Bolton NHS Foundation Trust – Board Meeting 28th June 2018

Location: Boardroom **Time: 0900**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00		Integrating Health and Care for Bolton	CEO	Presentation	To approve
09.30	1.	Welcome and Introductions	Chairman	verbal	
	2.	Apologies for Absence	Trust Sec.	Verbal	Apologies noted
	3.	Declarations of Interest	Chairman	Verbal	To note any declarations of interest in relation to items on the agenda
	4.	Minutes of meeting held 31st May 2018	Chairman	Minutes	To approve the previous minutes
	5.	Action sheet	Chairman	Action log	To note progress on agreed actions
	6.	Matters arising	Chairman	Verbal	To address any matters arising not covered on the agenda
	7.	Chairman's Report	Chairman	Verbal	To receive a report on current issues
	8.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
09.40	9.	Quality Assurance Committee Chair Report	QA Chair	Verbal	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
	10.	Finance and Investment Committee – Chair Report	FC – Chair	verbal	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
	11.	Workforce Assurance Committee – Chair Report	CEO	Report	CEO to provide a summary of assurance from the Workforce Assurance Committee and to escalate any items of concern to the Board
	12.	Urgent Care Delivery Board Chair Report –	CEO	Report	To receive a report on the Urgent Care Delivery Board
10.15	13.	Mortality – six month update	Medical Director	Report	To receive the mortality update
10.30	14.	NHS inpatient Survey	Director of Nursing	Report	To receive and note the results of the 2017 inpatient survey and associated actions

Time		Topic	Lead	Process	Expected Outcome
10.40	15.	Cancer performance	COO	Report	To receive an update on cancer performance
	16.	RTT update	COO	Report	To receive an update on RTT improvement plans
	17.	TIA update	COO	Report	To receive an update on implications of performance against the TIA target

Coffee

Time		Topic	Lead	Process	Expected Outcome
11.20	18.	Sickness absence update	Director of Workforce	Report	To receive an update on actions to achieve the sickness absence target
11.30	19.	Workforce Annual Report	Director of Workforce	Report	To receive the Workforce Annual Report
11.40	20.	NHS Staff Survey	Director of Workforce	Report	To receive the results of the 2017 staff survey
11.50	21.	Performance Report	Chief Executive	Report	To receive
Strategy					
12.10	22.	Winter Plan	COO	Report	To discuss and note the plans for Winter 2018/19
Governance					
12.40	23.	Governance declarations -	Trust Sec	Report	To approve
12.50	24.	CNST		Report	To approve
Reports from Sub-Committees (for information)					
	25.	Any other business			
Questions from Members of the Public					
	26.	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					
13.00	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				

Report to:	The Board, Bolton NHS Foundation Trust The Board, NHS Bolton Clinical Commissioning Group, and The Cabinet, Bolton Council,		
Date:	28th June – 2nd July 2018		
Report of:	Health and Wellbeing Executive	**Report No:**	
Contact Officer:	David Herne – Director of Public Health	**Tele No:**	
Report Title:	**Integrating Health and Care for Bolton**		
Confidential / Non Confidential:	(***Non-Confidential)*** This report does **not** contain information which warrants its consideration in the absence of the press or members of the public		
Purpose:	This report sets out the strategic approach and required steps to progress the establishment of Bolton's Strategic Commissioning Function and an Integrated Care Partnership for Health and Social Care.		
Recommendations:	The Council's Cabinet, NHS Bolton Clinical Commissioning Board and the Board of Bolton NHS Foundation Trust, as the core statutory partners, are requested to; • Agree the strategic approach and framework described in this report and sign up to a Memorandum of Understanding on this basis as a demonstration of their commitment. • Agree the milestones as set out in sections 4.8 and 4.9 for the Strategic Commissioning Function and section 6.7 for the Integrated Care Partnership. • Agree to receive further detailed updates on specific pieces of work which will underpin the implementation of the two core components to deliver an Integrated Health and Care system.		
Decision:			
Background Doc(s):	• *Bolton Locality Plan : https://www.boltonccg.nhs.uk/the-bolton-plan-for-health-and-social-care* • *Integrated Commissioning for Health and Social Care - report to Cabinet 6th November, 2017*		

(for use on Exec Rep)

Signed:

	Leader / Executive Member	Monitoring Officer
Date:		

Summary:
(on its own page with background docs)

1 Introduction

1.1 All partners in Bolton's health and care system are passionate about improving both the services people experience, and the outcomes for Bolton's ever changing population.

1.2 We have a shared Bolton Vision for a healthier place and people as set out in our Locality Plan for Health and Social Care ;

"Bolton will be a vibrant place built on strong cohesive communities, successful businesses and healthy, engaged residents. It will be a welcoming place where people choose to study, work, invest and put down roots. We want our people and our place to prosper and we will make this happen by driving inclusive growth and reforming our services, in partnership, to promote wellbeing for all"

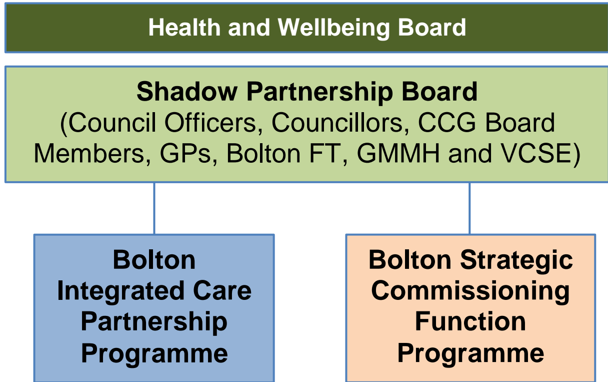
1.3 The Locality Plan describes how, in the face of increasing demand and limited resources, we must work together to sustain a financially and clinically sustainable health and care system. The integration of both commissioning and provision are critical to the delivery of this ambition; enabling the best use of our resources in a climate where "do nothing" is not an option.

1.4 This report sets out the proposals and first steps for these two interdependent programmes of work and recognises the need for strong political and clinical leadership to drive forward our Integrated Health and Social Care System. They are;

- **Bolton's Strategic Commissioning Function (SCF):** bringing professionals, politicians and clinicians together to make decisions on the best use of the Bolton Pound and to influence the wider determinants of health.

- **Bolton's Integrated Care Partnership (ICP):** joining up health and social care provision to improve outcomes for local people and, in the process, reduce demand on hospital and long term care. This will have its foundations in a neighbourhood approach to design, development and delivery of services.

1.5 The above developments will initially be overseen by a Shadow Partnership Board that will be operational from July 2018, it will be oversee the development programmes for both the Strategic Commissioning Function and the Integrated Care Partnership for Bolton as demonstrated below;



1.6 In the development of both the Strategic Commissioning Function and the Integrated Care Partnership, our overarching principles are to:

- Promote prevention and independence
- Provide person-centred health and care services

- Deliver more care in communities and by communities
- Support staff through new service models with integrated systems and pathways
- Use pooled resources more efficiently

1.7 This report sets out the ambition and the steps to move forward the SCF and ICP and seeks the approval of the core statutory partnerships to commit to the developments as set out in the report and to work with wider partners to deliver the transformation required.

2 Background - Case for change

2.1 Bolton's Population

2.2 Bolton has a growing and changing population, which will reach 300,000 over the next decade, with increasing numbers of both older people and those living with complex long-term conditions. It is recognised that the GP registered list of patients is already exceeding this figure.

2.3 Although people are living longer, they are not necessarily doing so in good health meaning demand for services is predicted to increase e.g. the number of people aged 65+ with dementia is expected to grow by 35.9% to 4,203 in 2025.

2.4 Bolton is also seeing an increase in the numbers of school age children with a particularly rapid growth in 0-4 year olds; meaning further pressures on our primary and secondary schools as the numbers of children in them rises. This will bring increasing demand on health and care services for those children with those needs.

2.5 In addition, we have increasing diversity within our population. We need to ensure that our health and care services are fully equipped to deal with the pace of this demographic shift.

2.6 Whilst Bolton does well on some measures of our population's health and wellbeing, there are many areas where we can do much better:

- **Outcomes for children;**
  - Bolton has more mothers who smoke at time of delivery and fewer women who breastfeed,
  - There are higher numbers of low birthweight babies,
  - More children living in low income families,
  - Higher rates of childhood obesity
  - More hospital stays for alcohol related harm in children

- **Outcomes for adults;**
  - Life expectancy for men and women in Bolton is slightly lower than the national average, but there are marked inequalities across the borough.
  - Life expectancy is over 10 years less for men and women in our most deprived areas compared to the most affluent and the situation is not improving.
  - Disability- free life expectancy; both men and women are likely to spend, on average, a quarter of their life with some form of disability.
  - Heart disease and cancer are the leading cause of people dying before they get old. For early deaths from heart disease, Bolton ranks 120th out of 150 local authorities in England, and 110th for early deaths from cancer.
  - Bolton sees higher than average levels of alcohol related harm, smoking related deaths, and hip fractures in older people, more deaths from drug misuse and more hospitalisation for self-harm.
  - Bolton adults are less likely to be physically active than people elsewhere in England.

- **Social care outcomes**
  - The proportion of adults who are still at home 91 days after discharge from hospital into rehabilitation or re-ablement is lower in Bolton than the national average
  - Permanent admissions to nursing and residential care are higher than average.
  - Few adults and their carers report having as much social contact as they would like
  - A lower proportion of adults with a learning disability with care needs are in paid employment compared with the rest of England.

2.7 Bolton has much to be optimistic about with forecasts suggesting increasing economic prosperity over the next ten years and an increase in employment opportunities. We need to ensure that our local population is both skilled and able as well as fit and healthy enough to respond to this growth. If not, residents in Bolton, particularly in the most deprived areas, may not benefit from the economic prosperity and the job opportunities created over the coming decade.

2.8 To meet the twin challenges of our changing population and to improve outcomes, we need a new approach that redesigns care around a person's individual needs regardless of diagnosis, with a graduated increase in support as needs rise, particularly towards the end of life. Many people in Bolton need support from both NHS and social care services and the way we arrange services can lead to gaps, duplication and confusion. We need a person and community centred approach to health and social care services to ensure that the **right care is offered in the right place at the right time.**

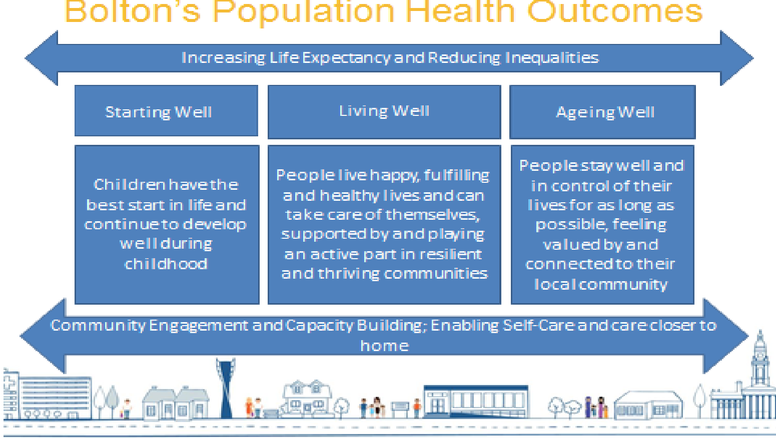
2.9 This integrated care can deliver improved patient experience as well as clinical outcomes. It can reduce use of acute and emergency care through better co-ordination with primary and community care services; reducing the need for multiple assessments and visits to different providers, supporting people to remain within their communities and maintaining their independence.

3 Our shared vision for a healthier Bolton

3.1 Our vision is about changing how health and care is commissioned and delivered to help people live healthy lives, and empower local people to support themselves. To change things, we need to work differently. This means making services more joined up, training staff to work in new ways, and supporting people to become more independent and control their own health and wellbeing. There will be a shift of services to be more focussed in communities, and away from acute settings ensuring only those that need hospital care access this when needed and are away from home for the shortest time necessary.

3.2 The financial challenge facing all of us means we will have to look carefully at what the 'Bolton pound' can and should pay for. We have already set out in our Locality Plan, our commitment to develop a population and whole family approach to the way we deliver health and social care. In future, health and care will span organisational boundaries and integrate care services; it will be rooted in the assets that lie within our neighbourhoods both the materials and the people.

3.3 The vision is for the whole life cycle and addresses the core priorities to enable children and adults to 'Start Well, Live Well and Age Well'.



3.4 Experience tells us that fragmented and disjointed care results in missed opportunities to intervene early. Systematic and joined up planning and delivery of health and care services at sufficient scale is needed to have the required impact. Integration of health and care services will mean we can :

- Prevent people becoming ill and enable them to look after themselves
- Better support the increasing numbers of people who need both NHS and social care services
- Harness the support of services which help people to attain better health like housing, education and employment
- Address the gaps, duplication and confusion caused by the way we currently arrange our services

3.5 The route to delivering this integration and improvement will be through the following two work streams;

Bolton's Strategic Commissioning Function
We will make decisions on the best use of Bolton resources together;
bring professionals, politicians and clinicians together;
influence the wider determinants of health

Bolton's Integrated Care Partnership
We will build a neighbourhood focused approach to joining up all health and social care that reduces demand on hospital and long term care.

The following sections describe these two components in greater detail.

4 A Strategic Commissioning Function (SCF) for Health and Social Care for Bolton

4.1 The SCF will focus on commissioning to improve our priority outcomes, but doing so through collaboration, co-design and co-production. It will bring together the different, but complementary skills within the Council and the CCG. The existing Bolton Commissioning Partnership Board already makes decisions on prioritisation of expenditure for a limited pooled budget. Under this governance, the local principles for joint commissioning have already been agreed:

- to improve integration of services
- to avoid gaps and duplication
- to make effective use of all skills available, whether political, clinical or managerial

4.2 The SCF proposal is to build on existing joint arrangements and pooled resources, rapidly expanding into a single, Strategic Commissioning Function for health and care services, built around our decisions on the development of our Integrated Care Partnership (ICP), which will:

- have a whole system approach to investing the Bolton pound
- build a sustainable Health and Care system
- make decisions in full view of all partners and the communities which we serve
- have professional and clinical leadership, political oversight and democratic accountability at its heart
- operate to agreed principles, values and behaviours
- improve health and care outcomes by influencing the cause of ill health as well as treating it
- commission at the right spatial level, i.e. GM, Bolton, Locality or Neighbourhood

4.3 The SCF will be a partnership that looks and feels like a single commissioning partnership but its form and function must be acceptable to the membership of both partnerships.

4.4 Whilst there is a powerful argument now for bringing these two commissioning systems together, this must be done in the right way. There are specific legal accountabilities that cannot be delegated to a joint arrangement. This means that as statutory public bodies, Bolton CCG and Bolton Council will maintain their legal and statutory responsibilities.

4.5 The SCF will build a single partnership across the system, replacing the current parallel arrangements. It will have the right balance between accountability to the local population and the insight from the expertise of the clinical community. It will maximise the joint benefits of having both clinical and elected member voice and leadership in commissioning decision-making.

4.6 It will bring together the strengths of Bolton Council and Bolton CCG; making commissioning (and decommissioning) decisions based on need, end to end pathways and appropriate allocation of resource to deliver defined outcomes and whilst contractually holding providers to account, delivering effective procurement and developing and managing the market. Our overarching principles will be to:

- Promote prevention and independence
- Provide person-centred health and care services
- Deliver more care in communities and by communities
- Support staff through new models and integrated systems and pathways
- Use pooled resources more efficiently

4.7 Our journey to the SCF will be a staged approach between now and 2021, with clear governance for the development process, working towards a single commissioning strategy that does what's right for Bolton. We have a significant shared ambition, but we will also build in to the process key decision points where the discussion can be paused if necessary to review and refine plans. Initially there will be a single adult financial pooled budget, incorporating relevant public health spend and built around decisions on ICP development, with a plan to move ultimately to a single, unified function covering all Children's Services as well as all Primary, Community and Acute services.

4.8 In 2018/19 we will:

- Create new shadow governance for developing relationships, learning and decision making
- Agree approach and scoping for formal decision making and governance for an increased pool in excess of a £100m with a clear ambition to increase incrementally
- Commence working towards a single team;
  - Joint team meetings
  - Co-location of teams
- Establish formal Memorandum of Understanding
- Commence developing proposals for integrated approach to support functions
- Commence developing proposals for integration of other spend including children's/primary care/surgery spend

4.9 In 2019/20 we will:

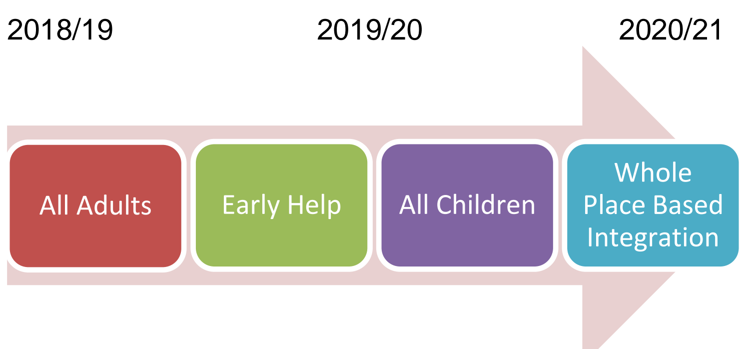
- Implement a formal Section 75 arrangement for **ALL** appropriate budgets that can be managed in that way
- Implement integrated approach to support functions
- Integrated policy, strategy and reform approach
- Shadow arrangements in place for children's/primary care/surgery spend and commissioning teams

5 An Integrated Care Partnership for Bolton

5.1 A fundamental enabler to deliver the health and social care vision is the development of an Integrated Care Partnership (ICP) where providers work together to deliver the outcomes and ambitions for the population of Bolton. An ICP will work collaboratively with commissioners to co-design new models of care and set the strategic direction and outcomes for the population.

5.2 It is recognised that the formation of an ICP requires both a top down strategic steer and bottom up innovation and design of delivery in neighbourhoods. The future form of the ICP will require strong strategic leadership to consider the options available and understand the case for change to influence the future vehicle and form of the ICP that is right for Bolton. This will consider the maturity of the partnership and core partners' infrastructure and will learn from developments regionally and nationally. The bottom up approach will build on the foundations of work to date in integrated care, and move at scale and pace to consider whole neighbourhood models of care and families as this moves forwards.

5.3 It is proposed that this would require taking a phased approach to the ICP and Neighbourhood developments in parallel to the emerging Strategic Commissioning Function and be delivered in following phases;

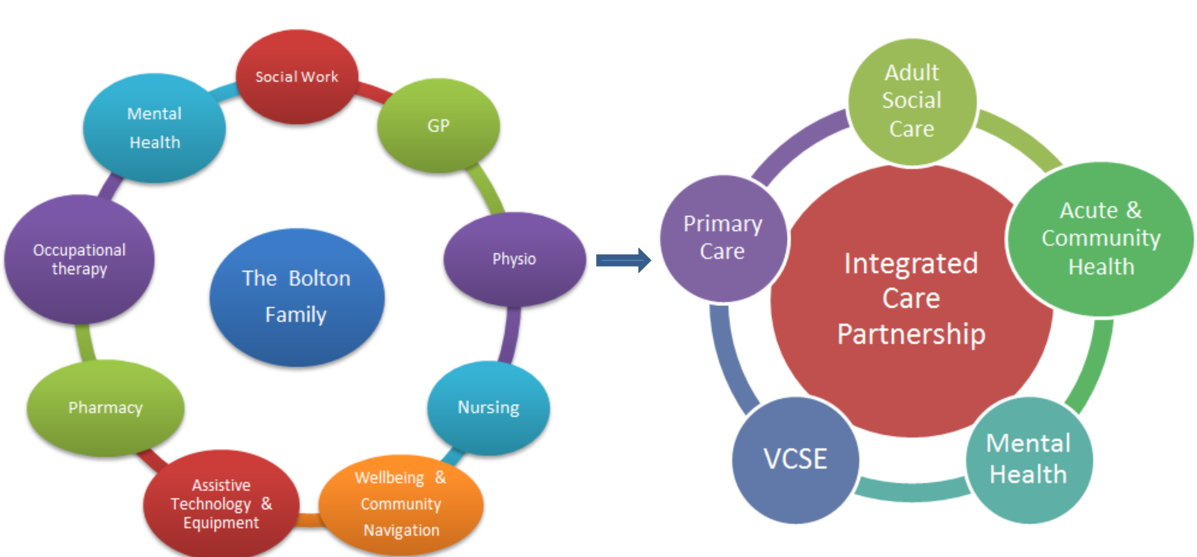


5.4 The neighbourhood model of care will prioritise its focus in 2018/19 on adults with health and/or social care needs, integrating services with a person and community centred approach. The neighbourhoods for Bolton will be designed around 30-50,000 populations and will therefore deliver in 9 neighbourhoods, bringing services together in partnership with VCSE and in future, wider public sector partners. At the core will be clinical leadership and strengths based approaches that recognise the assets that people and their communities have, moving away from condition specific approaches that is inherently passive, seeing problems to treat, to a model that ensures that people's needs are looked at holistically.

5.5 The key priority design aspects for neighbourhoods in response to engagement of people with lived experience will be to improve;

- Co-ordinated access and person centred care – 'tell my story once'
- Holistic assessment and 'Think Home First', with shared care records
- Support that is local, with choice and control for 'just enough care'
- Pathways for prevention and self-management
- Access to intermediate tier and specialist care when needed
- Upscale the use of assistive technology and community solutions

5.6 Work to date through GP leadership, Nesta and the review of Integrated Neighbourhoods has recognised the need to bring the following professionals together in a neighbourhood to wrap support and pathways around people, these then influence the core partnership of providers required in the Integrated Care Partnership;



The Neighbourhood Model to Integrated Care Partnership

6 The Ambition for the ICP

6.1 The ambition for Bolton's Integrated Care Partnership is to bring together a partnership of providers as identified above and influenced from the emerging integration designs for neighbourhoods. It is proposed that the development of the partnership will be supported by Bolton NHS Foundation Trust as the main statutory provider within the partnership. This will bring system wide leadership to the development of the partnership and an infrastructure to support the necessary transformation needed.

6.2 The partnership's principles will be to;

- Promote prevention and independence
- Provide person centred health and care services
- Deliver more care in communities and by communities
- Support staff through new models and integrated systems and pathways
- Use pooled resources more efficiently and effectively

6.3 The ICP will be a fully integrated care system of health, social care, and third sector providers collaborating together to take control of outcomes for the population. It will consider how best to use resources effectively across the partnership and, in the future, move to integrate budgets and resources where possible to make best use of the Bolton pound. The transformation requires a number of services to come out of the hospital and to be delivered in the community, with some at a neighbourhood level and others that are more specialist to be provided at a Bolton level.

6.4 The development of the ICP will need to consider the challenges locally and nationally, and the governance will recognise the constraints of current national regulations and legislation, as well as political debates and perceptions of such ventures as Accountable Care Systems (ACO). Through its development, the ICP will need to build trust, collaboration and system leadership to oversee, design and deliver integration and transformation. It is proposed that, in its first stages, the ICP will be constituted with a partnership agreement as a Memorandum of Understanding and will not exist as a distinct legal entity, this will formalise the commitment and set out the arrangements by which the partners will work together.

6.5 The Foundation Trust will;

- Provide system leadership to bring together provider partners
- Maintain and further develop options for the partnership approach for Bolton's ICP
- Ensure the partnership is truly cross sector and maximises the opportunity for provider partners to contribute and feel valued in the partnership
- Act as conduit on behalf of the partnership developments and take lead responsibility in the day to day relationship with the SCF
- Establish and maintain the governance and support service networks that will be essential to the range of services in scope as they grow and integrate

6.6 Ultimately, it is anticipated that the ICP will develop and take responsibility for the population budget to deliver whole system outcomes and a contract that reflects this ambition. The future vehicle for delivery will need to be determined through undertaking a full appraisal of options, maturity assessment and case for change for decisions moving forwards.

6.7 In summary the key milestones to establish the ICP will be;

- The Partnership to test ways of working, but for there to be no changes to current contractual/funding or constitutional arrangements within 2018/19.
- To establish a provider partnership agreement by September, 2018.
- To complete a full appraisal of different options for future models post 2019/20, including a maturity assessment and case for change by December, 2018.

6.8 The first year's focus for the partnership will be on the following areas in developing new ways of working, and using resources effectively:

- Redesigning and implementing a neighbourhood model of care based on health and care services for adults
- Redesigning the scope of services that support admission avoidance, supported discharge and intermediate tier services including discharge to assess pathways.
- Developing primary care; including GP leadership, and enhanced primary care workforce, and a new service for extended and out of hours primary care
- Delivering a coherent population health, wellbeing and prevention programme including social prescribing, community asset building and navigation
- Increasing and investing in integrated mental health and integrated learning disability services
- Transforming the hospital services from acute focus into community

7 Summary

7.1 The key aspects as set out in this report are required to progress the integration of health and social care for commissioning and provision to improve the experience, outcomes and sustainability of the system;

- Creation of a unified single Strategic Commissioning Partnership between the Council and CCG, with new shadow governance for developing relationships, learning and decision making.
- Scoping out governance and decision making to oversee an increased financial pooled budget to be overseen by the Strategic Commissioning Function.
- Scoping and alignment of support functions for both the Strategic Commissioning Function and Integrated Care Partnership.
- Creation of a partnership of providers to be recognised as Bolton's Integrated Care Partnership to test new ways of working and build on neighbourhood models of care, and that this will be supported by Bolton NHS Foundation Trust.
- To complete a full appraisal of different options for future models and vehicle for the Integrated Care Partnership post 2019/20, including a maturity assessment and case for change for future Cabinet and Board approval.

