resolution (MIS@resolution.nhs.uk) by Monday 14 October 2019. Further detail on the appeals process will be communicated at a later date. The payments to be made under the maternity incentive scheme will be communicated to trusts by the end of November 2019.

For trusts who have not met all ten maternity actions

Trusts that have not achieved all ten actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such trusts must submit an action plan together with the Board declaration form by 12 noon on Thursday 15 August 2019 to NHS Resolution (MIS@resolution.nhs.uk). The action plan must be specific to the action(s) not achieved by the trust and must take the format of the template (see Appendix 1). Action plans should not be submitted for achieved safety actions.



Send any queries relating to the ten actions to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.
Minimum evidential requirement for trust Board	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15 August 2019.
What is the relevant time period?	**From Wednesday 12 December until Thursday 15 August 2019**
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 1
Are you using the PMRT to review perinatal deaths?

Technical guidance	
What should we do if we do not have any deaths to review within the time period?	If you do not have any babies that have died from Wednesday 12 December to Thursday 15 August 2019 then you should partner up with a trust to which you have a referral relationship to participate in case reviews. NHS Resolution will verify with MBRRACE-UK data the number of deaths occurring in your partner trust in the relevant period.
How does the involvement of the Healthcare Services Investigation Branch (HSIB) in investigations affect meeting this action?	It is recognised that for a small number of cases (intrapartum stillbirths and early neonatal deaths) investigations will be carried out by HSIB that will contribute to the report generated by the PMRT for a baby. Achieving section b) of the standard may therefore be impacted on by timeframes beyond the trust's control. This should be noted in the quarterly report and if this is the case, those babies not included in calculating the 50%.
What does multidisciplinary review mean?	Helpful guidance can be found at the following website: www.npeu.ox.ac.uk/mbrrace-uk
We have contacted parents, but they do not want to be involved - what should we do?	Please document accordingly within the review in the PMRT.
Parents have not responded to our messages, and therefore we are unable to discuss the review - what should we do?	Parents should guide the process and advise how involved they would like to be. The trust should record the attempts made to make contact with the parents within the review in the PMRT.
Is the quarterly review of the Board report based on a financial or calendar year?	This can be either financial or calendar year.

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).
Minimum evidential requirement for trust Board	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will cross-reference self-certification against NHS Digital data.
What is the relevant time period?	The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019. One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019. One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Technical guidance	
What do we do if we are unable to submit data to MSDS for a particular category	If a trust feels that there are exceptional circumstances, they should raise this with NHS Digital at an early stage. This might include evidence of a fall in birth rate, or of services covered in the assessment not being available at the trust.

Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019	
	Mandatory categories 1-3 must be met to pass Safety action 2
1	January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)
2	MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales
3	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019
	14 of the 19 optional categories 4-22 must be met to pass Safety action 2
4	Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019
5	January 2019 data contained valid smoking at booking for at least 80% of bookings
6	January 2019 data contained valid smoking at delivery for at least 80% of births
7	January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)
8	January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)
9	January 2019 data contained method of delivery for at least 80% of births
10	January 2019 data contained valid baby's first feed for at least 80% of births
11	January 2019 data contained valid in days gestational age for at least 80% of births
12	January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded
13	January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded
14	January 2019 data contained valid place type actual delivery for at least 80% of births
15	January 2019 data contained valid site code for at least 80% of births
16	January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births
17	January 2019 data contained valid Apgar score at five minutes for at least 80% of births
18	January 2019 data contained valid fetus outcome code for at least 80% of births
19	January 2019 data contained valid birth weight for at least 80% of births
20	January 2019 data contained valid figure for previous live births for at least 80% of bookings
21	MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance
22	January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Required standard	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN
Minimum evidential requirement for trust Board	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.

Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) By Sunday 3 February 2019 b) By Sunday 3 February 2019 c) By Sunday10 March 2019 d) By Sunday 19 May 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 3
Can you demonstrate that you have transitional care facilities in place and are operational to support the implementation of the ATAIN Programme?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: www.bapm.org/sites/default/files/files/TC%20Framework-20.10.17.pdf www.bapm.org/sites/default/files/files/NCCMDS.%20Neonatal%20HRGs%20and%20Reference%20Costs%20-%20A%20Guide%20for%20Clinicians%20Dec%202016.pdf
What is the suggested time period for transitional care pathways?	We would expect that all trusts should at least have pathways agreed by 31 January 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?

Required standard	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.
Minimum evidential requirement for trust Board	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) 2018 GMC National Training Survey (covers the period 20 March to 9 May 2018) b) Six month period between January 2019 and June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 4
Can you demonstrate an effective system of medical workforce planning?

Technical guidance	
What if training opportunities are not being lost due to rota gaps and action plan not deemed necessary?	If training opportunities are not being lost due to rota gaps, then a copy of the trust Board minutes acknowledging and recording this, including the relevant 2018 GMC National Training Survey results, should be submitted to RCOG instead.
Anaesthesia Clinical Services Accreditation (ACSA) standards and action	
1.2.4.6	**Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff**
2.6.5.1	**A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident**
2.6.5.2	**A separate anaesthetist is allocated for elective obstetric work**
2.6.5.3	**Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies**
2.6.5.4	**Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)**
2.6.5.5	**There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)**
2.6.5.6	**The duty anaesthetist for obstetrics should participate in labour ward rounds**
How is an elective caesarean section list defined?	A scheduled list, resourced separately from the general workload of the delivery unit. A separately run list requires a full theatre team and should include a consultant obstetrician and a consultant anaesthetist. The list should be managed in the same way and to the same standards as other elective surgery lists. This may not be cost effective in units with a low elective workload (e.g. one or fewer elective caesareans per weekday or approximately 250 planned operations per year) but for all other units, separate resources should be allocated.

What is level two care or a level two maternal critical care patient?	Since 2007, the obstetric population has been included in the Intensive Care Society (ICS) definitions of levels of care in the adult population. Levels of care as defined by the ICS: **Level 0** Patients whose needs can be met by normal ward care **Level 1** Patients at risk of deterioration, needing a higher level of observation or those recently relocated from higher levels of care **Level 2** Patients requiring invasive monitoring/intervention that includes support for a single failing organ (excluding advanced respiratory support i.e. mechanical ventilation) **Level 3** Patients requiring advanced respiratory support alone or basic respiratory support in addition to support of one or more additional organs
Please access the following for further information on the ACSA standards	https://www.rcoa.ac.uk/system/files/ACSA-STDS2018.pdf

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board
Minimum evidential requirement for trust Board	A bi-annual report that includes evidence to support a-c being met. This should include: •A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. •Details of planned versus actual midwifery staffing levels. •An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls

	•Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	Any consecutive three month period between January to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 5
Can you demonstrate an effective system of midwifery workforce planning?

Technical guidance	
What midwifery red flag events could be included (examples only)?	• Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637

Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Required standard	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).
Minimum evidential requirement for trust Board	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts at end July 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 6
Can you demonstrate compliance with all four elements of the SBL care bundle?

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle and guidance: www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
Further guidance regarding element 2 of the SBL care bundle	In reference to element 2 of the Saving Babies' Lives care bundle, compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.

Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Required standard	User involvement has an impact on the development and/or improvement of maternity services.
Minimum evidential requirement for trust Board	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From January 2019 to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Required standard	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.
Minimum evidential requirement for trust Board	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts by Thursday 15 August 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 8
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Technical guidance	
What training should be included?	Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops.
What training syllabus should be used?	Training syllabus should be based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas.
Should there be feedback?	There should be feedback on local maternal and neonatal outcomes.
Which maternity staff attendees should be included?	Maternity staff attendees should be 90% of <u>each</u> of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity theatre and maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) There will be other relevant clinical members of the maternity team that for best practice should be included in maternity emergency training for example neonatal clinical staff however evidence of their attendance is not required to meet the safety action.

What if staff have been booked to attend training after 15 August 2019	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto training and/or have not attended training, then they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold?	No, you will need to evidence to your Board that you have met the threshold of 90% for each of the staff groups before Thursday 15 August 2019.

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Required standard	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS) b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff
Minimum evidential requirement for trust Board	• Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three • Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally • Evidence of attendance at one or more National Learning Set or the annual national learning event • Evidence of engagement with relevant networks and the collaborative LLS • Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff • Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns
Validation process	Self-certification to NHS Resolution using the Board declaration form

What is the relevant time period?	a) All Board level safety champions and exec sponsor for MNHSC must have set up the required mechanisms for supporting quality and safety improvement activity in both the trust and LLS by Sunday 27 January 2019 b) Must be implemented by Wednesday 27 February 2019 c) Must be implemented by Wednesday 27 March 2019 with ongoing feedback to staff on a monthly basis
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 9
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: • https://improvement.nhs.uk/documents/2440/Maternity_safety_champions_13feb.pdf • https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/ • https://improvement.nhs.uk/documents/2956/MatNeo_Collaborative_Driver_Diagram_June_2018.pdf • https://improvement.nhs.uk/resources/patient-safety-collaboratives/

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Required standard	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.
Minimum evidential requirement for trust Board	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.
Validation process	Self-certification to NHS Resolution using the Board declaration form NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.
What is the relevant time period?	1 April 2018 to 31 March 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 10
Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Technical guidance	
Where can I find information on the Early Notification scheme?	Early Notification scheme guidance has been circulated to NHS Resolution maternity contacts. Please contact ENTeam@resolution.nhs.uk to request further copies.
What are qualifying incidents?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]** • Was therapeutically cooled (active cooling only) **[OR]** • Had decreased central tone **AND** was comatose **AND** had seizures of any kind.