8 Recommendations

8.1 The Council Cabinet, NHS Bolton Clinical Commissioning Board and the Board of Bolton NHS Foundation Trust, as the core statutory partners, are requested to;

- Agree the strategic approach and framework described in this report and sign up to a Memorandum of Understanding on this basis as a demonstration of their commitment.
- Agree the milestones as set out in sections 4.8 and 4.9 for the Strategic Commissioning Function and section 6.7 for the Integrated Care Partnership.
- Agree to receive further detailed updates on specific pieces of work which will underpin the implementation of the two core components to deliver an integrated health and care system.

May 2018 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/17/110	21/12/2017	Infection control review	full report to QA Committee	TAC	Jun-18	agenda item QA committee complete
FT/18/43	31/05/2018	Gender pay gap	James M to forward Gender Pay gap report to JN	JM	Jun-18	complete
FT/18/45	31/05/2018	SI report 112030 unexpected death	TAC to discuss with SH and revise final report to reflect Board discussion - final approval by email	TAC	Jun-18	complete
FT/18/44	31/05/2018	Waste management internal audit report	for review at Exec Director meeting	ES	Jun-18	complete
FT/18/42	31/05/2018	Finance Committee Annual Report	Update F&I committeeTerms of reference as discussed (change wording from review to approve	AW	Jun-18	complete Terms of Reference updated
FT/18/20	29/03/2018	Pathology reconfiguration	follow up report on risks to June Board	JB	Jun-18	agenda item
FT/18/18	29/03/2018	Winter plan	Winter plan to June board of Directors	AE	Jun-18	agenda item
FT/18/29	26/04/2018	Performance report	Update on changes to breach allocation and cancer pathway	AE	Jun-18	agenda item
FT/18/30	26/04/2018	Sickness Absence	update in June 2018 with trajectory to reach 4.2%	JM	Jun-18	agenda item
FT/18/40	31/05/2018	Performance report	Briefing note to provide update on the sector approach to TIA patients	RW/AE	Jun-18	agenda item
FT/18/41	31/05/2018	RTT trajectory	Update to provide further detail on the risks to achievement	RW/AE	Jun-18	agenda item
FT/18/15	29/03/2018	Patient Story	Director of Nursing to pick up issues relating to patient information and practical advice	TAC	Jun-18	Verbal update
FT/18/19	29/03/2018	Gender pay gap	Follow up report to Workforce Assurance Committee to clarify data queries and follow up on actions taken	JM	Jun-18	verbal update
FT/18/23	26/04/2018	Patient Story	Discuss plans for SCBU environment at Strategic Estates Board	JB	Jun-18	verbal update
FT/18/39	31/05/2018	Data Centre replacement	Confirm that options for cloud hosting have been fully covered	JB	Jun-18	Verbal update
FT/18/46	31/05/2018	department visit - Opthalmology	RW to address item escalated with regard to dispensing "diamox"	RW	Jun-18	Verbal update
FT/18/25	26/04/2018	Access to Bolton Care Record	Action for QA Committee to look at actions to address Junior Doctor access to Bolton Care Record	AE	Jul-18	
FT/17/117	21/12/2017	Equality and Diversity	update on E,D&I	TAC	Jul-18	
FT/18/16	29/03/2018	Discharge medication	update report on discharge medication to the QA committee	SH	Jul-18	
FT/17/96	30/11/2017	Performance report	TAC to provide update on trajectory to achieve recommended fill rate	TAC	Jul-18	
FT/18/05	25/01/2018	Nurse staffing report	next report to include further information on retention/attrition	TAC	Jul-18	
FT/18/31	26/04/2018	Data Security	update on plans for full implementation	AE	Jul-18	
FT/17/92	26/10/2017	Board Assurance Framework	Audit Committee to discuss potential to revise report to include a projected score if actions have desired effect	ES	Oct-18	date changed to align with BAF presentation to Board
FT/18/38	31/05/2018	Patient Story	six month update on Patrick's story to QA committee	ES	Oct-18	

Key

complete	agenda item	due	overdue	not due

Agenda Item No: 08

Meeting	Board of Directors

Date	28 June 2018

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 • Board Assurance Framework summary

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	Jackie Bene Chief Executive

All information provided in this written report was correct at the close of play 20/06/2018 a verbal update will be provided during the meeting if required

1. Awards and recognition

March 18:

Team: CDU – who were nominated twice in month for the professional and safe way they dealt with a small fire in the department; they remained calm and ensured that agreed safety protocols were followed to the letter and patient safety was not compromised.

Employee: Jane Lim Staff Nurse on D1 Ward – we received a nomination from a member of the public about the care Jane provided to her mother whilst on D1 ward; Jane was described as being caring, lovely and respectful.

April 18:

Team: Golden Discharge Team – nominated as a new team which has quickly come together to make a positive impact on the care and support we provide to our patients and our wards; the team work together very well across the professional boundaries and grades and have created and embraced a shared vision to assist with timely patient discharges.

Employee: Marilyn Day – Clerical Supervisor in Health Records – Marilyn was nominated by her colleagues and manager for the support, dedication and hard work she provides in her role; Marilyn is described as always positive, and someone who puts others before herself. She is seen as a real role model for the service.

CIO of the year

Our Chief Informatics Officer Phillipa Winter is one of three CIOs shortlisted in the Digital Health Awards 2018. The peer-voted awards will be presented at the networking dinner at the Digital Health's Summer Schools, Birmingham, 19 July.

2. Stakeholders

2.1 NHSI/NHSE

Prime Minister's speech on NHS funding

On 18th June the Prime Minister announced a new five year funding settlement for the NHS. An NHS Provider briefing summarising the announcement is appended to this update.

Urgent Care Escalation Meeting

Along with colleagues from Bolton CCG and Stockport and WWL FT and CCG I attended an urgent care escalation meeting on 6th June to provide a review of winter 2017/18 and an outline of plans for 2018/19 including plans to reduce length of stay especially for superstranded patients and DToCs.

Pauline Philip, national director of urgent and emergency care at NHS England and NHS Improvement, has written to acute trusts, CCGs, STPs and others to announce a new national ambition to reduce bed occupancy by reducing the number of long stay patients (and long stay bed days) in acute hospitals by 25%. For Bolton this figure is based on a baseline of 101 patients in 2017/18. Achieving this will require concerted effort across the whole health and care system.

18 Weeks

NHS Bolton CCG received a letter from Jeremy Hunt expressing congratulations on the improvement against the 18 week RTT target in March 2018.

NHS 70th Anniversary

The Trust will be represented at a number of national events taking place over the next month to celebrate the 70th anniversary of the NHS,. Within the Trust plans are well underway for our Summer Fair on 7th July 2018.

Findings of the Gosport Independent Panel

Board members may have heard recent media reports following the publication of an independent panel review which concluded that more than 450 elderly patients were given opioid drugs they did not need. The Director of Quality Governance will review chapters 4 and 12 of the report and offer both the End of Life Committee and Medications Safety Committee chairpersons a view as to whether something like this could happen again

2.2 CQC

The Director of Nursing met with our new Lead CQC Inspector Jonathon Driscoll for a quarterly review meeting. A new template is now in use for these meetings with line by line scrutiny across the metrics within the insight report (previously reviewed at QA committee)

2.3 Greater Manchester Devolution

No update

2.4 North West Sector

An Exec to Exec meeting was held with WWL on 19th June 2018 to review progress against the workstreams identified for collaboration. An update will be provided within the part two meeting.

2.5 Bolton

An update on the development of an MoU for collaboration across the local health economy will be presented to the Board for discussion

Reportable Issues Log

Issues occurring between 22/05/18 and 20/06/18

3.1 Serious Incidents and Never events

One SI declared in June relating to an unexpected admission to the neonatal unit following birth on delivery suite on 28 May 2018.

3.2 Red Complaints

One red rated complaint has been escalated relating to clinical care – this will be investigated in accordance with the policy

3.3 Whistleblowing

Nothing to report

3.4 Media issues

We received positive local media coverage for Sir David Crausby's visit on 8th June to present NHS70 parliamentary nomination certificates to the Stroke team and to the ED minors team.

Content given to the media in the form of press releases and archive pictures as part of the NHS 70 celebrations has resulted in a number of articles in the local press. We have also attracted a lot of local publicity for the Summer Celebration event on July 7.

Communications also supported the management of information around the recall of breast screening, liaising with staff within the organisation, managing patient expectation/ fears by publishing content on our website and social media, and responding to press inquiries.

4 Board Assurance Framework

The Board Assurance Framework has been developed to provide the Board with assurance with regard to the actions in place to ensure achievement of the objectives in the 2017/19 Operational Plan.

The risk score – the product of the likelihood of failing to achieve and the impact of a failure to achieve each objective is reviewed monthly in alignment with the production of the performance report.

For objectives given a score of 16 and higher, the full Board Assurance Framework sets out the risks to achieving the objective, the controls and assurance in place to mitigate the risks and the actions required where there are gaps in controls or assurance. A summary of this is provided on the following page.

A full review of the BAF will be undertaken during July and August, the Risk Management Committee are also considering whether additional assurance could be provided through a Corporate Risk Register.

	Trust Wide Objective	Lead	I	L		June	May	April	Feb	Key Risks/issues	Key action	Oversight
1.1	Reduce healthcare acquired infections	DON as DIPC	4	4	-	16	16	16	16	Sub-optimal of robust clinical engagement with Antimicrobial Stewardship. Areas for improvement identified in external review in March 2018	Implementation of all key actions from th IPC review – July 2018	IPC committee
1.2.1a	For our patients to receive safe and effective care (pressure ulcers)	DON	5	2	-	10	10	10	10	No identified risks, sharing, learning arrangements robust.	Maintain current governance arrangements and enhance ward based training (calibrated to releasing staff safely)	QAC and Harm Free Care
1.2.1b	For our patients to receive safe and effective care (falls)	DON	5	3	-	15	15	15	15	Sub-optimal adoption of all preventative falls measures consistently	Implemented updated Falls Action Plan	QAC and Harm Free Care
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	3	-	16	16	16	16	Escalation of ill patients, Increase in HSMR/RAMI	Roll out mortality review process Drive further improvement in ward observation KPI's Ensure Patient Track Oversight Group delivers on action plan Deliver on Quality Account 2017/18 sepsis actions (March 2019)	Mortality reduction
1.4	Staff and staff levels are supported	DON	4	5	-	20	20	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 to be approved by the Board in August 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	Late decisions in A/E Beds coming up late Lower discharges at weekends Staffing in key departments Urgent Care pressure and increased demand on Diagnostic and Elective work	Urgent Care programme plan SAFER ECIP support Enhanced pathways as part of the new streaming model commences Oct 2018	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability	DOF	5	4	-	20	20	20	20	Healthier Together Access to Transformation Fund Delivery of cost improvement plans Lack of workforce leading to agency cost pressures Impact of GM theme work Fragmentation of commissioning Organisational change NHS funding settlement Efficiency requirements	Develop Estates Master Planning Implement Capital planning process – RIBA implementation Develop strategic approach to cost improvement Locality plan delivery Joint system savings approach LCO Development Strategic financial planning for 5 year timeframe	IPM F&I comm System groups:-System Board Strategic Estates group HWBE
4.4	Compliance with NHS improvement agency rules	DoW	4	4	-	16	16	16	16	Sickness absence Workforce shortage Gaps in rotas	Additional admin support for wards. Ongoing recruitment Targeted actions to address sickness absence	IPM Workforce comm
5.4	Achieving sustainable services through collaboration within the NW sector	CEO	5	4	-	20	20	20	20	Estates and IT challenges Healthier Together/GM devolution	Board paper June 2018 on collaboration Exec to Exec and Board to Board with WWL Q2	Board F&I
5.5	Supporting the urgent care system	COO	5	4	-	20	20	20	20	Intermediate care delays Late bed availability Delayed transfer/discharge of medically well patients Lack of Social Care Capacity	Estates improvements to A&E – Phase 2 (new resuscitation and ambulance triage) expected completion July2018 Phase 3 (increased triage/consultation rooms and new reception/ wait area) expected Oct 2018	Urgent care prog board

All information provided in this written report was correct at the close of play 20/06.18 a verbal update will be provided during the meeting if required

Prime Minister's speech on NHS funding commitment: 18 June 2018

Today the Prime Minister Theresa May has announced a new five year funding settlement for the NHS, giving the service real terms growth of more than 3 per cent for the next five years. In a major speech today at the Royal Free London NHS Foundation Trust and two interviews over the weekend she has also tasked the NHS with producing a 10-year plan to improve performance, specifically on cancer and mental health care, and unpick barriers to progress.

This briefing summarises the announcements and includes our view on the announcements. Our press statement is also copied at the end of this document.

Key announcements

Government reveals more money for the NHS

- The government has announced a major new package of funding for the NHS covering the five financial years from 2019-20.
- The average annual uplift is 3.4 per cent per year above inflation – based on Office for Budget Responsibility projections.
- The funding is frontloaded, meaning the annual rates of growth are: 3.6%; 3.6%; 3.1%; 3.1%; 3.4%.
- This will equate to £20.5bn more revenue in real terms compared with 2018-19.
- A further £1.25bn has been found to deal with an increase in pensions costs associated with the new Agenda for Change pay deal.
- The funding is for the NHS England commissioning budget only. This means it does not include capital funding, public health, health education, or social care.
- In an appearance in front of the Public Accounts Committee this afternoon, Simon Stevens said there was an explicit commitment from the government that the adult social care budget would be set to not put further pressure on the NHS.
- Although there have been assurances that these will be protected, there is no hard data on these areas and it is not clear whether these budgets, which have been cut in the past, will be restored to or simply ring-fenced at their current levels.
- This afternoon, Simon Stevens told MPs the extra money does include funding for an increase in Agenda for Change salaries from next year.
- How the increase will be funded is unclear. While the prime minister has emphasised that some of it will come from monies no longer being paid to the European Union, along with tax and borrowing rises, the "Brexit" element has been disputed by economists.

A 10 year plan

- In return for the increase in funding, the NHS has been tasked to develop a 10-year plan, via an "assembly" convened by national leaders. The prime minister has emphasised that this should have strong clinical input.
- The 10-year plan, which will likely be delivered by the autumn budget, should set out how the service intends to deliver major improvements in mental health and cancer care.
- Ministers may be considering legislative reform: the prime minister described the number of contracts held between NHS organisations as a "problem", and said she wanted the service to suggest ways of breaking down any barriers that might hold up progress, including in the regulatory framework.
- The prime minister set out five priorities for the NHS: Putting the patient at the heart of how care is organised; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention; and "true parity of care" between mental and physical health.
- The prime minister said she would like to see the 10-year plan set out ambitious "clinically defined access standards" for mental health.
- And, she said clinicians should confirm the NHS is focused on the right performance targets for both physical and mental health – indicating that ministers may be willing to reconsider key performance standards.

NHS Providers View

The government's recognition that the NHS needs significantly more money, urgently, and a credible long-term plan for improving care, is welcome.

The 3.4 per cent average annual real terms uplift is at the upper range of what the service could realistically expect given the pressures on the public finances – but is at the lower end of what the NHS needs to remain viable. It is significantly better than the NHS has received in recent years, and is of another order to what other public services have had since 2010. However it is still below the 3.7% average real terms growth the NHS has seen during its history.

It is also for the best that the funding is frontloaded as the provider sector needs cash upfront as soon as possible to return to balance. The confirmation that it will not include a further £1.25bn to cover a specific pensions cost is an encouraging sign that the government is serious that this new funding is spent on improving care.

However we should be under no illusion that this money will fix every problem the NHS has straight away. Workforce numbers to support improved capacity will not be able to rise overnight, and better service models take time to develop, test and implement. Most importantly, even if the £4bn underlying deficit stops growing, it means that much of this new money is effectively already being spent on services as they currently are. This must be borne in mind when it is decided what more should be asked of the service in return for the new money.

While provider trusts will agree with the prime minister that the 10 year plan should include a route out of deficit for every organisation, the government must know that this will be a tall order as long as extra funding only just keeps up with demand and cost growth. It will be impossible unless well-led trusts are offered the chance to reset their finances – for example ending the high-interest loans regime currently affecting some of the trusts most in need of assistance.

The new funding settlement only covers the core NHS England commissioning budget. There have been broad commitments to protect public health funding, health education, social care and capital – however we would like to be assured that these essential budgets, which have been cut in recent years to the detriment of the service, will be restored. We are particularly disappointed that there is no clear link between this announcement and the future of social care, as a long-term plan for one cannot be made without clarity and security for the other. Likewise the prime minister was right to identify prevention as a priority – the government must now back this up with serious investment.

Making mental health services a central theme in the Prime Minister's speech was appropriate and timely. These vital, life-saving services deserve national focus and we look forward to working with the government and arm's length bodies to work out how they can be expanded and patient experience improved.

The decision to ask the service itself to draw up the ten-year plan, with an emphasis on clinical input, is preferable to a set of requirements being handed down from Whitehall. It suggests that the government understands that any plan has a better chance of succeeding if it has buy-in from the frontline from the beginning. We will work with national leaders to ensure this is a meaningful process of engagement.

We will watch with interest how proposals to cut bureaucracy develop. The prime minister's speech today emphasised the difficulties caused by legislation and contractual barriers, and we would like to see these unpicked, although would caution against a large-scale reorganisation as these tend to be disruptive and take focus away from delivery. However in the past "cutting bureaucracy" has been used as a pretext for reducing spend on management, which in recent years has gone so far that is now impacting on the service's ability to operate effectively.

The prime minister has invited "the health and care community", as part of the 10-year planning process, to make proposals on where existing legislation and regulation create barriers to better care. This is the right approach, as the current framework is not fit for purpose. We look forward to helping inform this work, in the understanding that a service as large and as vital as the NHS will always need regulation, but this should be streamlined and not duplicative. We would like to see organisational obstacles to better care unpicked, although would caution against a large-scale reorganisation as these tend to be disruptive and take focus away from delivery.

We note the prime minister's comments that the 10 year plan should improve efficiency. We agree that every penny of taxpayers' money should be spent as wisely and effectively as possible, but would caution that the current rate of savings cannot be safely sustained: since 2010 much of the total saved has been

through holding down pay, and last year nearly £900m of provider-side efficiencies came non-recurrently. Generating more savings will have to come from large-scale service transformation which will require upfront investment.

While we share ministers' enthusiasm for technology as a key enabler of the best quality healthcare, we must not mistake it for an alternative to investing in skills or capacity.

NHS Providers press statement

Responding to the Prime Minister's speech on a long-term plan for the NHS, the chief executive of NHS Providers, Chris Hopson, said:

"We welcome the extra funding and ambitions for a long term plan to improve the quality of care the NHS is able to provide to the public. The NHS has faced a decade of austerity but we now have an opportunity to invest in our staff, buildings and services to meet the expectations the public rightly has.

"The proposed annual increases are in line with the level needed to maintain current services against rapidly rising demand. We know that to deliver improvements beyond this we will need to do more to make the NHS as efficient as possible. But we must be realistic about what more can be achieved given the NHS is already outperforming the wider economy on productivity. NHS trusts delivered efficiency savings last year of £3.2bn – this firmly places the NHS as one of the most efficient health care systems in the world.

"This welcome funding settlement will also still mean we face difficult choices on what our priorities should be. It is vital that NHS trusts have a strong role in shaping and agreeing the delivery plan so that the NHS frontline has a set of financial and performance goals that are realistic and can actually be delivered.

"A key part of this will be the delivery of a comprehensive plan to ensure we have the right staff and skill mix in place to deliver high quality services. It will also mean ensuring we are able to join-up and integrate services for the public much more effectively than we are now able to. The existing legislation continues to be a barrier to more integrated care and causes unnecessary bureaucracy, so we welcome the Prime Minister's offer for NHS leaders to develop proposals for how the legislation may be simplified.

"Finally, we welcome the Government's commitment to addressing social care as well as other critical areas of health expenditure, such as public health and prevention, that are not covered in this announcement. We are clear that fixing NHS funding without doing the same for these other vital areas will simply store up problems for front-line health services, as well as falling short of the care and support the public needs."

Committee/Group Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	20 June 2018	Date of next meeting:	18 July 2018
Chair:	Andrew Thornton	Parent Committee:	Board of Directors
Apologies:		Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story		The division shared a patient story to illustrate the service provided by the bladder and bowel service through the healthy bowel clinic. The case shared illustrated the benefits of the service and the can do attitude of staff who showed compassion through the provision of patient centred care	CCG Committee representative to raise issue of funding and guidance for GPs on benefits of transanal irrigation
Clinical Governance and Quality Committee		Positive assurance from divisional reports, stillbirth report, and nutrition group report. Update provided on Good to Outstanding reviews No significant risks escalated but some areas with potential moderate risks including mortuary breaches, facilitating safer discharge with medicines and responding to actions in SI reports	The committee noted the actions in place to address the issues raised. Frequency of Infection Control Committee increased to monthly
Divisional Quality Report – Elective Care		Comprehensive report providing clear overview of areas of challenge and assurance that actions are in place to address issues	Pharmacy update scheduled to the August QA committee
Divisional Quality Report – Family Care		Comprehensive report providing clear overview of areas of challenge and assurance that actions are in place to address issues.	

	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

Inpatient Survey Results		Overall strong performance, improved performance on 47 of 63 indicators and better than other Trusts for 48 of 63 indicators. Performance worse than other trusts for 15 indicators and performance deteriorated from previous year for 9 of the 63 indicators	Action to publicise the strong performance Agenda item for Board
Sepsis Report		Comprehensive report providing assurance of significant year on year improvement in terms of improved mortality for this group of patients	Report noted
Nutrition six monthly report		Update provided on the work undertaken to address the food standards as outlined in the Department of Health toolkit	Report noted – six monthly updates requested
Dementia update		Update provided on the structured programme to deliver quality initiatives and enhance care	Report and action plan noted
Infection Control – External Review		Proactive external review commissioned to review the Trust's process for managing the risk of C. difficile. A number of actions highlighted particularly with regard to antimicrobial stewardship and decontamination	Actions noted
Radiology Reporting		Update provided following a report provided in response to a CQC review in Portsmouth. The Committee noted the update but had some concerns with regard to reporting times	Follow up report to provide assurance with regard to median waiting time and any clinical consequences of reporting delays
CNST report		Comprehensive report and evidence to support Board declaration for CNST discount incentive. Committee members reviewed the declaration and challenged the evidence provided to assure themselves with regard to the declaration	The QA Committee agreed to recommend Board approval of the declaration (Board agenda item)

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Committee/Group Chair's Report

Patient Experience, Inclusion and Partnership Committee		The PEIP Committee Chair reported receipt of assurance through a number of comprehensive reports including Q4 complaints and PALS report and the Bowel Cancer Screening Patient Experience update	Report noted
Mortality Committee		SHMI 106, RAMI 89.23 (both "as expected)	Report noted
Risk Management Committee		Progress made with regard to iFM risk registers Health and Safety Chair report identified action being taken to ensure staff receive appropriate education in relation to IOSH and COSHH. Positive PwC report on risk management arrangements within divisions	Report noted
Safeguarding Committee		Report advised that the Committee were assured by updates from the Safeguarding team	
Comments			
Risks Escalated			

	No assurance – could have a significant impact on quality, operational or financial performance;
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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

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	19th June 2018	Date of next meeting:	24th July 2018
Chair:	Allan Duckworth	Parent Committee:	Board of Directors
Apologies:	D Wakefield, A Ennis	Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Finance Report (Month 2)	Amber	Director of Finance	Key points noted from the Finance & Activity Report: - The Trust has a year to date deficit of £2.1m when STF and impairments are excluded from the position; £1.1m worse than plan. - Against the control total the Trust has a deficit of £1.0m; £0.9m less than plan. - There are no Balance Sheet adjustments released into the position. - Agency costs are at £1.5m against a year to date plan of £1.0m. - ICIPs at £0.4m are £0.9m below plan for the year. - The month end cash balance is £10.0m which is better than plan by £6.0m this month. - Year to date capital spend is £1.6m which is £0.2m above the capital plan. - The Trust Use of Resource Rating is 3 as at the end of Month 2 which is below plan. Another disappointing month with further under performance against control total targets due largely, once again, to under achievement of ICIP/pay spend/reduced income. Lack of progress in addressing agency spend and Divisional forecasts, (including development of a full ICIP programme) is of particular concern.	Key material risk for the year remains Divisional performance/ICIP delivery. Agency spend was once again significantly over plan and continues to cause particular concern. Strong concern was also expressed at the significant and ongoing variances between Divisional forecasts and Trust plans. **The lack of reported progress in these priority areas prompted a call for urgent action to demonstrate improvement/mitigation by the end of Quarter 1**. A risk that PSF targets may be missed was also raised and will be escalated. The cash position continues to improve but the underlying causes for concern remain. Cash and Balance Sheet strength are still regarded as key risk areas for the year.