	The above definition is based on the criteria set by the Each Baby Counts (EBC) programme of the RCOG. As a guide, if any incident of severe brain injury occurs which meets the above criteria and is accepted by EBC, then NHS Resolution will treat it as a qualifying incident. Incidents of intrapartum stillbirth or neonatal death as defined by EBC do not need to be notified.
General Data Protection Regulations points	We strongly recommend that all families be told of NHS Resolution involvement at the outset. NHS staff are bound by the statutory Duty of Candour. This includes an obligation to advise the 'relevant person' (i.e. the patient/their family) what further enquiries into the incident the trust believes are appropriate, one of which will be the Early Notification process. The NHS Constitution states that patients have the right to an open and transparent relationship with the organisation providing their care. This is central to maintaining the relationship of trust between the trust and family and in promoting an open and safe learning culture. NHS Resolution's Early Notification scheme involvement should be communicated soon after the incident, to coincide with notification that an internal investigation will take place. For more information please see *Saying Sorry* leaflet https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Saying-Sorry-2017.pdf NHS Resolution are able to seek disclosure of medical records without the consent of the patient/family. However it is important that individuals know that their personal data is being shared with NHS Resolution, even if you are not asking for their consent. It may also, in some circumstances, be helpful to have an indication of their authority/agreement to their information being used. However, this should not be conflated with 'consent' as the legitimising condition under GDPR. Footnote: under the General Data Protection Regulation, processing is necessary for (1) the management of healthcare systems and services (under Article 9(2)(h) GDPR/Schedule 1 paragraph 2 of the Data Protection Act 2018); (2) the establishment, exercise or defence of legal rights (under Article 9(2)(f) GDPR); and/or (3) undertaken in the substantial public interest (that is, the discharge of functions conferred on NHS Resolution further to s. 71 of the NHS Act 2006 – further to Article 9(2)(h) GDPR).

What if we are unsure whether a case qualifies for the Early Notification scheme?	If the case meets the above criteria and has been accepted by Each Baby Counts, it will be treated as a Qualifying Incident. Should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We are unsure about how to grade an incident, what should we do	The risk assessment wording has recently been amended to bring it in line with assessments used regularly by front-line staff. It is hoped that this makes the process of grading risk more straightforward. However, should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We have reported all qualifying incidents, but have not reported within the required 30 day timescale. Will we be penalised for this?	Trusts are strongly encouraged to report all incidents within the 30 day timescale set out in the reporting guidelines however there will be no penalty for reporting incidents from 2018/19 outside of the 30 day timescale. Trusts will meet the required standard if they can evidence to the trust Board that they have reported all qualifying 2018/19 incidents to NHS Resolution and this is corroborated with data held by NNRD.

FAQs for year two of the CNST maternity incentive scheme

Does 'Board' refer to the trust Board or would the Maternity Services Clinical Board suffice?	We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we may escalate to the appropriate arm's length body/NHS system leader.
Where can I find the trust reporting template which needs to be signed off by the Board?	Please follow the link to the Board declaration form **(see link below).**
What documents do we need to send to you?	Send the Board declaration form to NHS Resolution. Ensure the Board declaration form has been approved by the trust Board, signed by the chief executive and, where relevant, an **action** plan is completed **(see link below)** for each action the trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the trust Board.
Do we need to discuss this with our commissioners?	Yes, your submission should be discussed with commissioners prior to submission to NHS Resolution.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on Thursday 15 August 2019**. If a completed Board declaration form is not returned to NHS Resolution by **12 noon on Thursday 15 August 2019**, NHS Resolution will treat that as a nil response.

Will NHS Resolution be cross checking our results with external data sources?	Yes, we will cross reference results with external data sets from MBRRACE-UK, NHS Digital and the NNRD for the following actions: Safety action 1, Safety action 2 and Safety action 10 respectively. Your overall submission may also be sense checked with CQC maternity data.
What happens if we do not meet the ten actions?	Only trusts that meet **all ten** maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet **all ten** safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via MIS@resolution.nhs.uk
Please can you confirm who outcome letters will be sent to?	CNST maternity incentive scheme outcome letters will be sent to chief executive officers, finance directors and your nominated leads.
What if my trust has multiple sites providing maternity services	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole trust
Will there be a process for appeals this year?	Yes, there will be an appeals process and trusts will be allowed 14 days to appeal the decision following the communication of results.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the CNST incentive scheme and why maternity?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to us in 2017/18, obstetric claims represented 10% of the volume and 48% of the value of new claims reported. These figures do not take into account the recent change to the Personal Injury Discount Rate.