Key	Description
Red	No assurance – could have a significant impact on quality, operational or financial performance;
Amber	Moderate assurance – potential moderate impact on quality, operational or financial performance
Green	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

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
2018/19 Capital Plan	Amber	Director of Finance	The Committee received an updated paper outlining the 2018/19 Capital Programme together with details of the approach used to prioritise the plan. (As previously reported, there was an urgent need to prioritise bids to confirm the 2018/19 capex plan within the cap of £20.7m.)	The Committee agreed the process and approach adopted in prioritising the capital programme for 2018/19 as reasonable and will recommend this to the Board, subject to minor adjustments raised by the Strategic Estates Board. Some concern was expressed regarding the element of funding that will be internally generated (£2.1m) and will therefore be at risk if full year targets are not achieved.
Actions to Control Agency Spend	Amber	Director of Workforce	The Committee received a report from the Director of Workforce which provided an update on actions being taken to reduce agency spend to an acceptable tolerance level. The Trust has not met its agency target. During April the Trust spent £771k on agency staff, against a maximum target spend of £485k. This represents an increased spend against the previous year's Month 1 position of £72k and £286k above plan for this financial year.	Concern was expressed that the paper exposed a number of serious deficiencies in basic management discipline. The report did not, however, provide enough detail on delivery expectations and/or results that will be achieved by the actions identified. In this regard the report provided little in the way of assurance that current year Agency spend will be controlled in line with plans. It was agreed that a follow up report would be prepared **as a matter of urgency** in order to address these issues and to confirm operational and financial targets to be achieved.
Chair Report from CRIG	Green	Director of Finance	The Committee received the Chair's report from the CRIG meeting held on 12th June.	Chair report noted.

Colour	Key
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Committee/Group Chair's Report

Chair Report from the Strategic Estates Board	(Amber)	Chief Executive	The Committee received the Chair's report from the Strategic Estates Board held on 13th June. Urology was rated red due to the lack of assurance that the project can be delivered at the required speed.	Chair report noted.
Chair Report from the Digital Transformation Board	(Green)	Chief Executive	The Committee received the Chair's report from the Digital Transformation Board meeting held on 11th June. Good progress was reported and all programmes are RAG rated green.	Chair report noted.
Income and Cost Improvement Programme Assurance	(Amber)	Director of Finance	The Committee received a report which showed the level of ICIP identified by Division and workstream as at close of play on 5 June. The Committee noted the level of process detail but expressed strong concern at the lack of progress made to agree the full ICIP programme and in particular at the low level of risk rated schemes currently agreed. The poor ICIP delivery in M2 provided further cause for concern.	Strong concern was expressed at the lack of progress in terms of developing a full ICIP programme and in particular at the fact that the level of risk rated schemes remain very low and has not increased since Month 1. As a result the level of assurance that the ICIP programme will be achieved remains low. As well as quickly accelerating progress on agreeing a full ICIP programme the Executive was asked to urgently consider the potential for mitigation eg through non-recurrent schemes.

Key	
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Committee/Group Chair's Report

Report from NHS North West Procurement Development	(Amber)	Director of Finance	The Committee received an independent report which it had commissioned to obtain assurance on the procurement function from both the perspective of iFM as the supplier and the Trust as the customer receiving the services.	The report was generally positive and provided some useful recommendations for future improvements. The report did, however, highlight some areas for particular concern, eg lack of progress on current year ICIP targets and deficiencies in existing systems' capabilities leading to poor inventory control. Actions and recommendations to address concerns to be implemented. Revised KPIs will now be developed and future reports will also provide more focus on identifying specific opportunities and tracking achievement against plans.
Tender Update	(Green)	Director of Finance	The Committee received and noted an overview of the competitive tender exercises that the Trust is presently engaged in.	Report noted.
Any Other Business – Urology Business Case	(Amber)	Divisional Director of Operations, Elective Care	The Committee received an update on the Urology Business Case following approval to progress with the development of a modular unit at May's Board and subsequent discussion at the Strategic Estates Board. The updated draft paper was presented as AOB following a special request for feedback by Rayaz Chel due to a need to progress matters urgently.	The Committee provided verbal feedback on the draft paper. A further iteration of the Urology Business Case, taking account of the Committee's comments, would be presented to the Board at its meeting in June.
Comments				

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Committee/Group Chair's Report

Risks escalated for 2018/19

- Divisional Performance: Forecasts//ICIP identification and delivery/Pay Costs (agency) - key material risks for the year
- PSF Achievement
- National Pay award – potential funding shortfall
- Delivery of Capital Expenditure Programme
- Cash and Balance Sheet strength

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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

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Trust Board
Date of Meeting:	21st June, 2018	Date of next meeting:	21st June 2018
Chair:	Trish Armstrong-Child	Parent Committee:	Trust Board
Apologies:	Jackie Bene, Annette Walker	Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Key Points	Action/decision
Sickness/Absence Management	Amber	• Standing item. Update provided on Sickness Absence Action plan and steps being taken. • WAC noted sickness absence rate currently sits at 4.72% (May, 2018). Trajectories to deliver 4.2% discussed and included within Board paper. • Noted that Attendance Matters programme being rolled out in Acute Division, Integrated Community Services Division and IFM. • Noted that compliance against Sickness Policy in areas required focus. Clear evidence that were sickness policy followed then reduced absence levels.	Agreed actions: • Remain standing item • Divisions to ensure 100% compliance with Sickness Policy and Divisional delivery to be included within future report.
Review of Occupational Health Service	Amber	• First report from Occupational Health and whilst report received was helpful in understanding provision more work was required on KPI's, specifically whether KPI measuring what the Trust requires. Specifically how OH service is supporting the Trust in driving down absence or prevented potential absences.	Agreed that:- • Greater clarity required on the Governance arrangements of the Occupational Health Service. Agreed that Committee receive a quarterly update. • Next report to provide further / additional information on how interventions has expedited return to work or prevented potential absences • KPI's to be reviewed to ensure delivery what Trust requires

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Committee/Group Chair's Report

Recruitment & Retention report	(green)	• Updated provided on the coordinated actions being taken to improve recruitment and retention offering. • Detailed discussion on actions being taken for 'hard to fill' vacancies with indicative timelines included (some aspirational give market). • Alternative approaches to fill known medical pressures reviewed. • Reward and Retention approach re-energised.	Agreed that:- • Next report to be provided in two months' time outlining delivery against actions previously agreed
Training Nurse Associate Deep Dive	(green)	• This was the first standing item on 'Workforce Challenges - Deep dive'. • Strong progress being made in this area. Divisions committed to ensuring that role is built into their workforce planning programmes	Agreed that:- • To ensure TNA's included in Divisional Workforce Plans
Freedom to Speak Up Guardian	(amber)	• Freedom to Speak Up Guardian provided update report to the Committee on the actions taken since last Committee. • Whilst noting that the NHS Staff Survey provides evidence that our staff feel able to raise concern it remained evident that few concerns were being escalated to the Freedom to Speak Up Guardian. The Committee felt it appropriate that that the Executive Lead for this important item should be the Director of Workforce and that he would oversee this review in conjunction with the Freedom to Speak Up Guardian. • It was noted that the NHSI toolkit has recently been produced and that the Executive Lead would therefore be the appropriate person to undertake this review.	• Director of Workforce to become the Executive lead. • Fundamental review of Freedom to Speak Up process be considered. Where cost pressures identified then considered at Executive team before outcome of review being presented to August Committee. • Update provided to the Committee in two months' time

(red)	No assurance – could have a significant impact on quality, operational or financial performance;
(amber)	Moderate assurance – potential moderate impact on quality, operational or financial performance
(green)	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 Temporary Staff Usage and Spend	(Red)	• The Committee were updated on the current performance, together with the actions that are being taken throughout the Trust to reduce agency spend to an acceptable tolerance level. • The Committee received an update on all hard to fill posts that are driving our agency spend together with predicted dates for actual fill. • Detailed conversation ensued about the enhanced controls in place from 18th June and Divisions all confirmed support, as well as noting the monitoring arrangements in place at Departmental/Divisional and Trust level.	Agreed actions: • Receive a progress report at the next meeting on a more helicopter view on the enabling actions that are being taken to drive down Agency Spend (Escalation; recruitment; sickness and enhanced controls/governance). Review to include trajectories for Agency reductions. Noted that Finance Committee requested similar update
ICIP Workforce Workstreams	(Amber)	• Update the Committee on current delivery of Workforce related workstreams. All workstreams reviewed to ensure cost reductions do not have an adverse impact on quality of services	Actions agreed • Report noted
Workforce Dashboard	(Amber)	• The Committee noted the dashboard. Key matters arising from the dashboard had been discussed previous papers	Agreed that • Paper noted
Terms of Reference for Workforce Assurance Committee	(Amber)	• The Committee noted the minor changes to the Terms of Reference and noted that the review of the Terms of Reference were scheduled for September, 18.	Actions agreed • Update noted
Workforce Operational Group – Chair report	(Amber)	• The Committee noted the report.	Agreed that • Paper noted
Bolton Locality Strategic Workforce Board	(Amber)	• The Committee noted the report.	Agreed that • Paper noted
Medical Improvement Workforce Improvement Group – Chair report	(Amber)	• The Committee noted the report.	Agreed that • Paper noted

Comments

- Reduction in Agency Spend highlighted as a cause for concern and immediate / enhanced focus required.

Risks escalated - None

(Red)	No assurance – could have a significant impact on quality, operational or financial performance;
(Amber)	Moderate assurance – potential moderate impact on quality, operational or financial performance
(Green)	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

NHS Foundation Trust

Name of Committee/Group:	Bolton Urgent Care Delivery Board	Report to:	Bolton FT Trust Board
Date of Meeting:	12th June 2018	Date of next meeting:	10th July 2018
Chair:	Jackie Bene	Parent Committee:	Bolton System Resilience Board
Apologies:		Quorate (Yes/No):	Y

Key Agenda Items:	Assurance Yes/No	Lead	Key Points	Action/decision
Pre –hospital activity analysis	Partial/No	CCG	Good level of detailed analysis – shows very high A&E attendance and NWAS activity in May but no real explanation apparent. Also demonstrated key opportunities around frequent attenders, the <20 year olds and NH attendees	Emergency practitioners taking patients from NWAS stack to provide alternatives Ramp up Immedicare implementation across NH's The <20 year olds aim to be captured by increase in GP streaming activity
ECIP analysis of ambulance conveyance	Partial/No	ECIP	Good detailed audit of 50 patients – 47% appropriate conveyance Highlighted clear lack of available alternative pathways +/- NWAS crew compliance issues – 30% of pateints conveyed could have ended been managed in an alternative pre-hospital pathway.	Further work on community offer eg AAT availability to NWAS, emergency paractitioner in OOH service to take off NWAS stack and direct referrals fro NWAS to GP's and IMC need promoting again.
Front Door Streaming Audit	Partial/No	BFT/CCG	Audit of 113 A&E attendees in a 3 – 8pm time frame – 65 appropriate Of the remainder 28 should have gone to GP stream (20 actually did), 3 should have gone to own GP, 5 staright to speacialty, 3 to MH and the rest to other community pathways	Demonstrated opportunity to stream more (48) patients away from ED – in just a 5 hour period. Supports work developing on Streamming model.

Exception reports : • Immedicare work in NH's • Frailty Care Planning	 No No	 CCG CCG	 Better analysis shown and avoidance trends picking up Non –elective admissions still not reducing in this group.	 Further actions include audit and RCA of homes with high attendance – training being reinforced here. Actions to share plans using Graphnet and Bolton Care Record in progress
RAID pathway audit	Yes	MMHT	Very positive impact on speedy assessment in A&E by MH practitioners	Identified the need to develop a "safe and sober" unit – work in progress
Bed Modelling	Yes	BFT	Sophisticated tool now operational which shows that if LOS is reduced by just 0.3 days from now (red to green and SAFER work) , 120 admissions avoided per month (A&E streaming work) and a low intensity flu season (expected) we will have enough beds for winter with just B4 open.	Work on streaming and LOS to progress at pace.

Agenda Item No: 13

Meeting	Board of Directors

Date	28 June 2018

Title	Mortality Update

Executive Summary	This paper provides the scheduled six monthly update on Trust performance against mortality indicators. It describes progress in the implementation of the Mortality Review Process and outlines work performed and planned on important Quality Improvement areas underpinning mortality such as; learning from cardiac arrests, sepsis management, recognising and responding to the deteriorating patient and end of life care.

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	Clinical Governance and Quality Committee on 6th June 2018.

Next steps/future actions	As above			
	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	Steve Hodgson, Medical Director & Debbie Redfern, Quality Improvement Manager	Presented by	Steve Hodgson, Medical Director

Introduction:

Preventing avoidable death is a key aspect of delivering high quality care and the reducing mortality domain of our Quality Improvement strategy. It is important we continue to track our mortality indicators and understand how we benchmark against other organisations. However, factors such as population served, access to hospice care, variations in coding practice between Trust's and varying denominators mean that all mortality indicators should be viewed with a degree of caution. Preventing avoidable deaths should remain our key mortality objective. To this end 2017/18 has seen the rollout of our Mortality Review Process aimed at identifying avoidable deaths and associated learning. The main focus of preventing avoidable deaths remains recognising and responding to the deteriorating patient, prompt identification and management of sepsis, preventing harm such as medication errors and ensuring good quality end of life care.

This paper summarises Trust performance against our mortality indicators, describes continued roll out of the Mortality Review Process and outlines quality improvement work in areas such as sepsis, recognising and responding to the deteriorating patient and end of life care.

Mortality Performance

The trust mortality position has remained stable throughout 2017/18. We had concerns that removing Ambulatory Care Unit attendances from the admissions denominator would have an adverse impact on standardised mortality rates. However, early indications are that the impact has been less than anticipated.

i. Standardised Hospital Mortality Index (SHMI)

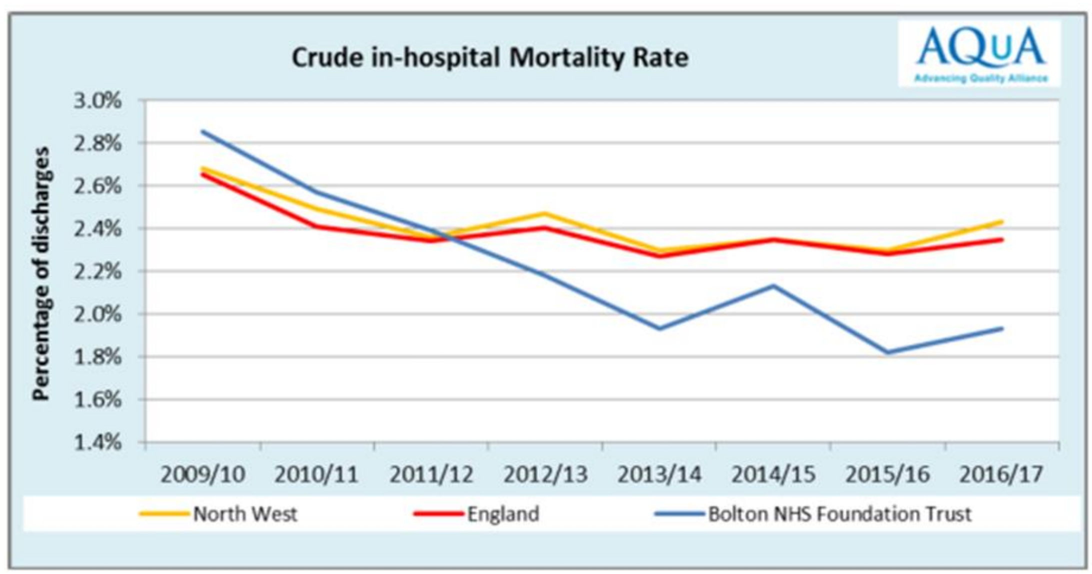
SHMI is updated quarterly on a rolling basis with a typical time lag of six months. The release of the January 2017 – December 2017 SHMI due on 6th June 2018 has been delayed nationally due to technical reasons.

SHMI is currently 106 (Oct 16 – Sept 17), a reduction from the previous position reported of 107 (July 16 – June 17) and still within the expected range. This period includes January 2017 which saw higher number of deaths than the previous year. The table below would indicate that the next release of SHMI for January 2017 to December 2018 will see a further reduction.

	SHMI	SHMI	HSMR	HSMR
Trust	**Published data (July 16 – June 17)**	**HED Data (Nov 16 – Oct 17)**	**Published data (July 16 – June 17)**	**HED Data (Nov 16 to Oct 17)**
Bolton FT	1.07	1.03	103.1	100.8
CMFT	0.0	1.14	0.0	89.0
Pennine Acute	1.04	0.96	97.3	95.5
Salford Royal	0.92	0.89	89.8	88.8
Tameside & Glossop ICFT	1.08	1.04	96.4	91.7
Stockport FT	0.95	0.93	101.6	100.9
UHSM	0.0	0.97	0.0	93.2
WWL FT	1.22	1.15	118.8	114.6

ii. Total Deaths / Crude Mortality

There were 1,266 deaths in the year 2017/18 compared with 1,253 deaths the previous year. Total number of spells (Elective and Non Elective) fell from 60,523 to 54,006. This resulted in our crude mortality rate increasing from 2.1% to 2.3%. The chart below demonstrates our performance on crude mortality compared with North West and England. Please note that unlike the above figures, this includes day cases.



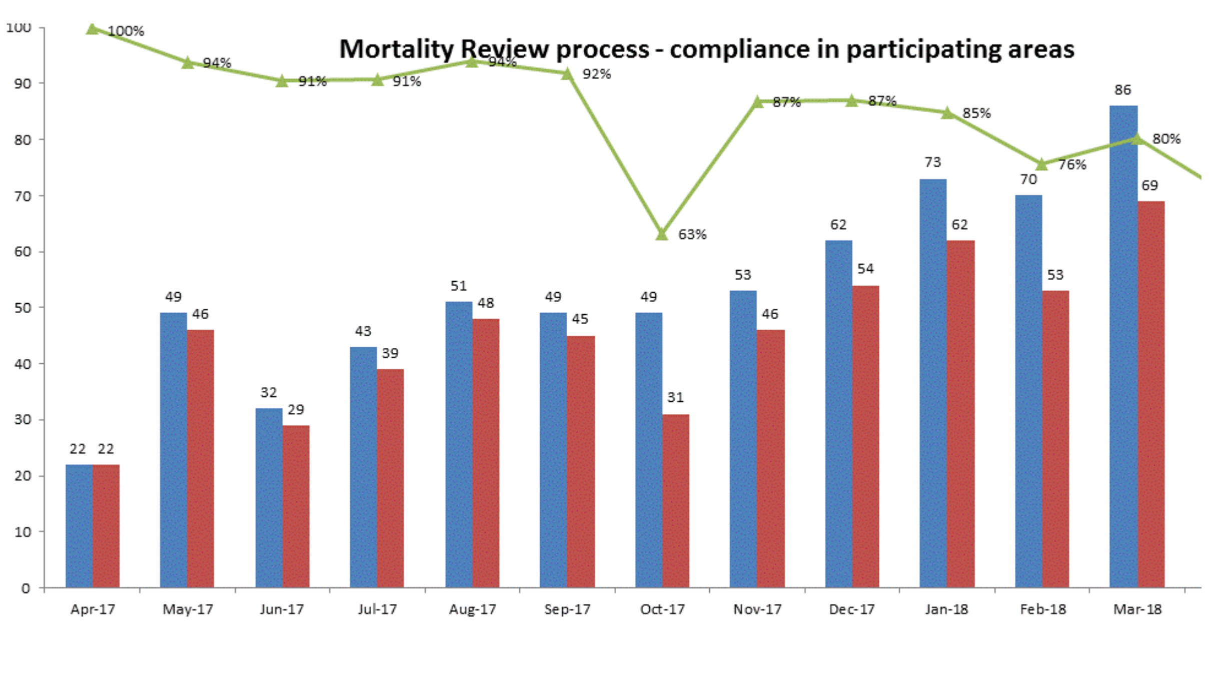
iii. Risk Adjusted Mortality Index (RAMI)

Our latest reported RAMI for period April 2017 – March 2018 was 89.2 compared with peer of 88.6 (peer is all acute trusts).

iv. Mortality Review Process

A mechanism for reviewing and learning from deaths (adult inpatients) has been tested and rolled-out to specialties using a phased approach. The aim of the process is to review deaths to identify and share learning, to determine our percentage of avoidable deaths and incorporate learning from deaths in patients with learning disabilities or mental health problems.

The chart below outlines compliance rates. In summary 544 out of 639 in-scope speciality deaths have been reviewed for 2017/18. This gives a compliance rate of 85.1% for 2017/18. Please note that our process has an inbuilt two to three month delay for completion of review of deaths subject to Coroners inquests taking priority for availability of notes.



Key areas of progress include:

- Successful roll out with mortality leads in Acute Medicine, General Surgery, Trauma & Orthopaedics, Respiratory, Urology, Gastroenterology, Endocrinology, Stroke, Cardiology and most recently Complex Care with phased introduction initially reviewing all weekend deaths.
- Cardiac arrest root cause analysis has been modified to incorporate the mortality review process to avoid duplication.
- Mortality Review Process Policy ratified
- Learning Disabilities Mortality Review Programme (LeDeR) – five staff members trained to work on LeDeR reviews, with additional training scheduled. From March 17, 14 cases were reported (to April 18).
- Maternal, New born and Infant Programme - all neonatal deaths, stillbirths, late miscarriages and maternal deaths are entered onto the MMBRACE database – 56 cases were submitted in 2017/18 and are reviewed locally through the Perinatal Group Meeting.
- Training of mortality reviewers has been sourced at Preston and Salford and has now commenced. James Pollard, Consultant Surgeon, has now been trained to deliver structured Mortality Review training in-house.
- All these processes identify lessons learnt and appropriate actions. Actions are monitored at Corporate (Serious Incident), Divisional (Divisional Summary Reviews) and via the Mortality Reduction Sub Group respectively.

Positives:

- Mortality review completion rates are gradually increasing.
- The process has facilitated improved engagement and mutual understanding between clinicians and coders to help improve future practice.
- Joint mortality review where cross departmental learning can be applied
- The process has enabled some specialties to focus more time in departmental mortality meeting on deaths with areas for learning.
- Reviews have highlighted themes for improvement with actions in departments to address.

Next steps:

- Further Structured Reviewer Trainer for Mortality Review Leads to facilitate cascade training in each specialty.
- As yet the number of deaths deemed avoidable of 0.65% (8 out of 1266 deaths) for 2017/18 is lower than the predicted 4-5%. This is being challenged at the Mortality Reduction Group Sub Committee meetings.
- Mortality Review Validation Clinic testing in June 2018, to validate reviews and capture items for corporate learning. The process for validating a sample of reviews has now been agreed whereby all deaths deemed to be avoidable undergo a Serious Incident Scoping meeting chaired by the Medical Director. Potential outcomes of the scoping meeting are Serious Incident investigation, Divisional review or communication of learning by the mortality review process.
- LeDeR – an action plan to ensure further members of staff trained and good practice is shared e.g. workshops in quarter one 2018/19 to review the process and consider how reviews are conducted in a timely manner.

v. Cardiac Arrest Root and DNACPR

- 18.4% of cardiac arrests that took place in 17/18 that were felt should have had a DNACPR instruction in place, this represents a 25% reduction on 16/17 figures. This represents achievement of our Quality Account aim for 2017/18.
- Revised Cardiac Arrest RCA standard operating procedure
- Escalation process established in event of delayed return of cardiac arrest RCA.
- Scoping meetings chaired by Medical Director – where potentially avoidable cardiac arrest identified
- Annual DNACPR audit with subsequent learning and actions points identified and implemented.

- Increased number of DNACPR forms that were completed and brought in with the patient, demonstrating that not only are these conversations taking place outside of the hospital but also that the patient is transferring this information with them. Annual DNACPR audit demonstrated improved performance in the following three areas:
- 92% of forms had a recorded discussion with patient and/or family.
- 96% of forms had reasons for DNACPR decision documented.
- Approximately 50% of DNACPR forms were found to be completed by the lead clinicians

Next steps:

- Ongoing work to co-ordinate learning from cardiac arrest RCA with that of mortality review process.
- DNACPR audit feedback, with education package for foundation year doctors.
- Consultant verification/countersignature of DNACPR when completed by junior doctor.
- Focus on revision of DNACPR after the hospital episode.

vi. Sepsis improvement:

- ***Sepsis CQUIN (Q4 17/18):***
  - 89% of applicable emergency patients were screened for Sepsis (Q4 17/18)*
  - 83% of patients admitted as an emergency and diagnosed with Red Flag Sepsis received treatment within 60 minutes of diagnosis (within the Sepsis CQUIN sample)*

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

- ***Critical Care Admissions with High Risk Sepsis***

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

- ***Policies, Guidance and Documentation***
  - Revision of sepsis policy, pathway and screening tools aligned with NICE guidance to ensure Trust standard is to screen any patients scoring NEWS 3+.
  - Benchmarked Trust compliance with NICE Quality Standards QS161: Sepsis.
  - Revisions of Trust KPI observations standards.
  - Scope requirements and establish Trust response to local implementation of NEWS 2.

- ***Education and Training***
  - Awareness raising and revision of reference materials regarding changes to sepsis policy, pathway and tools.
  - Scoping of sepsis e-learning package
  - Recognising and responding to patient deterioration – pilot training programme commenced September 2017.
  - Acute Illness Management training delivered on a monthly basis.
  - Sepsis Study Day delivered quarterly.

- Awareness week with ED nursing staff looking at observations standards, NEWS, escalation and triggers re-enforcing standards

- ***Monitoring, Governance and Quality Improvement***
  - Ongoing work to ensure temporary staff have the required knowledge and skills regarding NEWS observation standards and competencies.
  - ***Sepsis Virtual Clinic*** - quarterly casenote reviews to benchmark care provided to patients, who had sepsis coded at any stage in their hospital stay or on their death certificate, against trust and national standards. The first clinic targeted deaths in November 2017 when a spike in mortality was noted through live CHKS tracking. Findings from first clinic are below:
    - All patients were emergency patients going through the ED. Average time to antibiotics for the sickest patients from observations being recorded was under an hour and from time seen by clinician less than 20 minutes.
    - Of those patients that did not get screened none had red flag sepsis and all went on to have senior reviews and appropriate therapy commenced.
  - KPI Improvement Project – Focus on fluid balance KPI standard due to the potential changes in NEWS 2. Ten wards identified with measurement for improvement methodology supporting improvement work.
  - NEWS score on Extramed (patient flow system) in ED to act as a visual trigger for rapid assessment and treatment.

Next steps:

- Introduce the new National Early Warning Score (NEWS2) along with revised criteria for sepsis screening, revised documentation and targeted education to support implementation.
- NICE QS161: ensure compliance with all standards
- E-learning package.
- Sepsis patient information leaflets.
- Continue to embed rapid assessment ambulance handover model in ED.
- Scope Patient Group Directive (PGD) for administration of antibiotics in ED.
- Review of ED roles regarding initial assessment and antibiotics administration.
- Introduction of pro-calcitonin blood test: allows for more specific identification of bacterial causes of infection.
- Use of CHKS and other national data to measure sepsis mortality and unexpected deaths.
- Use of e-observations and patient track data to understand and focus sepsis management.
- Focussed quality improvement project on one ward to establish need for the recognition, management and escalation of patients with sepsis, develop local solutions and share learning to other areas.

vii. Recognising and Responding to the Deteriorating Patient Workstream

- Establishment of Patientrack Oversight Group with Terms of Reference
- Patientrack improvement project led by Foundation Year Doctors
- Development of regular Patientrack KPI report
- Foundation Programme teaching regarding Patientrack emphasing:
  - The importance of including all tasks requested out of hours on Patientrack
  - Large number of jobs inappropriate for foundation doctors on night shift
  - The need for accuracy of response times – new hand held devices to enable real time data capture will be implemented in May
  - Development of “On my way” function to allow acknowledgement of tasks and intention to complete.
- Amended Trust KPI observation standards
- Successful Deteriorating Patient Learning and Awareness Week w/c 30th April 2018.
- E-Observation business case approved

Next Steps:

- Implementation of NEWS 2 - to coincide with launch of E-observations in 2018/19
- Quality Account Priority focus on Acute Kidney Injury – outcome aim is to ensure 85% of patients with AKI are treated following the guidelines produced by 31/03/19.

Conclusion:

Our mortality indicators all remain in the ‘as expected’ range and are likely to do so throughout 2018/19. The Mortality Review Process is becoming embedded and is identifying learning that reinforces the importance of our ongoing Quality Improvement activity. In 2018/19 we need to balance the ability to screen all deaths with that to perform robust structured reviews of the deaths most likely to identify learning. Success of the Mortality Review Process will require embedding the monitoring and learning of the process at Divisional and Departmental as well as Corporate levels.

On personal reflection, my 5 years as Medical Director has reinforced the belief that the key components of successful mortality performance remain delivery of high quality clinical care and supporting the delivery of effective and compassionate end of life care across the health economy supporting frail and elderly people to die in their usual residence.

Agenda Item No : 14

Meeting	Board of Directors
Date	28th June 2018
Title	Summary of the National Adult In-patient Survey Results 2017
Executive Summary	This paper summarises the recent National Adult In-patient Survey 2017 Management Report for Bolton NHS Foundation Trust. There will also be a national publication with the key results for each organisation which will be published around 13th June 2018 which is undertaken by the Coordination Centre who publishes the national results on the NHS Inpatient Survey website. Until such times, Bolton NHS Foundation Trust is asked to embargo the publication of the 2017 survey results which uses the benchmarked analysis included in the feedback reports.
Previously considered by *Name of Committee/working group and any recommendation relating to the report*	

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	Tracy Joynson, Patient Experience Manager	Presented by	Trish Armstrong-Child, Director of Nursing

Summary of the National Inpatient Survey 2017

1.0 Background

Bolton NHS Foundation Trust Commissions Quality Health to undertake the National Adult Inpatient Survey. The preparation for the survey completion is supported by the Trust's Business Intelligence Unit with regards to data extraction and data cleansing. The survey was undertaken between August 2017 and January 2018.

The attached pack contains a number of documents:

- Survey Management report including the survey questionnaire as sent out to service users - Appendix 1
- Complete summary of all of the individual responses, Comments Report - Appendix 2
- An initial analysis of the survey findings – Appendix 3
- Examples of compliments provided in the Comments Report – Appendix 4.

The survey required a sample of 1250 consecutively discharged inpatients, working back from the last day of July 2017, who had had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey for example psychiatric patients and maternity patients.

Quality Health confirmed that of the 1250 questionnaires issued for Bolton NHS Foundation Trust, 392 were completed and returned.

The survey report is a confidential report from Quality Health to the organisation whose decision it is whether or not to publish it, or to publicise contents to staff or patients. However, Quality Health strongly advises, in the spirit of openness and transparency, that the results should be publicised through all available channels.

There will also be a national publication with the key results for each organisation which will be published around 13th June 2018 which is undertaken by the Coordination Centre who publishes the national results on the NHS Inpatient Survey website. Until such times, Bolton NHS Foundation Trust is asked to embargo the publication of the 2017 survey results which uses the benchmarked analysis included in the feedback reports.

2.0 Survey Transcription Errors

The CQC have confirmed the impact of the errors found in the questionnaire we used for the 2017 Adult Inpatient Survey that we were notified of in November 2017. Some of these resulted from transcription errors made by our contractor, Quality Health, while a question routing error was a result of an error made by the Survey Coordination Centre.

The CQC have informed us that they have excluded results for two survey questions for our Trust from national and trust level analysis. Unfortunately, the question routing error was found to have a negative impact on the response to two questions.

Data analysis carried out by the Survey Coordination Centre indicated that most of the errors did not affect the results of the survey. However a routing error impacted significantly on the numbers of patients skipping: questions 55 ("When you left hospital, did you know what would happen next with your care?") and 61 ("Did a member of staff tell you about any danger signals you should watch for after you went home?"). Patients who did respond to these questions were not representative and we felt that including your results for these two questions would not be appropriate. The following actions have been taken for **questions 55 and 61 only,** for your Trust and others similarly affected. Your data has been:

- Excluded from national results
- Excluded from benchmark results
- Excluded from CQC Insight
- Excluded from trusts tables.

The CQC have confirmed that the following actions have been taken for other outputs for all trusts:

- Excluded national historical comparison for both questions.

- Excluded the use of both questions in the trust variation report.
- Excluded the use of both questions in the subgroup analysis featured in the statistical release

Unfortunately, one of the question (Q61) is an Overall Patient Experience Score (OPES) question. After consultation with NHS England it is been decided that Q61 will be omitted from the OPES scoring for all trusts this year.

The CQC have acknowledged that this error has not occurred because of any actions on the part of our Trust, and they have offered their deep apologies that such exclusions have to be made. They have assured us that the CQC monitors the occurrence of errors in relation to the Inpatient Survey as part of its ongoing intelligence monitoring and will continue to highlight any omitted information in relation to this error as not being indicative of poor Trust performance.

3.0 Reading the Report

- **Important Note – Scored Questions**
  For each scored question in the survey, the individual responses are converted into scores on a scale from 0% to 100%. A score of 100% represents the best possible response and a score of 0% the worst. The higher the score for each question, the better the Trust is performing.

- **Benchmark Charts and Tables – Scored Questions Only**
  The benchmark charts (example below) show results for scored questions only.

Each scored question has a bar that represents the range of results across all Trusts that took part in the survey with Quality Health.

The bar is divided into three segments as follows:

- A red section: the lowest-scoring 20% of Trusts
- An amber section: the intermediate 60% of Trusts
- A green section: the highest-scoring 20% of Trusts

The black circle represents the score for the Trust. If the circle is in the green section of the bar, it means that the Trust is among the top 20% of Trusts surveyed by Quality Health for that question. The line on either side of the circle shows the 95% confidence interval (the degree of uncertainty surrounding the Trust's score).

3.0 Recommendations by Quality Health

It is important to note that the recommendations made below by Quality Health are general and actions should be built around these after further analysis of the data takes place. Examples of comments made by patients are provided beneath some of the recommendations:

Admission to Hospital

- Continue to review the provision of regular and updated information given to patients about their condition and/or treatment in A&E.
  - *The time waiting in A&E department because of a bleeding cut on my head before I had an x-ray.*

Waiting Lists and Planned Admissions

- Continue action to reduce waiting times as far as possible.
- Review the reasons for the number of times there have been changes of admission dates by the hospital particularly where these occur twice or more

- *My operation was postponed three times in a week. The constant starving/eating led to the worst constipation ever.*
- *Cancellations and the waiting list could have been improved. The hospital was superb once I got there, but I would have been saved a lot of pain had it happened when first scheduled.*
- *My operation was cancelled twice, I found this very distressing as I have never had an operation before and did not know what to expect.*

All Types of Admission

- Whilst shortage of beds is a national issue, the Trust should continue to monitor wait times and prioritise patients who are most at risk.
  - *Waiting time. Hours and hours waiting for bed in wards.*

The Hospital and Ward

- Take steps to ensure that patients moved at night are clear about why this change is necessary.
  - *Moved during the night when told wouldn't be due to age and possible stay.*
  - *I was allocated a bed in the middle of the night which was very frustrating for me.*

- Look at why some patients are saying there are high levels of noise from other patients at night. If necessary, measure noise levels to ensure that staff are aware of actual levels and can take action where needed.
  - *Patients could be asked to turn their mobile phones/tablets off early evenings as some people would prefer to rest and sleep, but can't as too noisy.*
  - *Noise at night on the main wards could have been better. Sleep was difficult to achieve.*
  - *Nurses need to stop standing about chatting and do their job, and stop being so noisy at night.*

- Look at why some patients still rate food as only fair or poor. Look at food quality, temperature, timing of food arriving and the operation of the catering contract.
  - *Indian vegetarian food could be improved*
  - *The food is the most bland, disgusting, unorganised chaos. Not once did I get what I had ordered in 9 days, also it was never hot or nutritious.*
  - *Food was lacking in size. I was constantly hungry.*
  - *The food was pretty dreadful.*

- Further ensure that patients are given help from staff when needed at meal times. Look at staff availability and ensure that suitable staff are available when needed. Undertake spot checks to ensure this is happening.
  - *Help with eating when it was obvious that difficulties were being experienced.*

Doctors

Further address communication issues between doctors, nurses and patients through the training and induction of junior staff.

- *Patients and family need to know about the different members of staff and their role. There are so many different types of uniform that it is difficult to tell who does what. Information give should be the same, no matter who gives it. Often given different information.*
- *No coordination between staff and no uniform for doctors.*
- *Doctors are slow to arrive and cause delays in treatment of patient because of the time issues. Due to time pressure doctors/consultants are rather brief.*
- *Not enough privacy when the doctors telling the patient bad news, you can hear everything and everybody can hear about your health problems. Could take them into a private room.*
- *Communication between staff and family could be improved.*
- *Told I had cancer without my wife being there to support me.*

Nurses

- Review staffing levels and skill mix in the light of patient perceptions of nurse staffing levels.
  - *Generally there are not enough members of nursing staff to carry out efficient, quicker caring of patients.*
  - *More nursing staff at night.*

- *Seems to be a shortage of nurses*

Your Care and Treatment

- One in four patients would like to be more involved in decisions made about their care. Continue to review methods by which staff can involve patients in decisions about their care and treatment.
  - *Patient's needs to be taken into consideration more, especially if they are elderly when giving information. Also, family should be able to get information much easier and more willingly. Some staff seem not to want to give any information. Relatives need to know what is happening.*
  - *The nurses did not always tell you if your observations were normal.*

- Further ensure that patients know there is a member of staff to talk to if they have any worries or fears, or need emotional support.

Operations and Procedures

- Share and celebrate the success in this section of the survey.

- Look what more can be done to further ensure that patients are given information and explanations about how they would feel after the operation/procedure, including anaesthesia and its effects. Look at the best method for giving this information and if possible tailor to the patient's needs

Leaving Hospital

- The main reason for delays in discharge was patients having to wait for medication to take home. Review the way in which discharge medication is ordered and delivered to the patient with a view to reducing delays or improving efficiency of the process.
  - *The wait for prescriptions has always been a problem and yet no one has the common sent to sort this out.*
  - *Time for Pharmacy to deliver medicines before leaving hospital.*

- Review process for giving patients clear and understandable information, both verbal and written, about what to do and what not to do after leaving hospital.
  - *My aftercare was non-existent. I didn't get spoken to about how my operation had gone. I was given painkillers at 6am but nothing afterwards (discharged approximately 5pm). I wasn't given any pain relief to take home. A nurse didn't contact me regarding stitches as I was told would happen by the pre-op doctor. When I woke up in the morning after being given tablets at 6am, a doctor was at the foot of my bed. He said "do you want to go home?" I replied "yes" and he said "OK then you can do". This is all the aftercare I was given.*
  - *Would have liked to have been given a list of what to do and not to do e.g. when I could drive again, exercise again.*
  - *No discharge letter, no medication given, told to see the GP, that took four days to get medication from them.*

- Look at the provision and clarity of information that is given to patients about the medication side-effects to watch for and what to do if they are worried.

  - *More information about medications you are still given such as Morphine and the side effects they can cause*

- Review how patients are given information about danger signals to watch for after discharge, and review the clarity of that information including what to do if they are concerned or worried.

- Review the extent to which clinical staff provide the patient's family with adequate information about caring for the patient.
  - *Discharge lounge failed to advise family of on way home– no one in. Left at a neighbours and not a close one at that.*

Overall

- Look for ways to improve patient feedback, as many patients would like to be asked about their views on the quality of their care.

- Ensure that information about how to complain is available for patients in hospital; staff are up to date on complaints procedures and able to explain and easily communicate this to patients.

5.0 Initial analysis of findings

The management report provided by Quality Health provides some benchmarking with other Trusts surveyed by them and also provided comparative response rages from the National Adult in-Patient Survey from 2016. An initial analysis of this has found that Bolton FT was:

- better on 47 out of 63 questions in 2017 compared with 2016
- worse on 9 out of 63 questions in 2017 compared with 2016
- better than other Trusts surveyed by Quality Health on 48 out of 63 questions
- worse than other Trusts surveyed by Quality Health on 15 out of 63 questions

6.0 Next Steps

The report was presented to Patient Experience and Inclusion Partnership Committee (PEPIC) on 9th April 2018 where the Patient Experience Manager provided an insight into the report findings. In order to demonstrate improvements in the areas highlighted for improvement, PEIPC tasked Divisions with taking these into account with current and future initiatives around patient experience and engagement. To support this, further analysis of the survey findings will be available once this has been populated onto SOLAR which is a database provided by Quality Health. This will allow Divisions the opportunity to further identify any trends and agree specific actions within individual service areas. Divisions have been asked to produce a Patient Experience Plan to demonstrate how they intend acting upon the recommendations made in the National Adult In-Patient Survey 2017 report and each Division will present their plan at PEIPC on 9th July 2018. The plans will be monitored at PEIPC quarterly thereafter.

Quality Health were invited into the Trust on 24th May 2018 to provide a presentation on the survey findings which was both well attended and well received.

7.0 Recommendations

The committee is asked to note the content of the National Adult Inpatient Survey 2017 report and the embargo on the report until national publication on 13th June 2018.

National Inpatient Survey 2017
Management Report

Bolton NHS Foundation Trust

Produced by Quality Health

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Introduction

The National Inpatient Survey was undertaken by Quality Health for Bolton NHS Foundation Trust between August 2017 and January 2018.

Methodology and Sampling

The methodology follows exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall National Inpatient Survey programme.

The survey required a sample of 1250 consecutively discharged inpatients, working back from the last day of July 2017, who had had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric patients and maternity patients.

Response Rate

The target response rate for the survey set nationally was to achieve at least 60% from the usable sample, and the number of usable responses should be at least 750.

392 completed questionnaires were returned from the sample of 1250 from Bolton NHS Foundation Trust. A group of 51 service users were excluded from the sample for the following reasons:

- Moved / not known at this address 17
- Ineligible 1
- Deceased 33

The final response rate for the Trust was 33% (392 usable responses from a usable sample of 1199).

Report Content

This report presents the survey results in a number of different ways. It sets out the full results in the same format as they appear in the questionnaire. It provides an analysis of issues where the organisation is achieving good results, as well as areas where management action is required. It provides benchmarking charts comparing results against similar organisations, and against previous years.

Quality Health has identified a number of conclusions arising from the survey and makes a number of recommendations for action. These are included in the Executive Summary and again at the end of each section in the main body of the report.

Introduction (continued)

Publishing and publicising your results

This is a confidential report from Quality Health to the organisation. The decision about whether or not to publish it − or to publicise contents to staff or patients − is entirely up to each organisation. However, our strong advice, in the spirit of openness and transparency, is that the results should be publicised through all available channels.

Having run the National Inpatient Survey in a multitude of NHS organisations over many years, we have found that the most effective organisations report to staff and patients on the outcomes of the survey; and tell staff and patients what they are doing as a result. This significantly improves the credibility of the process. Publicity could include:

- Presentations to the Board on key strategic issues
- Distribution of findings to Clinical Governance teams, and to Divisional and Departmental heads
- Discussions on the results with staff representatives
- Publication of results on the internet
- Display presentations in appropriate locations in the organisation.

Whatever decision is taken locally, there will be a national publication with the key results for each organisation, which will be published in May - June 2018. However, until the Co-ordination Centre publishes the national results on the NHS Inpatient Survey website, there is an embargo on the publication of any 2017 survey results which use the benchmarked analysis included in the feedback reports.

Observations and Recommendations

Accident and Emergency Department

Recommendation: Continue to review the provision of regular and updated information given to patients about their condition and/or treatment in A&E.

Waiting List or Planned Admission

Recommendation: Continue action to reduce waiting times as far as possible.

Recommendation: Review the reasons for the number of times there have been changes of admission dates by the hospital particularly where these occur twice or more.

All Types of Admission

Recommendation: Whilst shortage of beds is a national issue, the Trust should continue to monitor wait times and prioritise patients who are most at risk.

The Hospital and Ward

Recommendation: Take steps to ensure that patients moved at night are clear about why this change is necessary.

Recommendation: Look at why some patients are saying there are high levels of noise from other patients at night. If necessary, measure noise levels to ensure that staff are aware of actual levels and can take action where needed.

Recommendation: Look at why some patients still rate food as only fair or poor. Look at food quality, temperature, timing of food arriving and the operation of the catering contract.

Recommendation: Further ensure that patients are given help from staff when needed at meal times. Look at staff availability and ensure that suitable staff are available when needed. Undertake spot checks to ensure this is happening.

Doctors and Nurses

Recommendation: Further address communication issues between doctors, nurses and patients through the training and induction of junior staff.

Recommendation: Review staffing levels and skill mix in the light of patient perceptions of nurse staffing levels.

Your Care and Treatment

Recommendation: One in four patients would like to be more involved in decisions made about their care. Continue to review methods by which staff can involve patients in decisions about their care and treatment.

Recommendation: Further ensure that patients know there is a member of staff to talk to if they have any worries or fears, or need emotional support.

Observations and Recommendations

Operations and Procedures

Recommendation: Share and celebrate the success in this section of the survey.

Recommendation: Look what more can be done to further ensure that patients are given information and explanations about how they would feel after the operation/procedure, including anaesthesia and its effects. Look at the best method for giving this information and if possible tailor to the patient's needs.

Leaving Hospital

Recommendation: The main reason for delays in discharge was patients having to wait for medication to take home. Review the way in which discharge medication is ordered and delivered to the patient with a view to reducing delays or improving efficiency of the process.

Recommendation: Review process for giving patients clear and understandable information, both verbal and written, about what to do and what not to do after leaving hospital.

Recommendation: Look at the provision and clarity of information that is given to patients about the medication side-effects to watch for and what to do if they are worried.

Recommendation: Review how patients are given information about danger signals to watch for after discharge, and review the clarity of that information including what to do if they are concerned or worried.

Recommendation: Review the extent to which clinical staff provide the patient's family with adequate information about caring for the patient.

Overall

Recommendation: Look for ways to improve patient feedback, as many patients would like to be asked about their views on the quality of their care.

Recommendation: Ensure that information about how to complain is available for patients in hospital; staff are up to date on complaints procedures and able to explain and easily communicate this to patients.

Recommendation: Use SOLAR to interrogate your results and identify specific areas where issues may be prevalent.

Reading the Report

Standardised Data

Used in both the ***Benchmark Charts and Tables*** *and the* ***Longitudinal Charts*** *.*
This data provides the Trust with an indication of how scores rank when directly compared with the average scores, whilst supressing any differences that may be present due to local variation in terms of patient demographic profile. Standardising the data in this way ensures that any comparisons drawn are reliable when determining variations in scores and top and bottom performers.

The process undertaken to standardise the data is based on national methodology used by the CQC to produce the national benchmark reports and should be useful to provide an indication of what a Trust's national results are likely to be. However, please be advised that there will be minor differences between the numbers in this report and a Trust's official national benchmark report as Quality Health only has access to a proportion of the data whilst the national standardisation process will be based on the full dataset available for all Trusts.

Raw Data

Used in the ***Compositional Charts*** *.*
This data provides the Trust with an unadjusted view of exactly how service users have responded to the survey. This view of the data is important to ensure the Trust has full visibility of the survey results as a dataset in its own right. Comparisons with the unadjusted survey averages are also provided for information.

Longitudinal Charts - Scored Questions Only

Each scored question has a longitudinal chart showing the 2015, 2016 and 2017 scores for the Trust plotted against the equivalent score for all Trusts surveyed by Quality Health.

Compositional Charts - Raw Data - All Questions

The compositional chart uses data as reported in the Detailed Results Tables at the end of this report. It shows the range of responses to the specified question for the organisation and for all similar organisations in the Quality Health database (survey average). The vertical scale is always 0-100%. These charts exclude any non-specific responses such as don't know / can't remember.

Suppression

All scores within the benchmark charts and tables, and longitudinal charts pages are supressed if fewer than 30 respondents have answered an individual question. When scores are supressed, no RAG rating is assigned.

Reading the Report (continued)

Important Note - Scored Questions

For each scored question in the survey, the individual responses are converted into scores on a scale from 0% to 100%. A score of 100% represents the best possible response and a score of 0% the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts in any way, for example, they may be may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question is Q12 (*Did you change wards at night?*).

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

6. How do you feel about the length of time you were on the waiting list before your admission to hospital?

10 ₁ ☐ I was admitted as soon as I thought was necessary

5 ₂ ☐ I should have been admitted a bit sooner

0 ₃ ☐ I should have been admitted a lot sooner

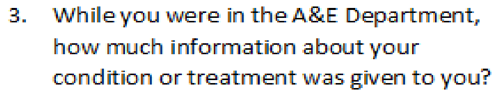
In the above example all three responses are scored. The first response is treated as being entirely positive, the second as partially positive and the third as negative. Such scoring should be taken into account when comparing raw percentages in the compositional charts against overall question level scores.

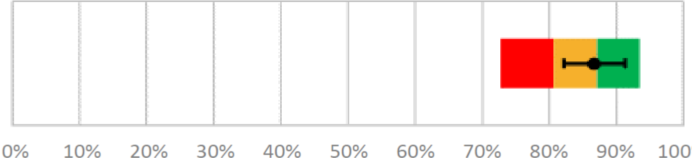
For full details of the scoring please refer to the Scored Questionnaire which can be accessed here:
http://www.nhssurveys.org/surveys/1107

Reading the Report (continued)

Benchmark Charts and Tables - Scored Questions Only

The benchmark charts (example below) show results for scored questions only.





Each scored question has a bar that represents the range of results across all Trusts that took part in the survey with Quality Health.