Q2) Why have these Safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), Obstetric Anaesthetists Association, Royal College of Anaesthetists, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England
- NHS Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Care Quality Commission

- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff

Q4) Who does the scheme apply to?

The scheme will only apply to acute trusts in 2018/19. However, given the schemes aim to incentivise the improvement of maternity services in all settings, we will consider extending it in future years.

Q5) How will trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at MIS@resolution.nhs.uk **by 12 noon on Thursday 15 August 2019.**

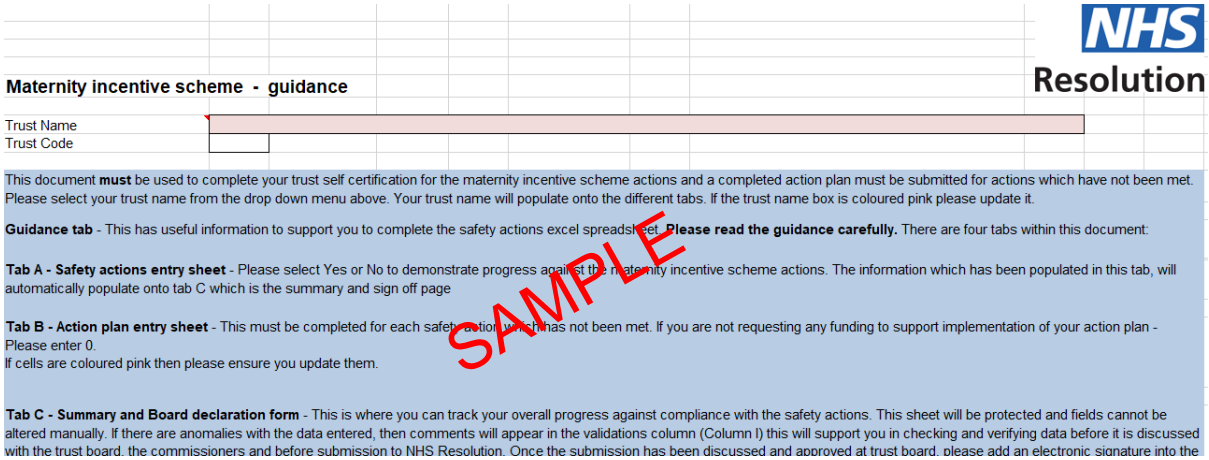
Please note that:

- Board declaration forms will be reviewed by NHS Resolution and discussed with Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the trust's responses, as detailed in the technical guidance above.
- **If a completed *Board declaration form* is not returned to NHS Resolution by 12 noon on Thursday 15 August 2019, NHS Resolution will treat that as a nil response.**

Appendix 1: Board declaration form and action plan template

To access the combined *Board declaration form and action plan template* visit:

https://resolution.nhs.uk/resources/board-declaration-form-and-action-plan-template



Maternity incentive scheme - guidance

NHS Resolution

Trust Name

Trust Code

This document **must** be used to complete your trust self certification for the maternity incentive scheme actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate onto the different tabs. If the trust name box is coloured pink please update it.

Guidance tab - This has useful information to support you to complete the safety actions excel spreadsheet. **Please read the guidance carefully.** There are four tabs within this document:

Tab A - Safety actions entry sheet - Please select Yes or No to demonstrate progress against the maternity incentive scheme actions. The information which has been populated in this tab, will automatically populate onto tab C which is the summary and sign off page

Tab B - Action plan entry sheet - This must be completed for each safety action which has not been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0.
If cells are coloured pink then please ensure you update them.

Tab C - Summary and Board declaration form - This is where you can track your overall progress against compliance with the safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, the commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the

SAMPLE

Maternity incentive scheme - Guidance

Resolution

Trust Name	**Bolton Hospitals NHS Foundation Trust**
Trust Code	**T264**

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

NHS Resolution

Section A : Maternity safety actions - Bolton Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

Maternity incentive scheme - Board declaration Form

Trust name	**Bolton Hospitals NHS Foundation Trust**
Trust code	**T264**

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Medical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Bolton Hospitals NHS Foundation Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:	
Position:	
Date:	