The bar is divided into three segments as follows:

- A red section: the lowest-scoring 20% of Trusts
- An amber section: the intermediate 60% of Trusts
- A green section: the highest-scoring 20% of Trusts

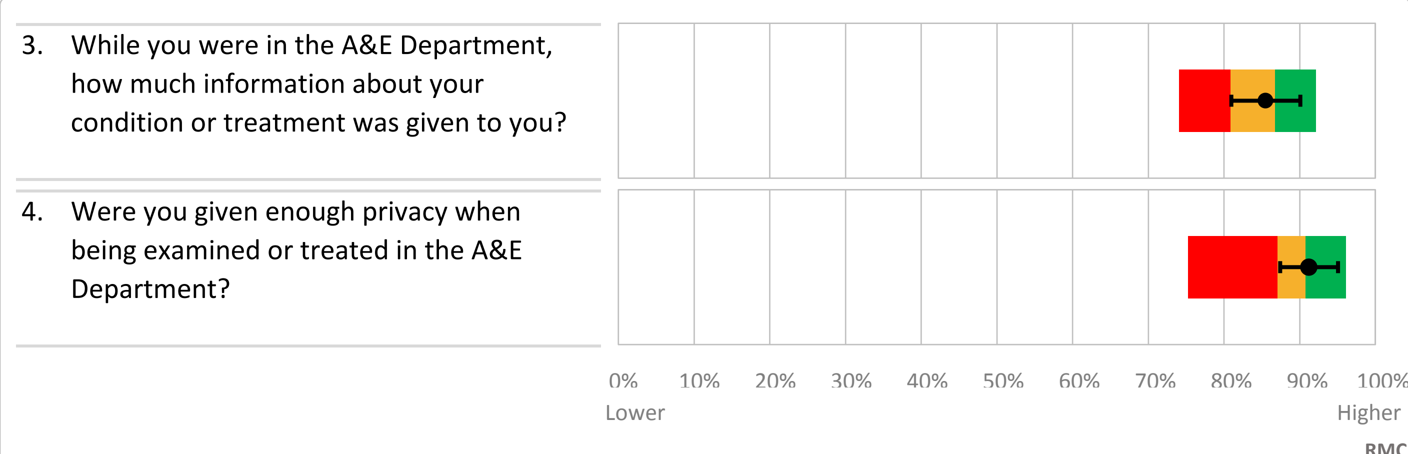
The black circle represents the score for the Trust. If the circle is in the green section of the bar, it means that the Trust is among the top 20% of Trusts surveyed by Quality Health for that question. The line on either side of the circle shows the 95% confidence interval (the degree of uncertainty surrounding the Trust's score).

Under each benchmark chart is a data table, detailing the following:

- The first column shows the question number and question text
- The second column shows the lowest score achieved across all Trusts in the Quality Health database
- The third column shows the highest value in the lowest scoring 20% of Trusts (i.e. the threshold or end of the red segment of the chart);
- The fourth column shows the lowest value in the highest scoring 20% of Trusts (i.e. the threshold or start of the green segment on the chart);
- The fifth column displays the highest score achieved across all Trusts in the Quality Health database
- The sixth column shows the base size or number of respondents for the question/Trust
- The seventh column shows the Trust's score for this year (as depicted by the black circle on the chart)
- The final column shows a RAG rating indicator. If a Trust's score falls within the lowest 20% of scores for that question, a red dot will be displayed. If a Trust's score falls within the intermediate 60% of scores for that question, an amber dot will be displayed. If a Trust's score falls within the highest 20% of scores for that question, a green dot will be displayed. If the Trust's score is supressed, no RAG rating is displayed.

					This Trust 2017		
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	Number of Respondents	Score	RAG Rating
3. While you were in the A&E Department, how much information about your condition or treatment was given to you?	72.7%	80.6%	87.1%	93.4%	172	86.7%	●

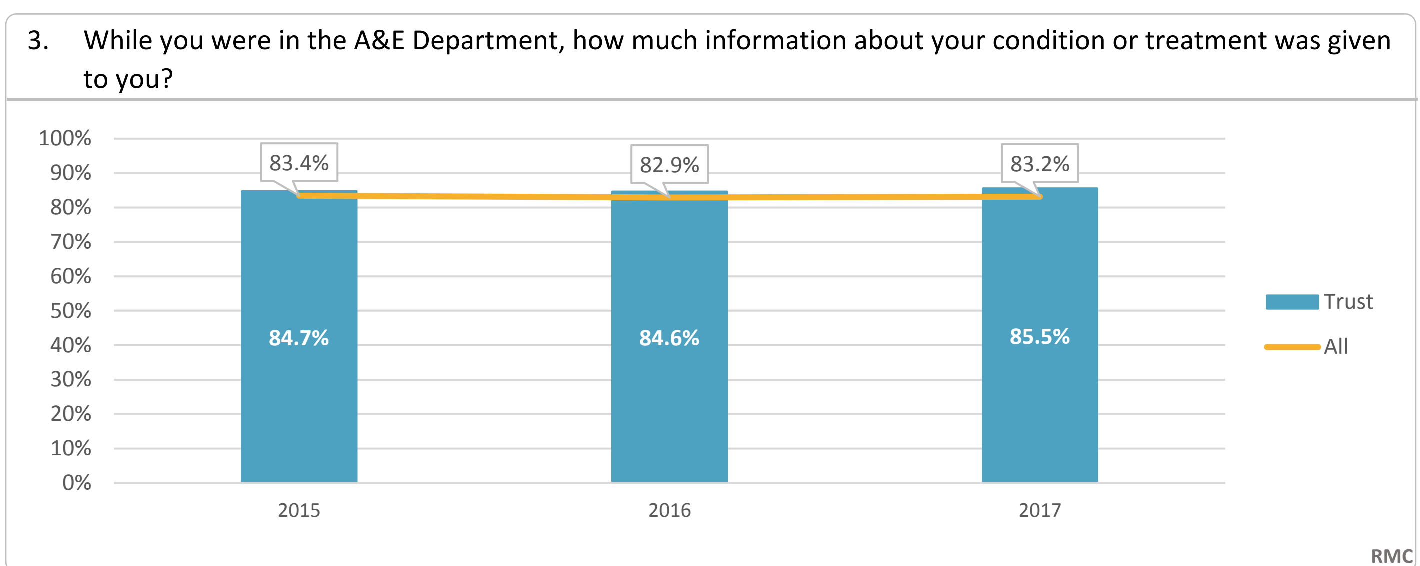
The Accident & Emergency Department - Benchmark Charts and Tables



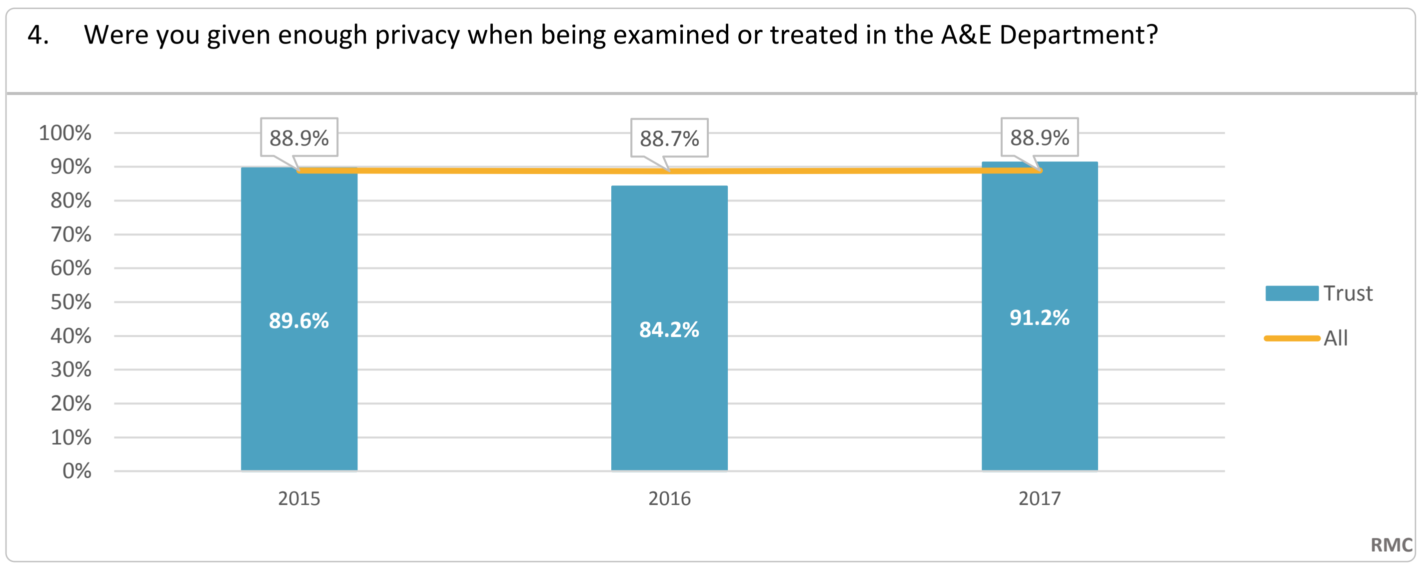
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
3. While you were in the A&E Department, how much information about your condition or treatment was given to you?	74.1%	80.9%	86.7%	92.2%	235	85.5%	● (amber)
4. Were you given enough privacy when being examined or treated in the A&E Department?	75.3%	87.1%	90.8%	96.1%	258	91.2%	● (green)

The Accident & Emergency Department - Longitudinal Charts

3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

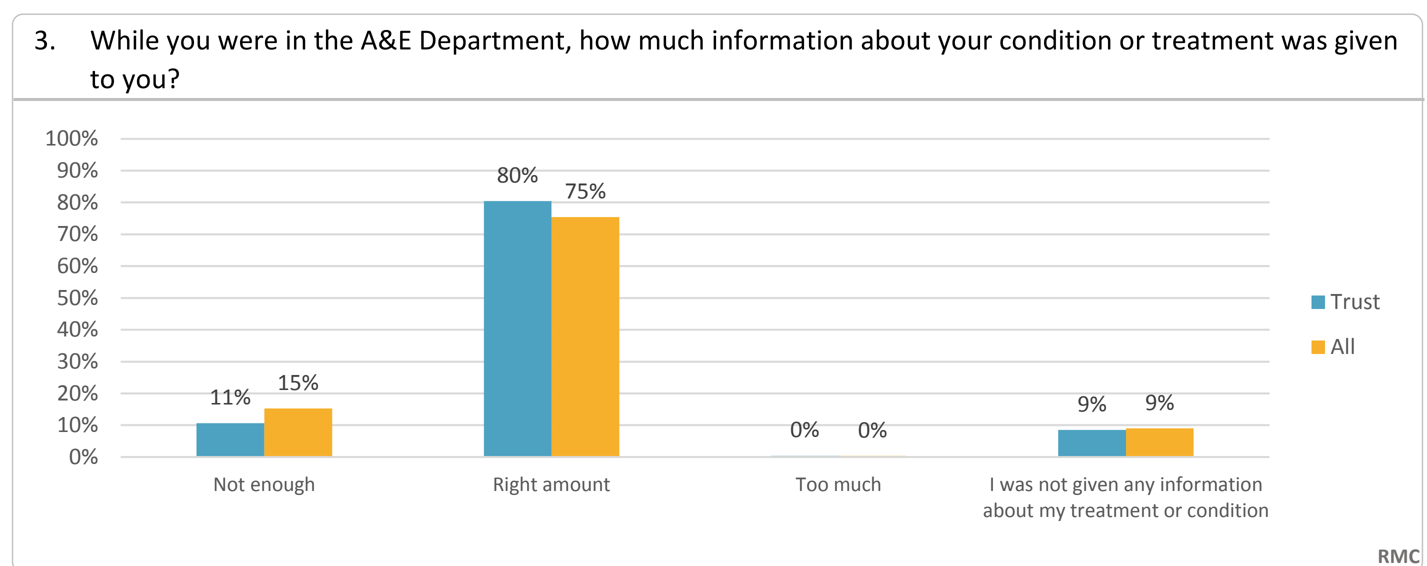


4. Were you given enough privacy when being examined or treated in the A&E Department?

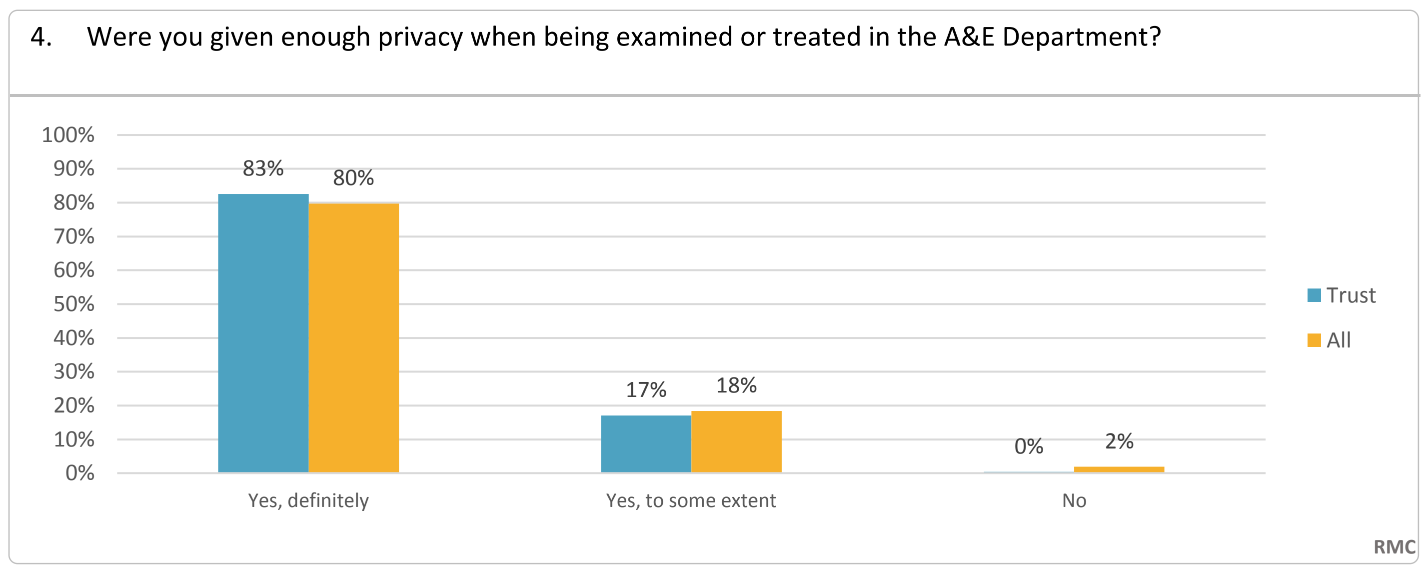


The Accident & Emergency Department - Compositional Charts

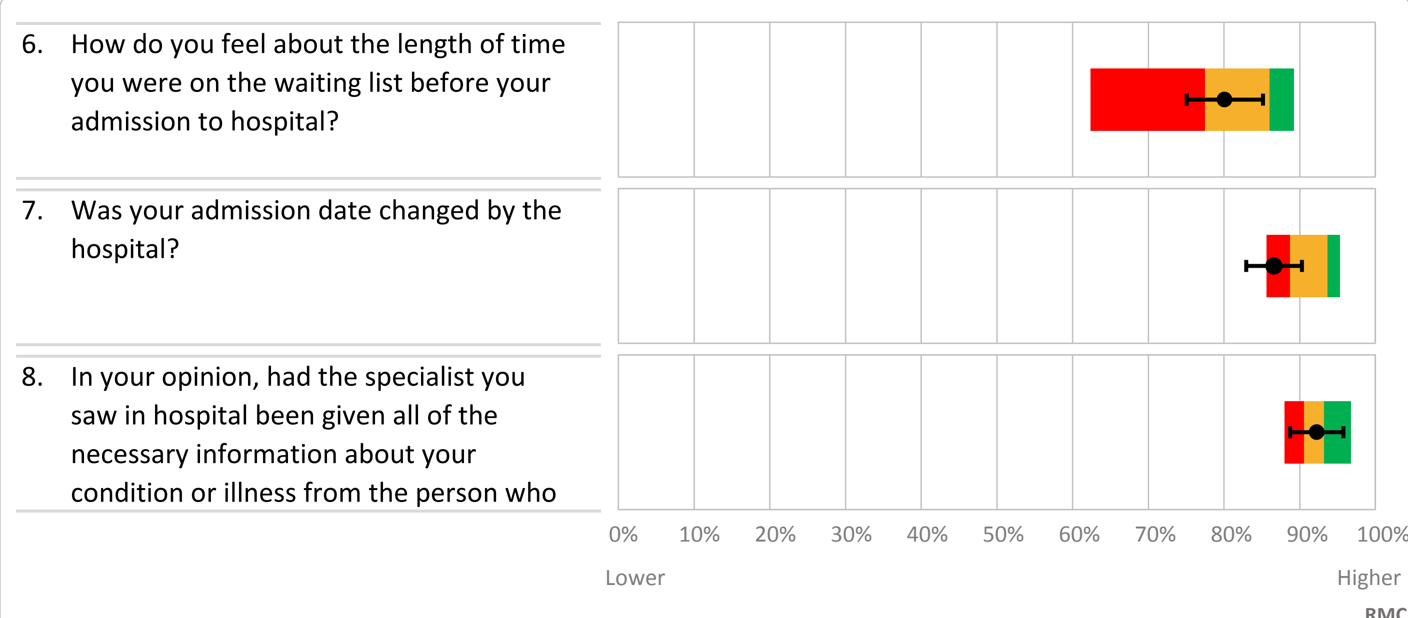
3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



4. Were you given enough privacy when being examined or treated in the A&E Department?



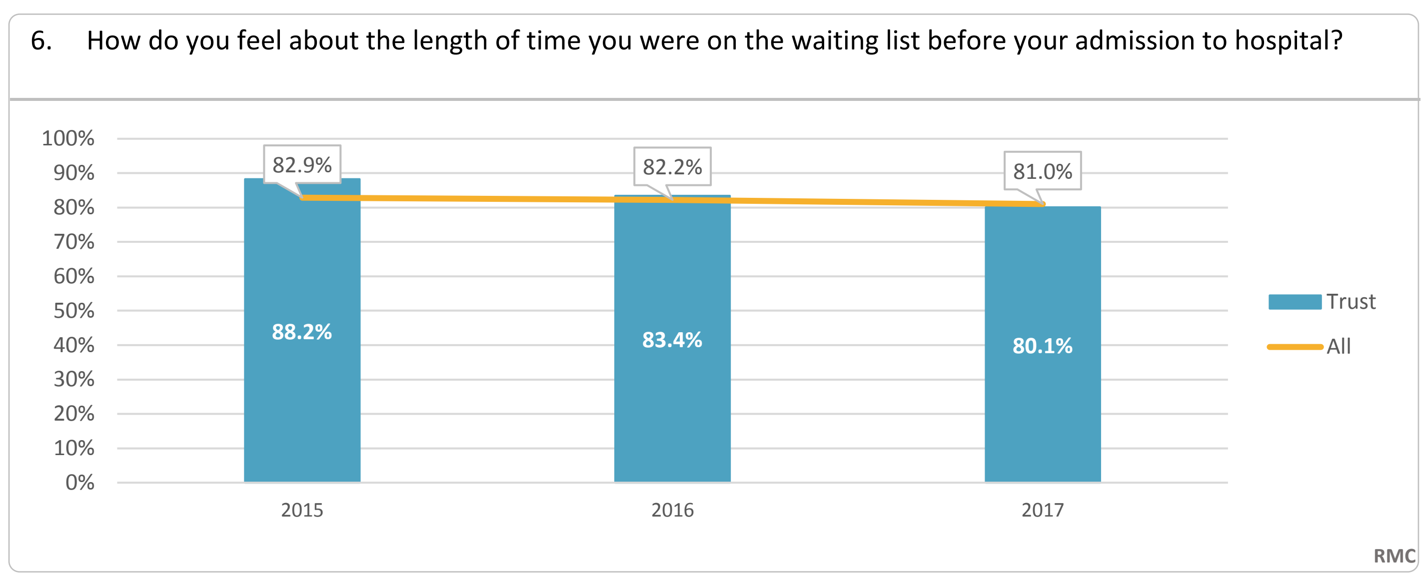
Waiting List or Planned Admission - Benchmark Charts and Tables



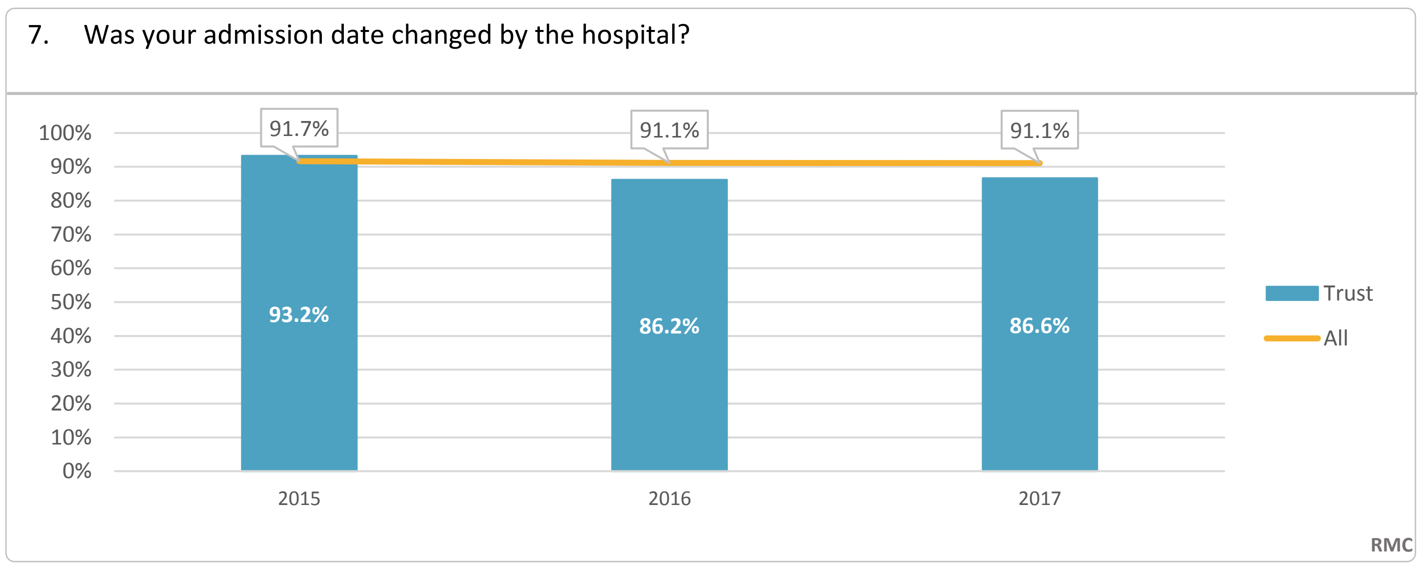
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	62.4%	77.5%	86.0%	89.2%	97	80.1%	●
7. Was your admission date changed by the hospital?	85.6%	88.7%	93.7%	95.3%	97	86.6%	●
8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who	88.0%	90.6%	93.3%	96.8%	95	92.3%	●

Waiting List or Planned Admission - Longitudinal Charts

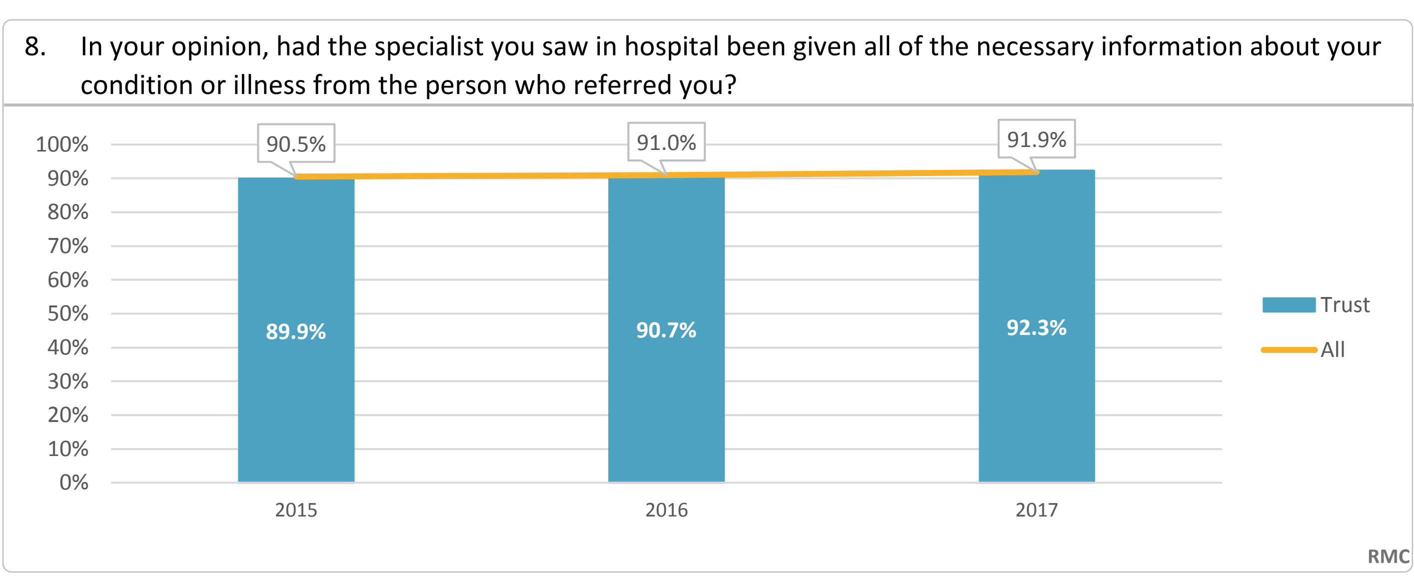
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?



7. Was your admission date changed by the hospital?

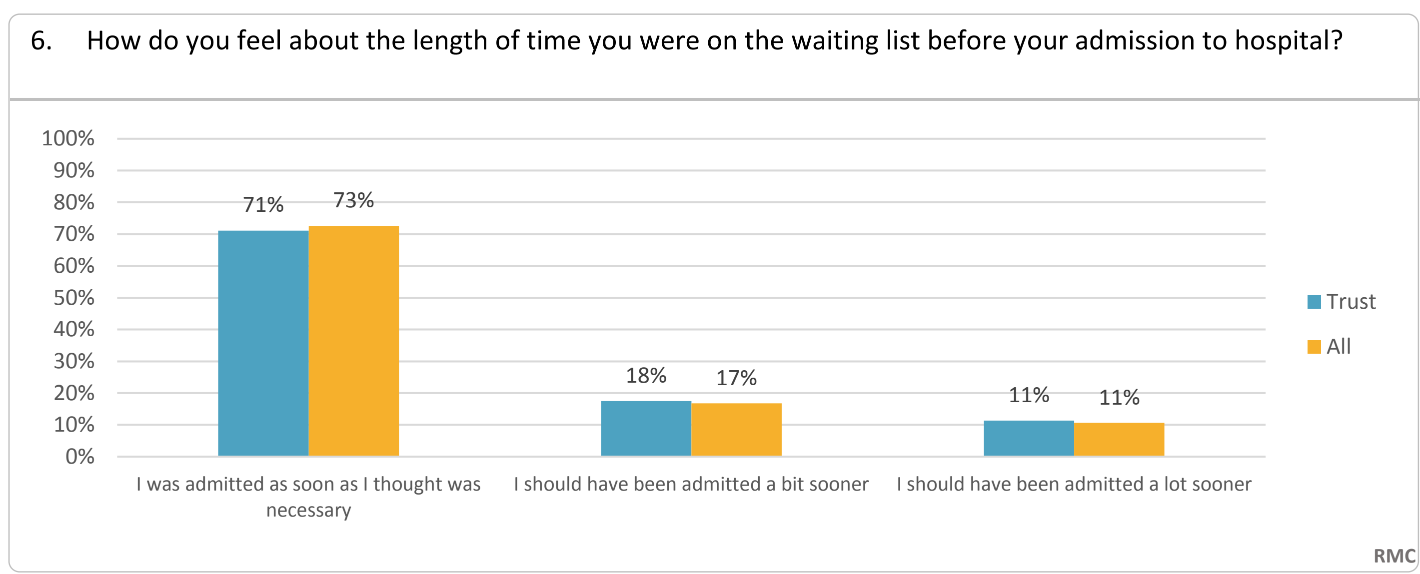


8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?

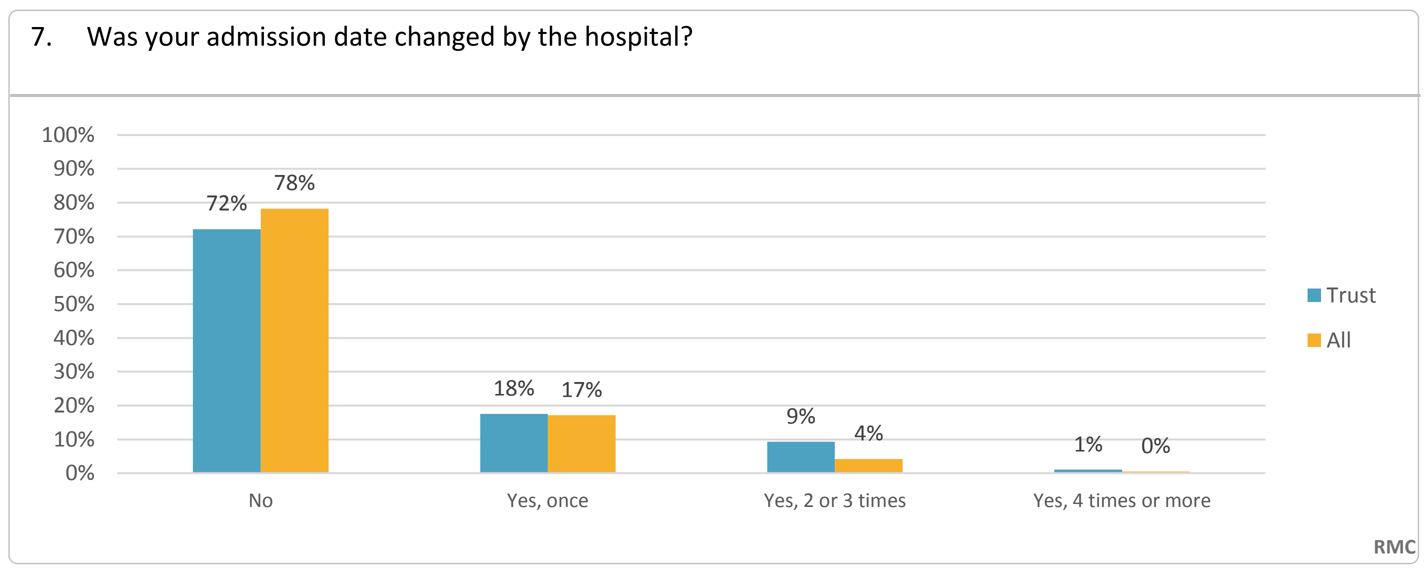


Waiting List or Planned Admission - Compositional Charts

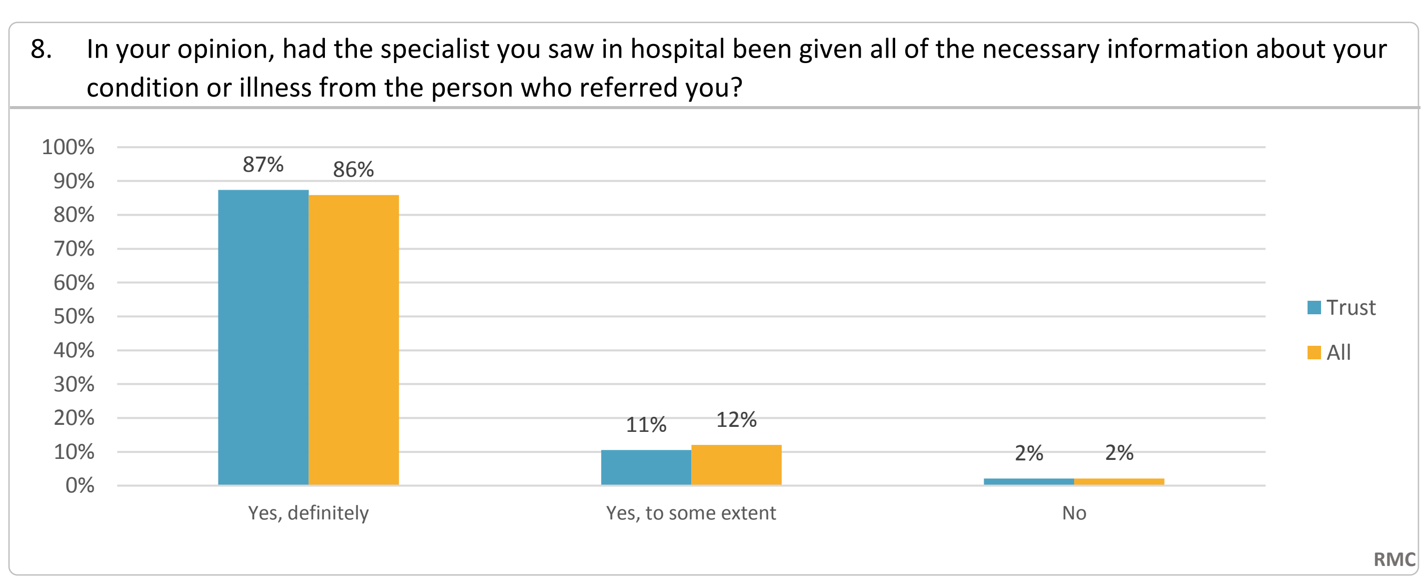
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?



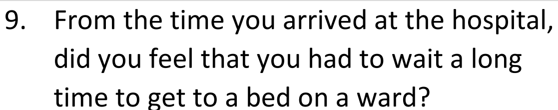
7. Was your admission date changed by the hospital?

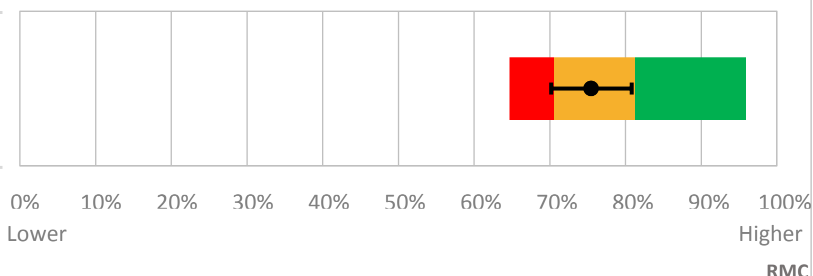


8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?



All Types of Admission - Benchmark Charts and Tables

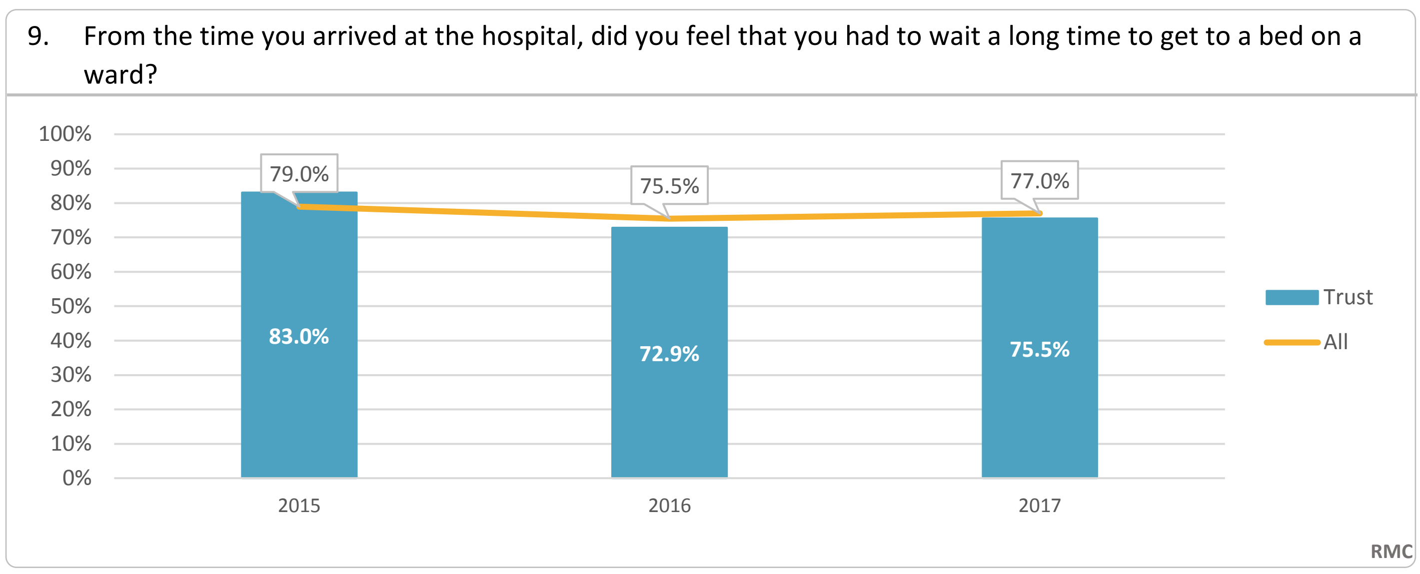




	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	64.7%	70.6%	81.3%	95.9%	382	75.5%	●

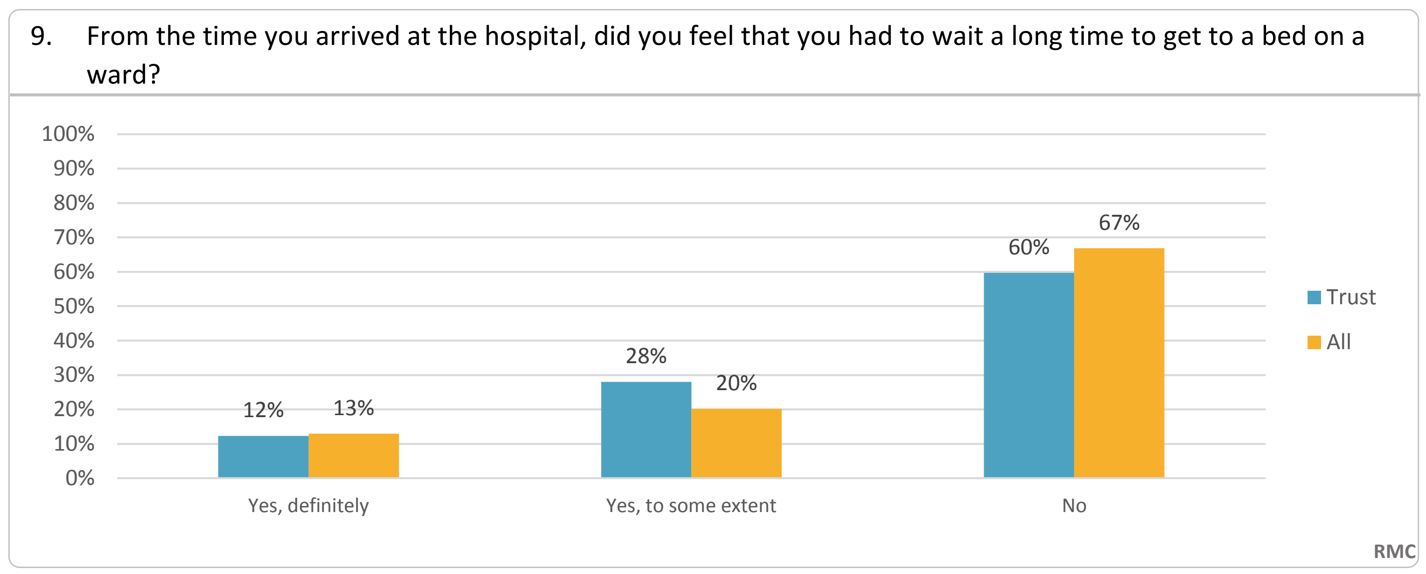
All Types of Admission - Longitudinal Charts

9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

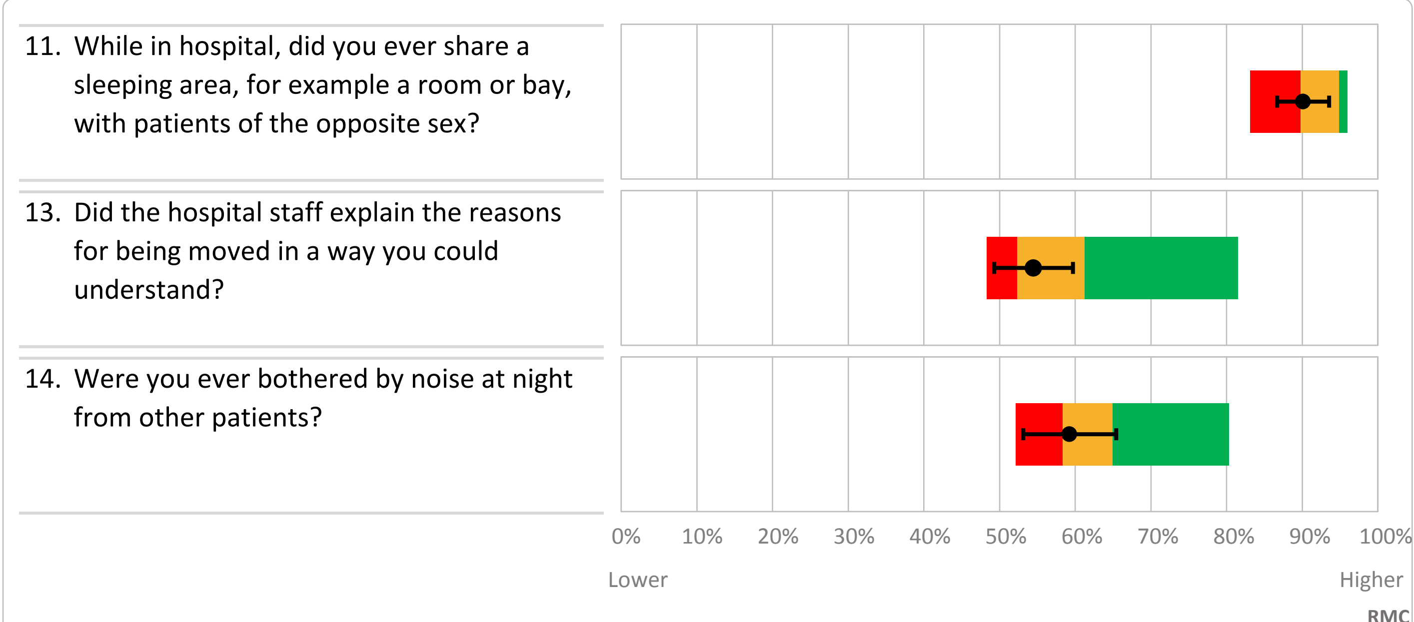


All Types of Admission - Compositional Charts

9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

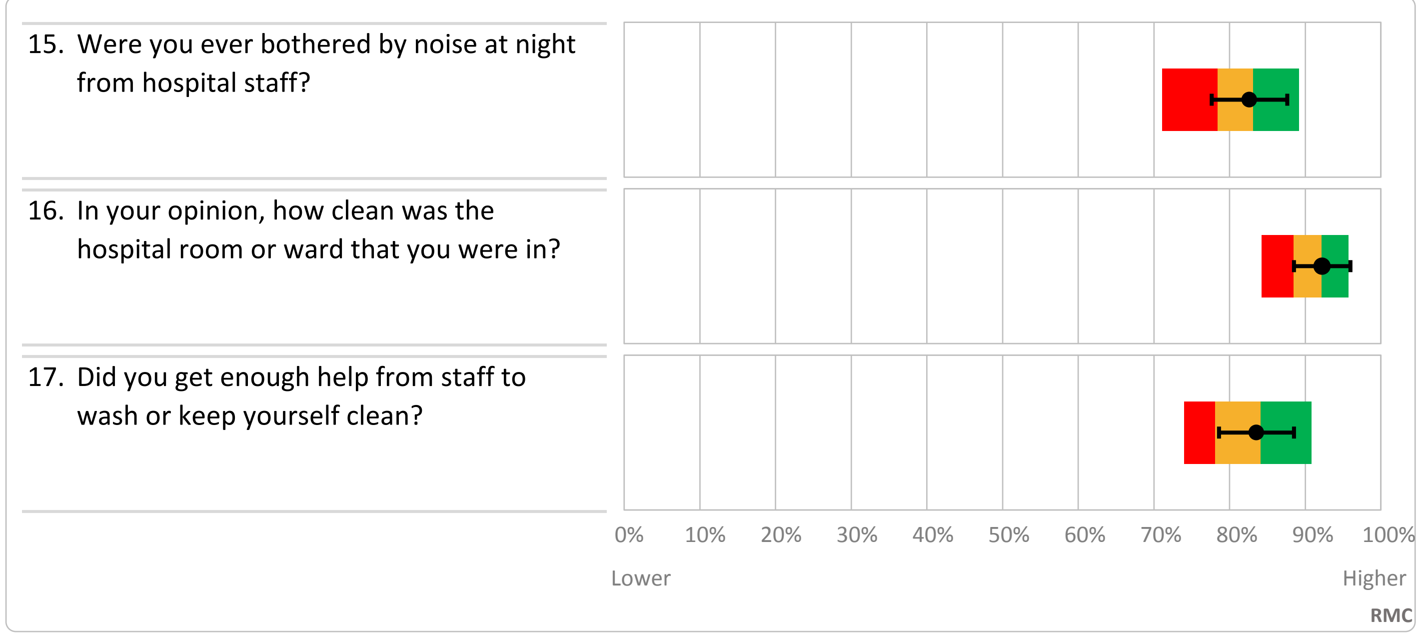


The Hospital & Ward - Benchmark Charts and Tables



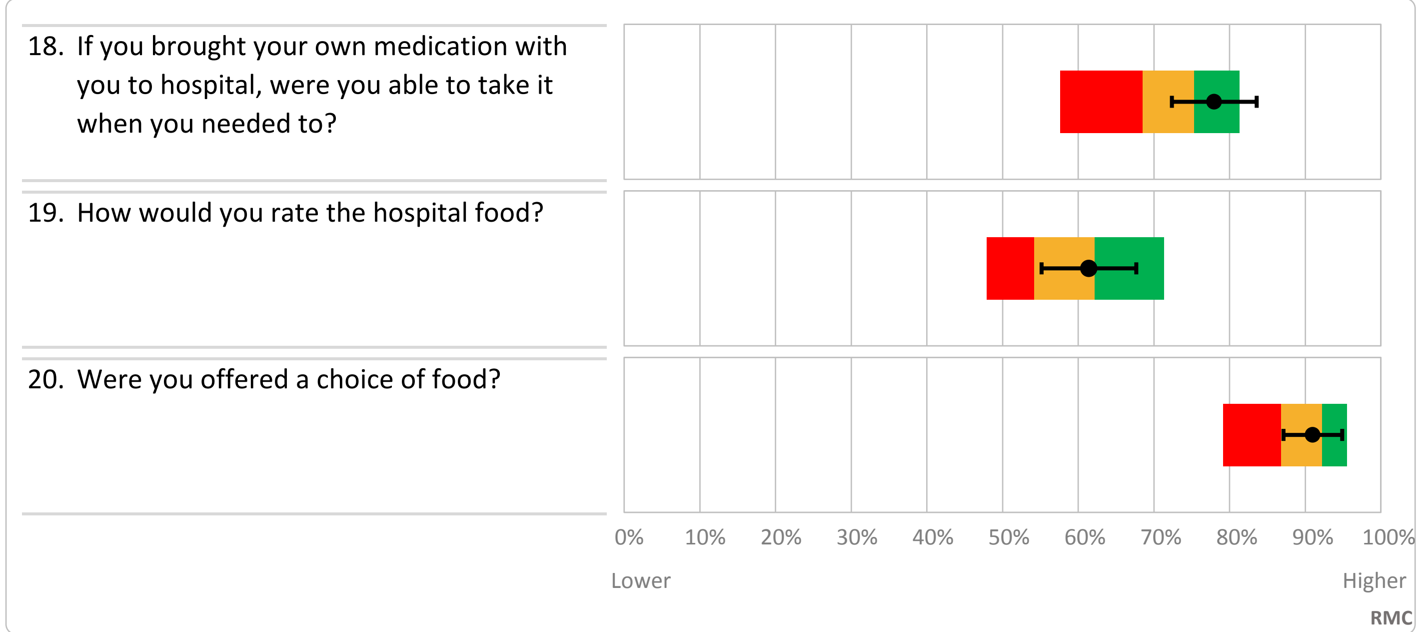
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
11. While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	83.1%	89.7%	94.9%	96.0%	387	90.1%	●
13. Did the hospital staff explain the reasons for being moved in a way you could understand?	48.3%	52.4%	61.2%	81.5%	78	54.5%	●
14. Were you ever bothered by noise at night from other patients?	52.1%	58.4%	65.0%	80.3%	382	59.3%	●

The Hospital & Ward - Benchmark Charts and Tables (continued)



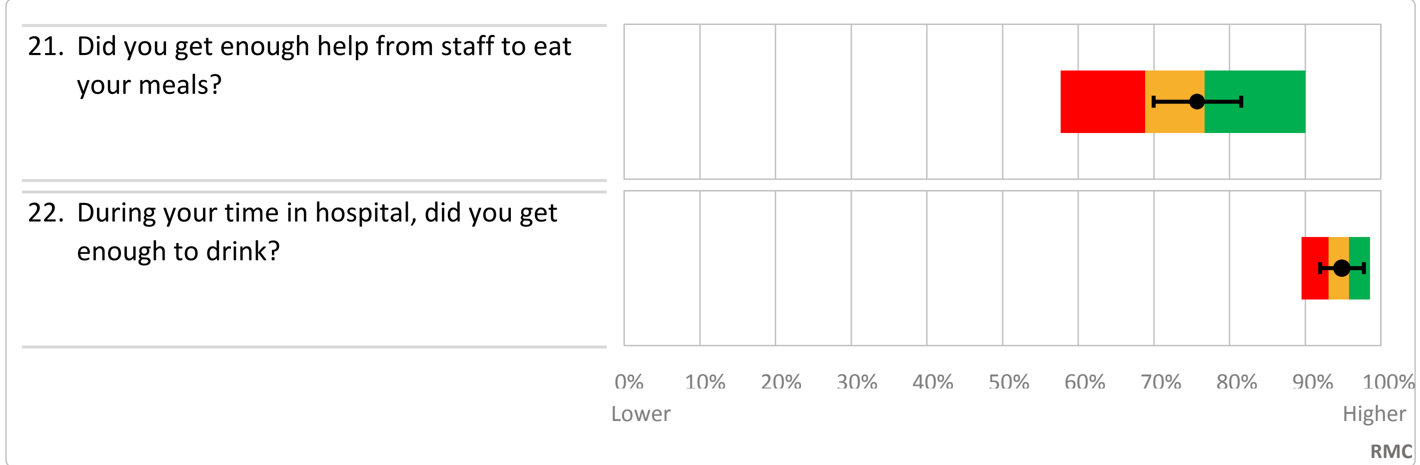
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
15. Were you ever bothered by noise at night from hospital staff?	71.1%	78.5%	83.1%	89.2%	382	82.6%	●
16. In your opinion, how clean was the hospital room or ward that you were in?	84.3%	88.5%	92.2%	95.8%	385	92.2%	●
17. Did you get enough help from staff to wash or keep yourself clean?	74.0%	78.1%	84.1%	90.8%	229	83.6%	●

The Hospital & Ward - Benchmark Charts and Tables (continued)



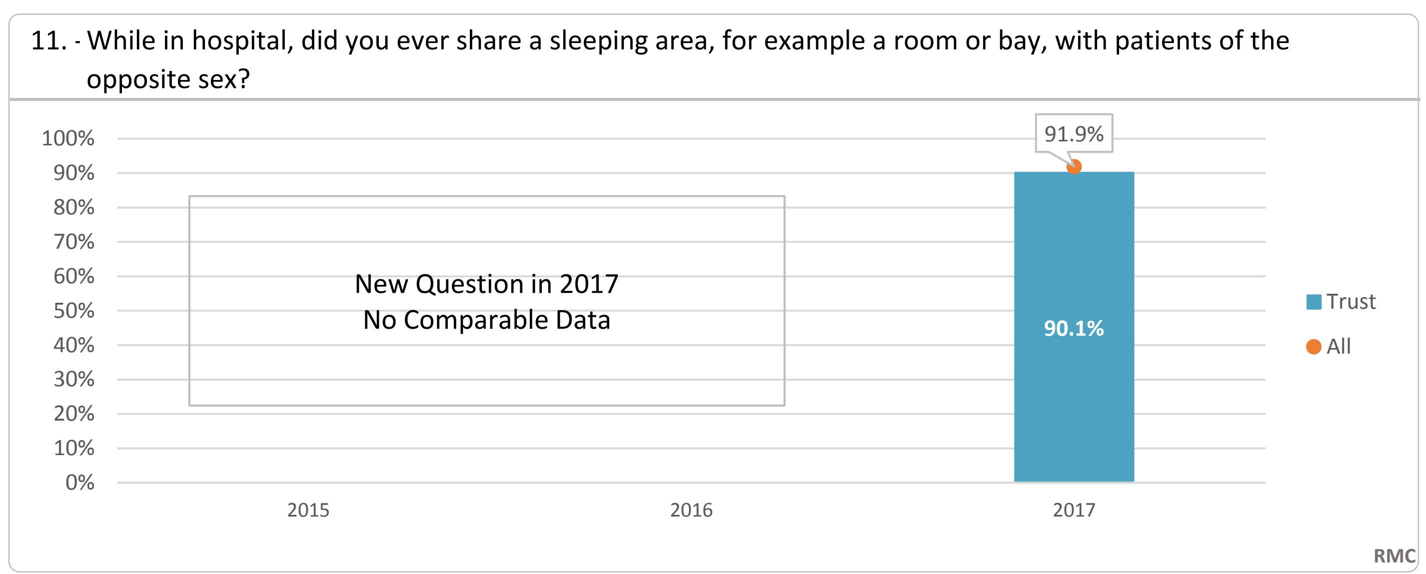
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
18. If you brought your own medication with you to hospital, were you able to take it when you needed to?	57.6%	68.5%	75.4%	81.3%	218	78.0%	●
19. How would you rate the hospital food?	47.9%	54.2%	62.1%	71.4%	369	61.4%	●
20. Were you offered a choice of food?	79.2%	86.8%	92.3%	95.5%	380	91.0%	●

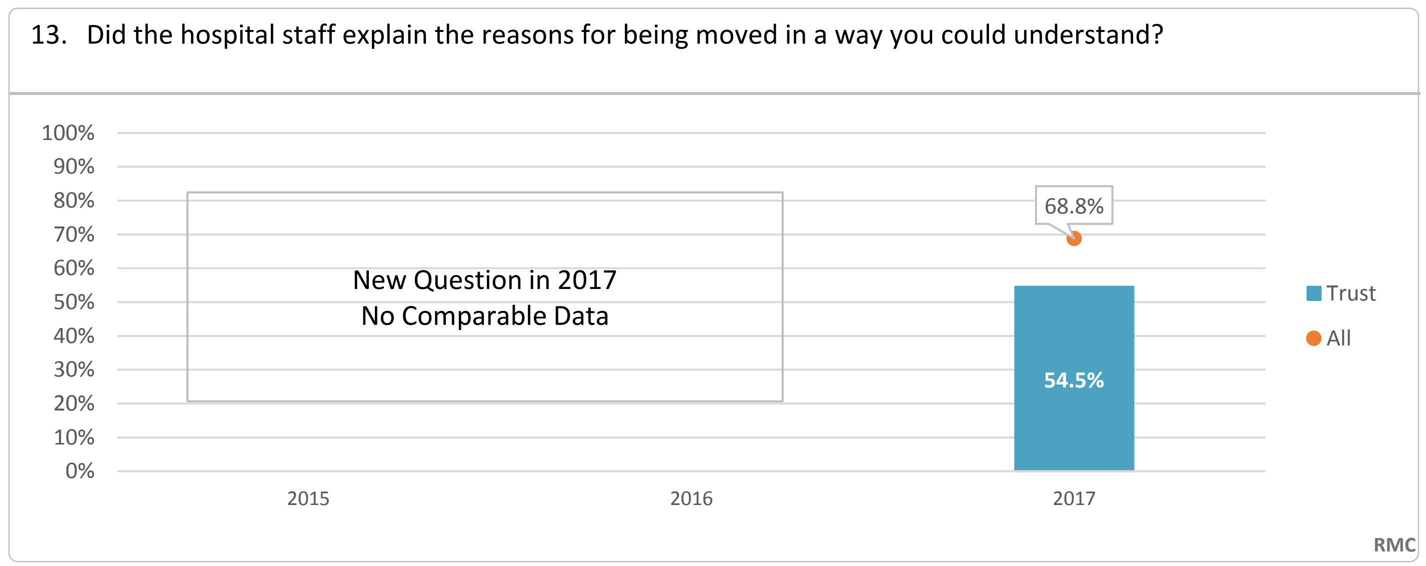
The Hospital & Ward - Benchmark Charts and Tables (continued)

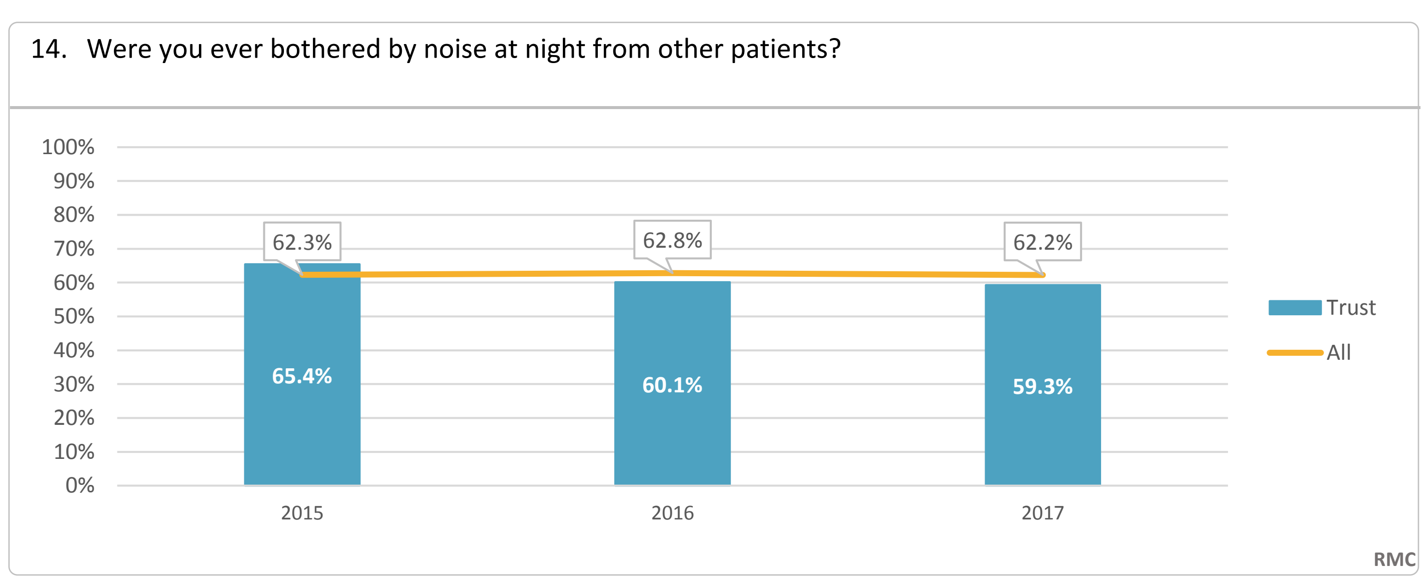


	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
21. Did you get enough help from staff to eat your meals?	57.7%	68.9%	76.7%	90.0%	80	75.8%	●
22. During your time in hospital, did you get enough to drink?	89.5%	93.1%	95.8%	98.5%	372	94.9%	●

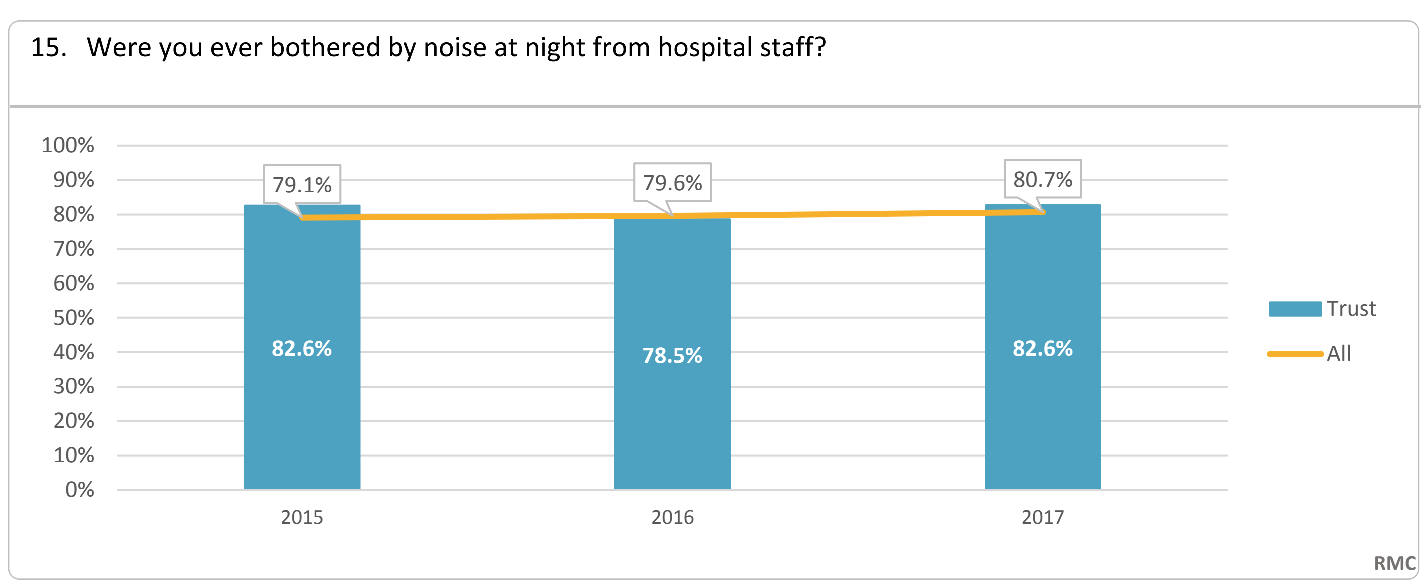
The Hospital & Ward - Longitudinal Charts

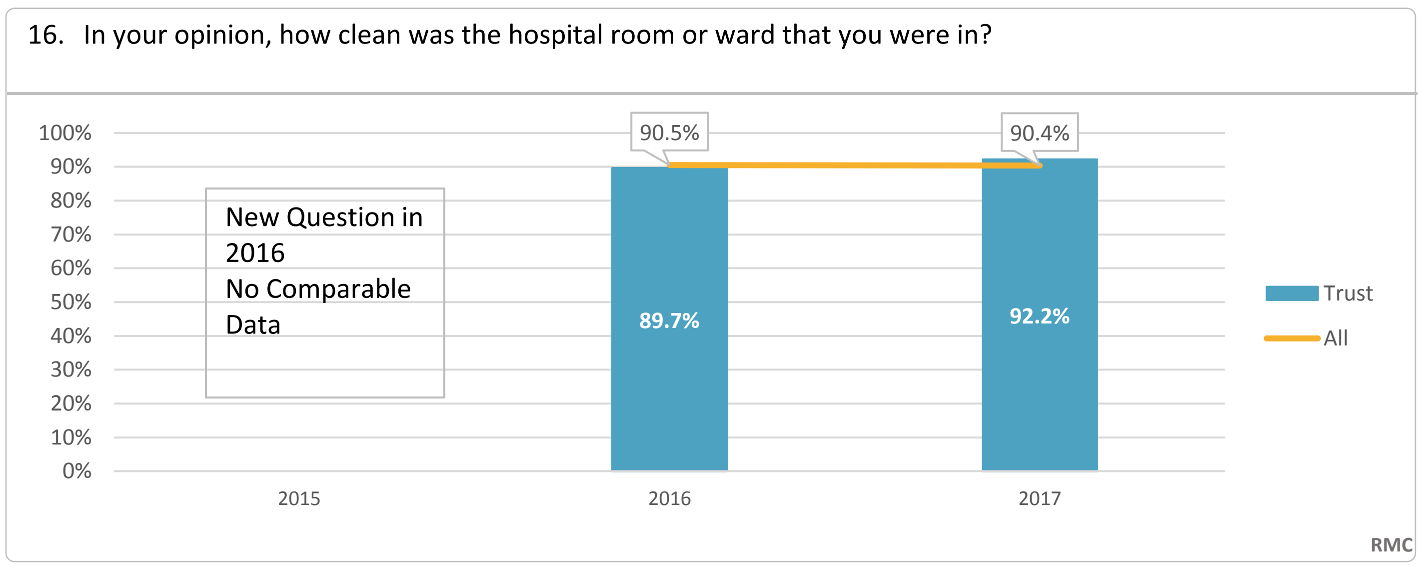


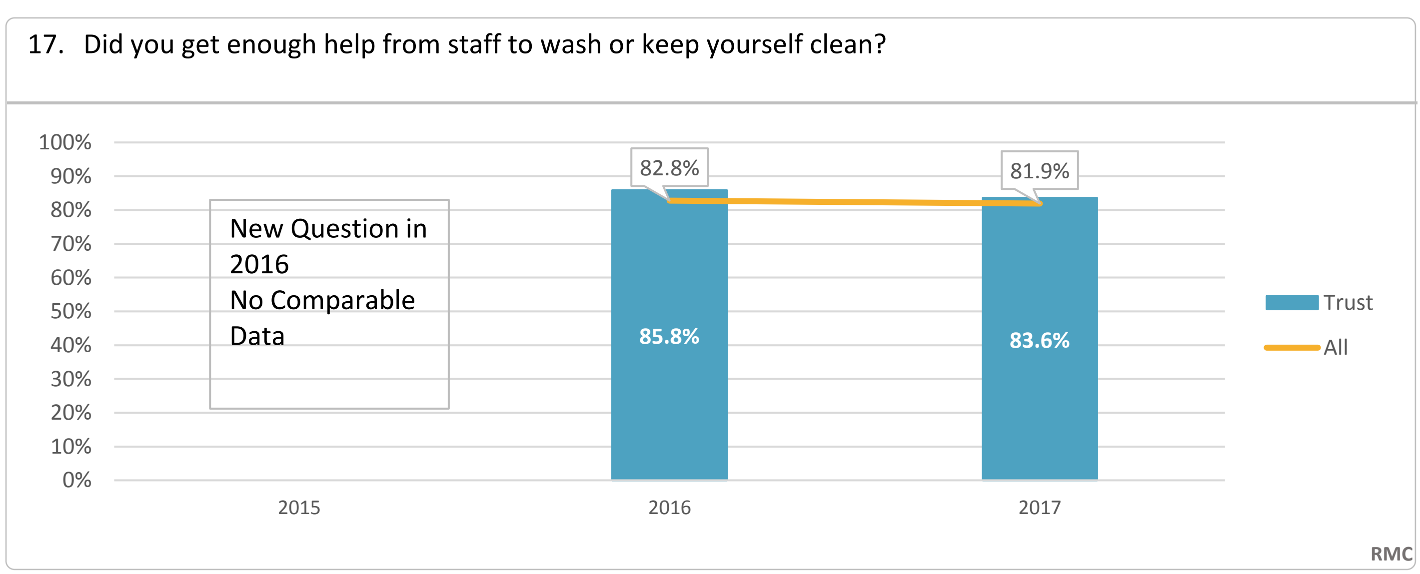




The Hospital & Ward - Longitudinal Charts (continued)

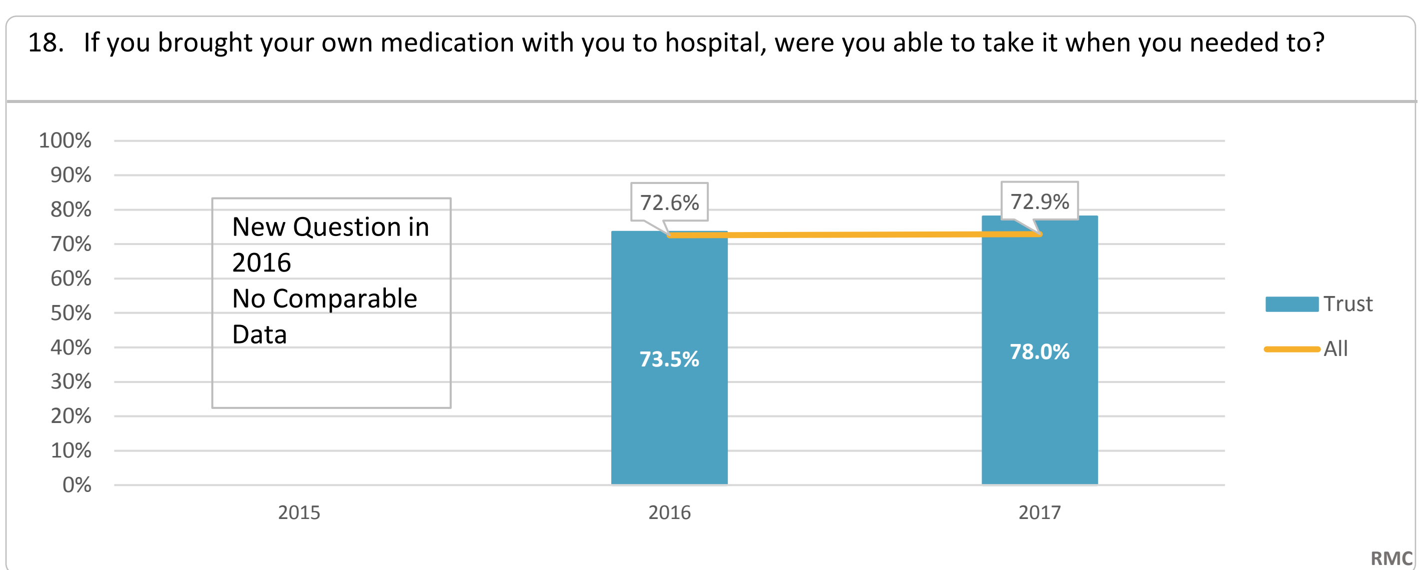




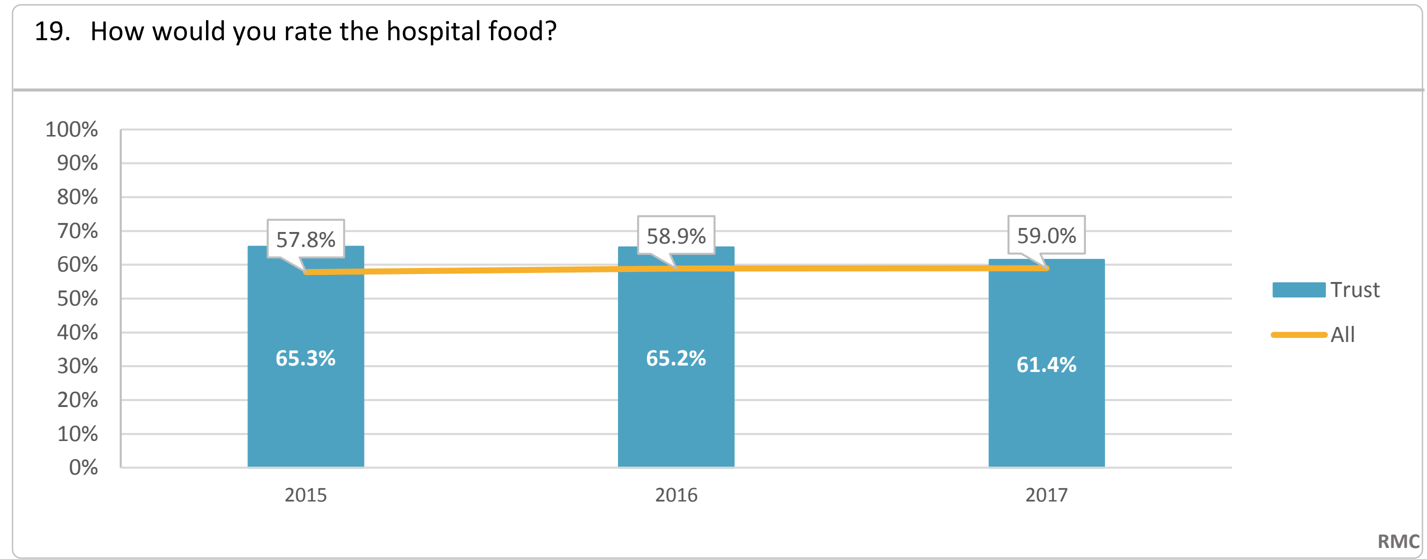


The Hospital & Ward - Longitudinal Charts (continued)

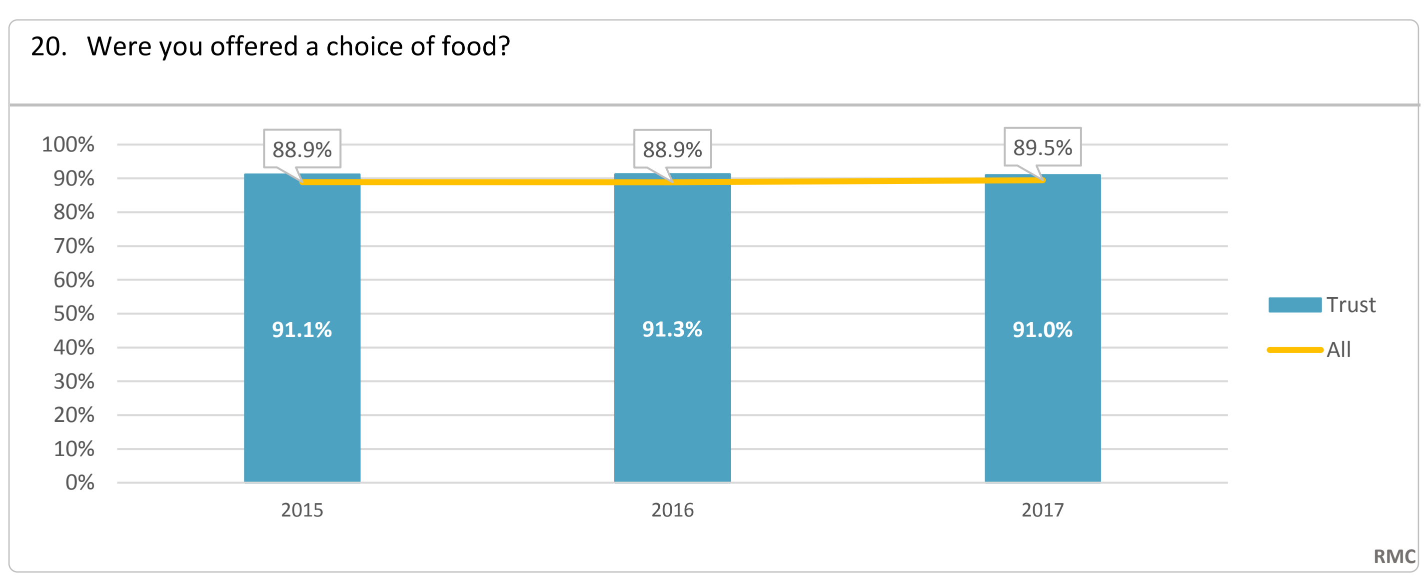
18. If you brought your own medication with you to hospital, were you able to take it when you needed to?



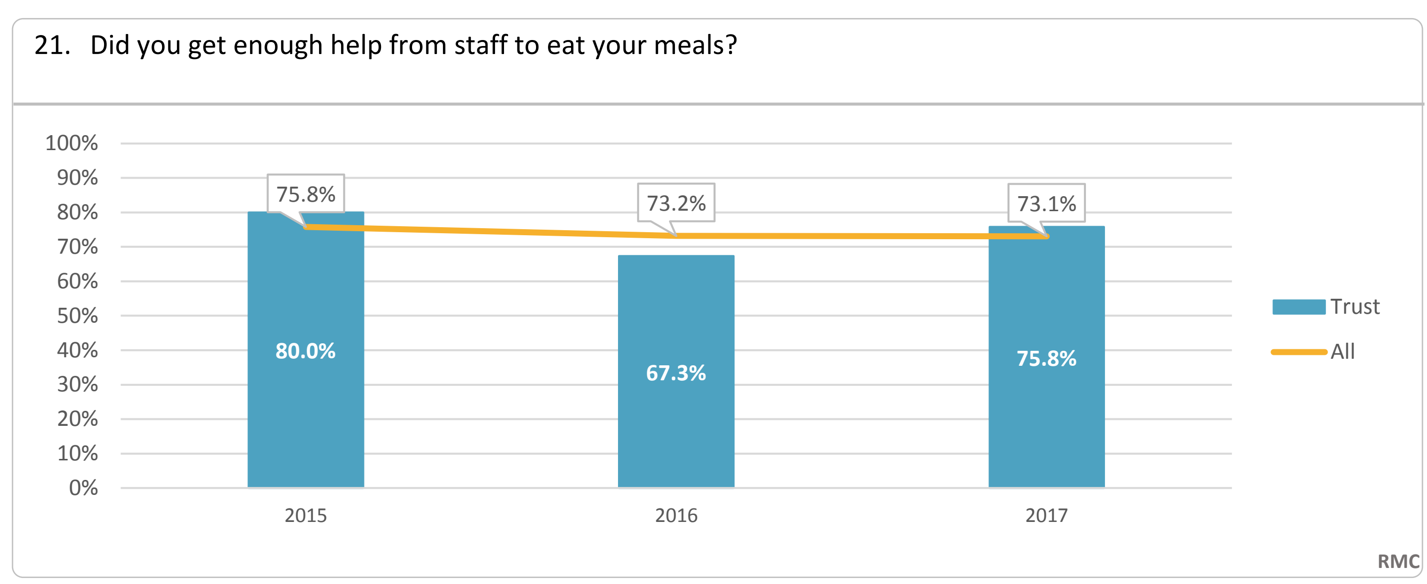
19. How would you rate the hospital food?

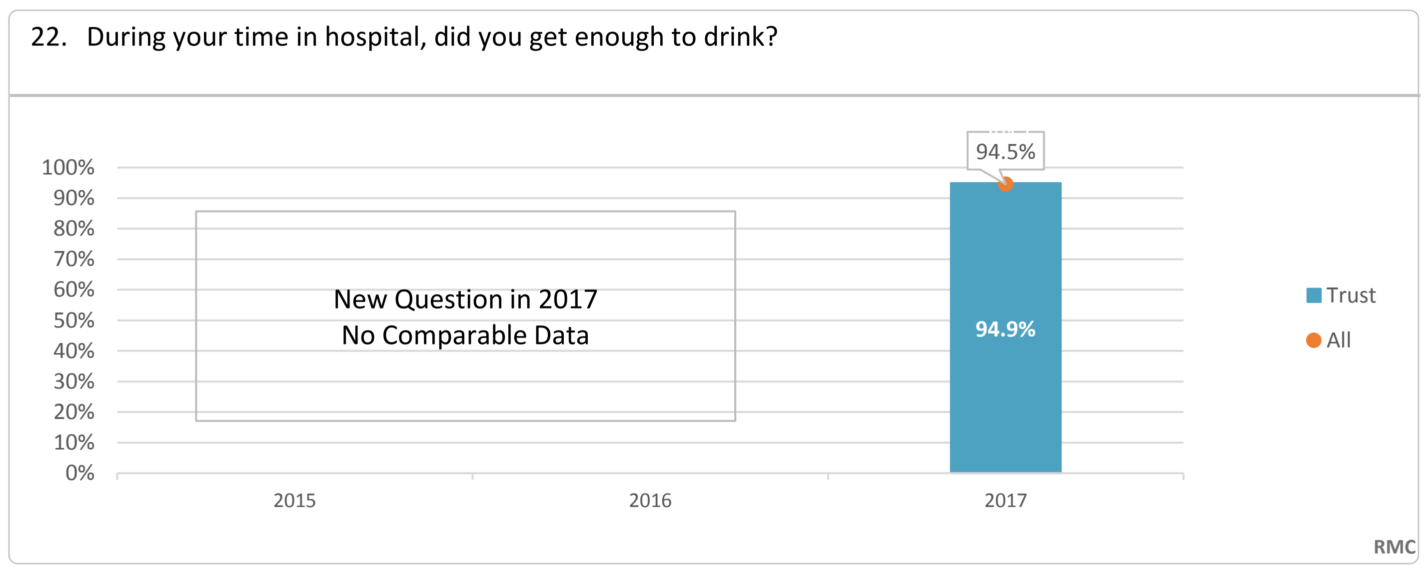


20. Were you offered a choice of food?

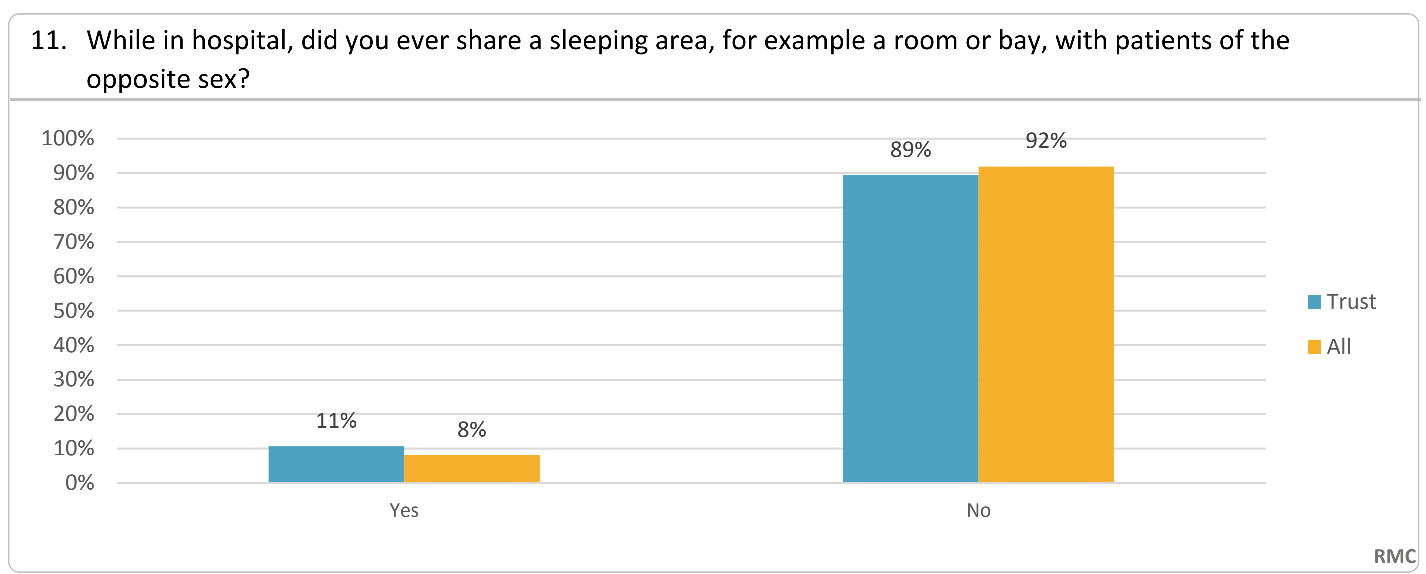


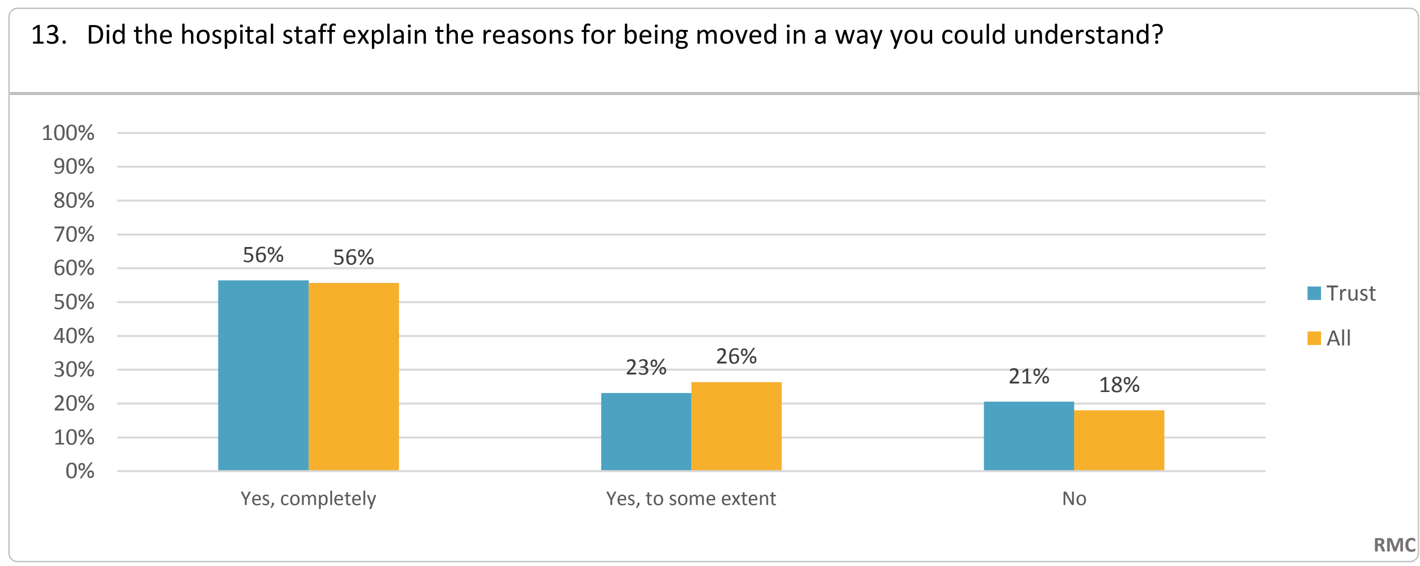
The Hospital & Ward - Longitudinal Charts (continued)

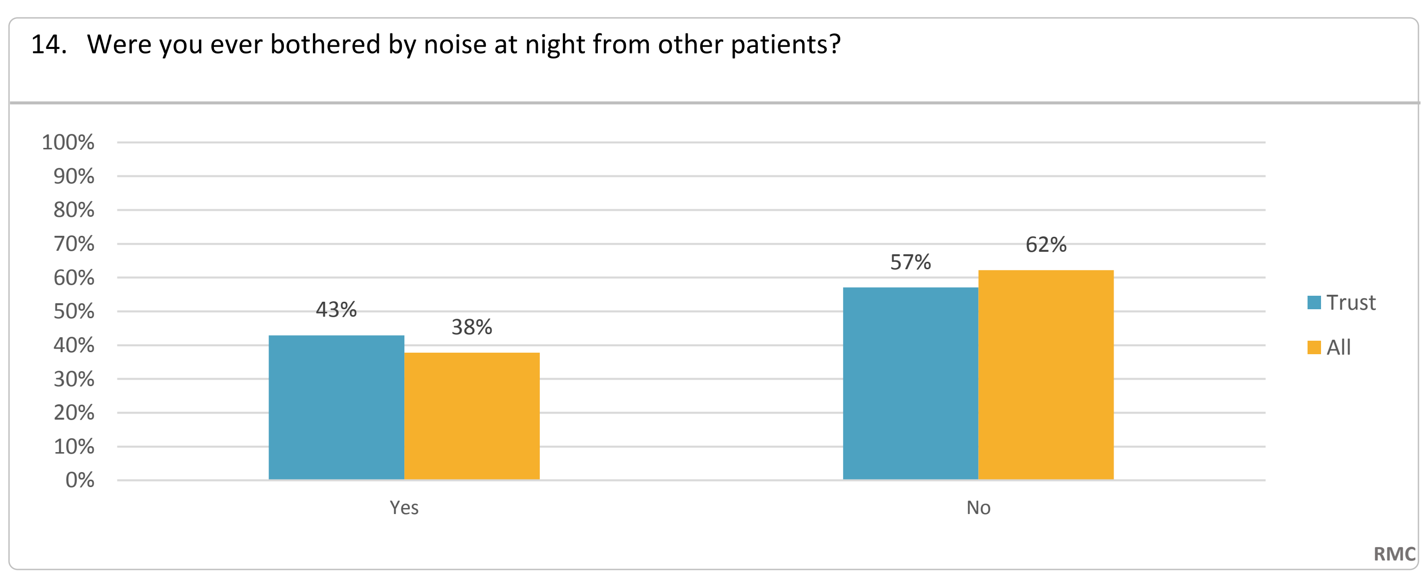




The Hospital & Ward - Compositional Charts

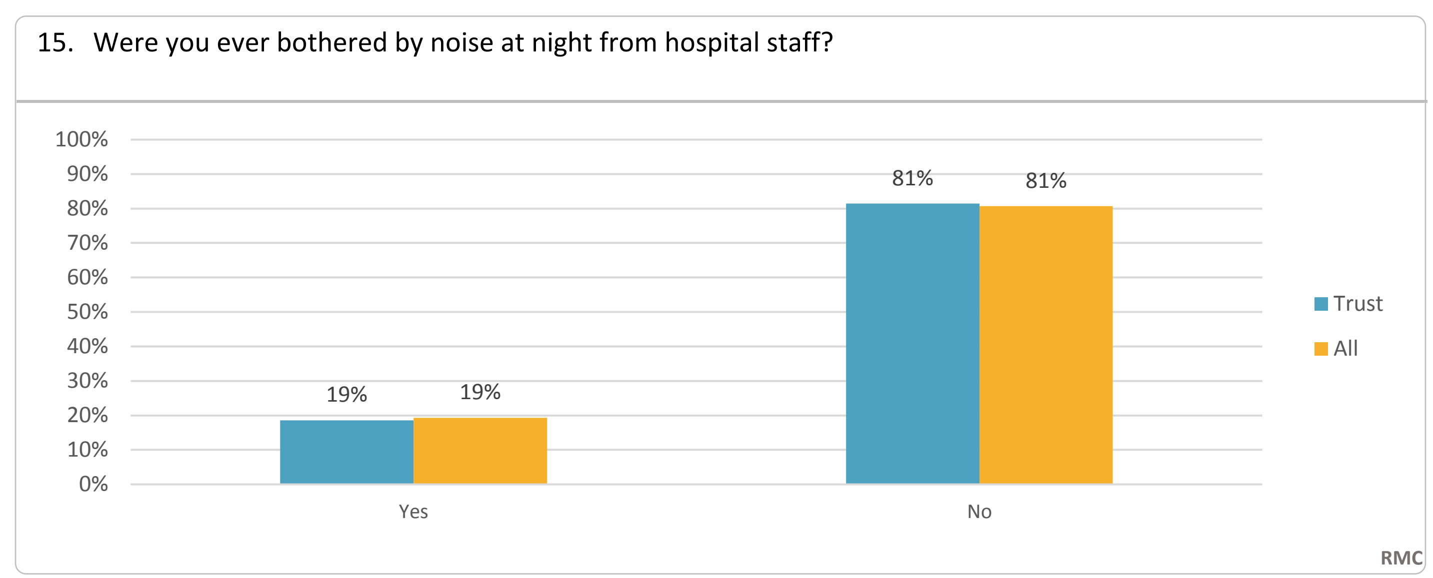




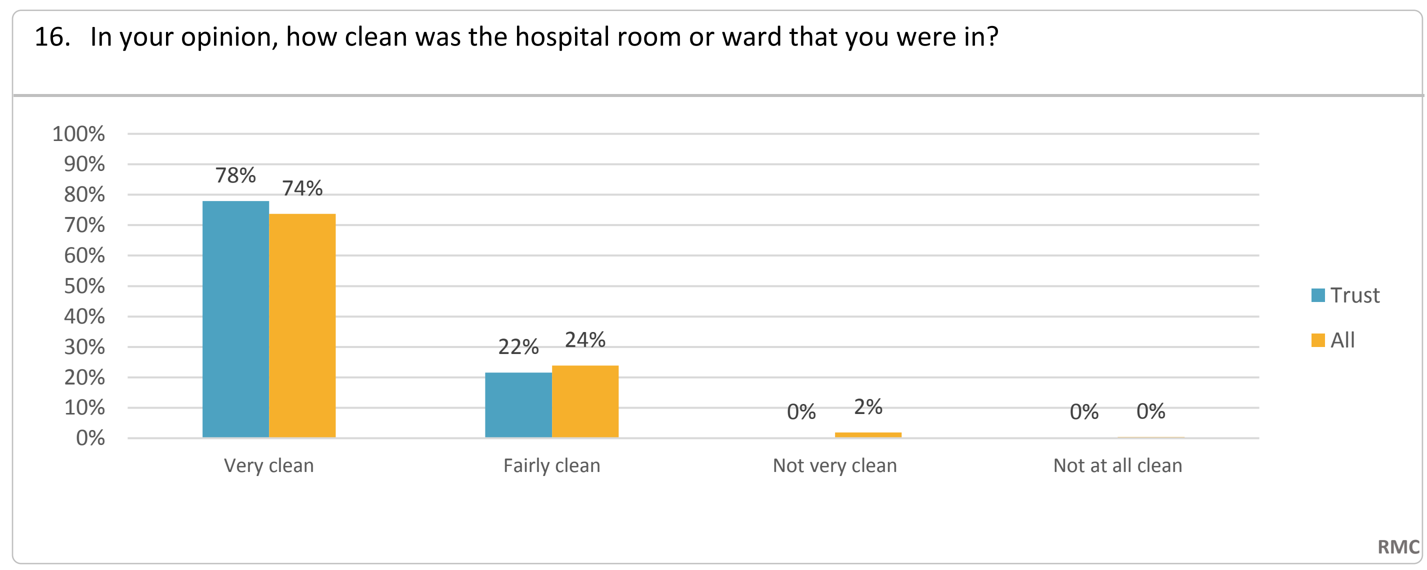


The Hospital & Ward - Compositional Charts (continued)

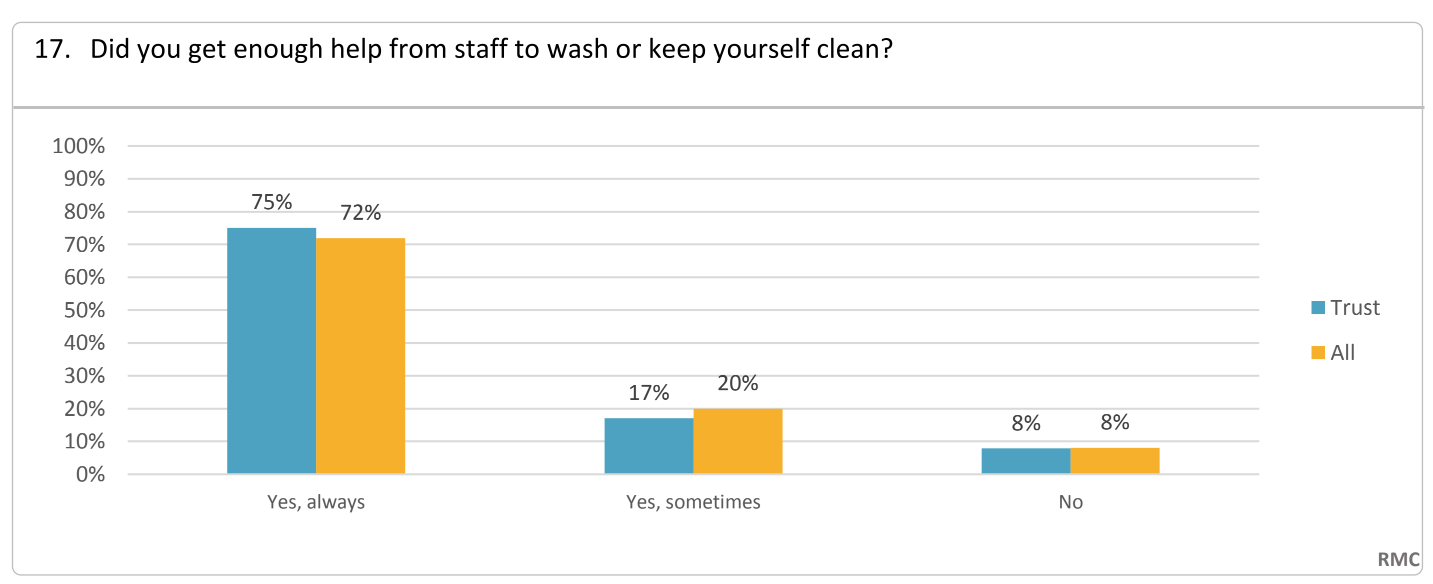
15. Were you ever bothered by noise at night from hospital staff?



16. In your opinion, how clean was the hospital room or ward that you were in?

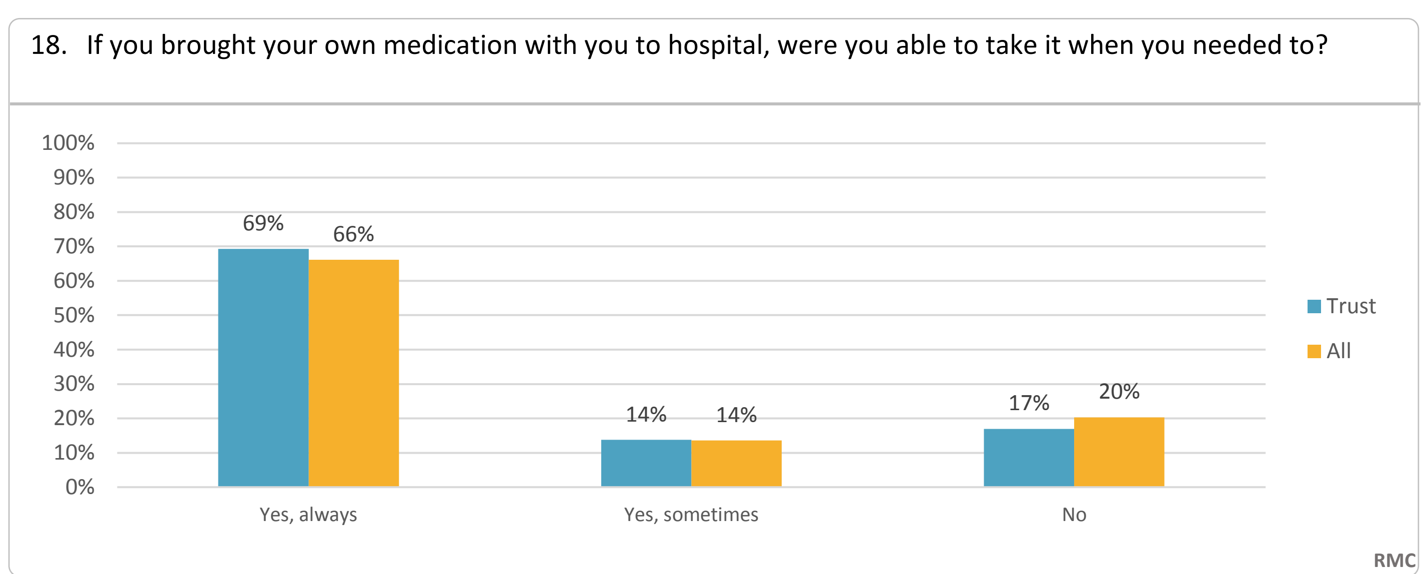


17. Did you get enough help from staff to wash or keep yourself clean?

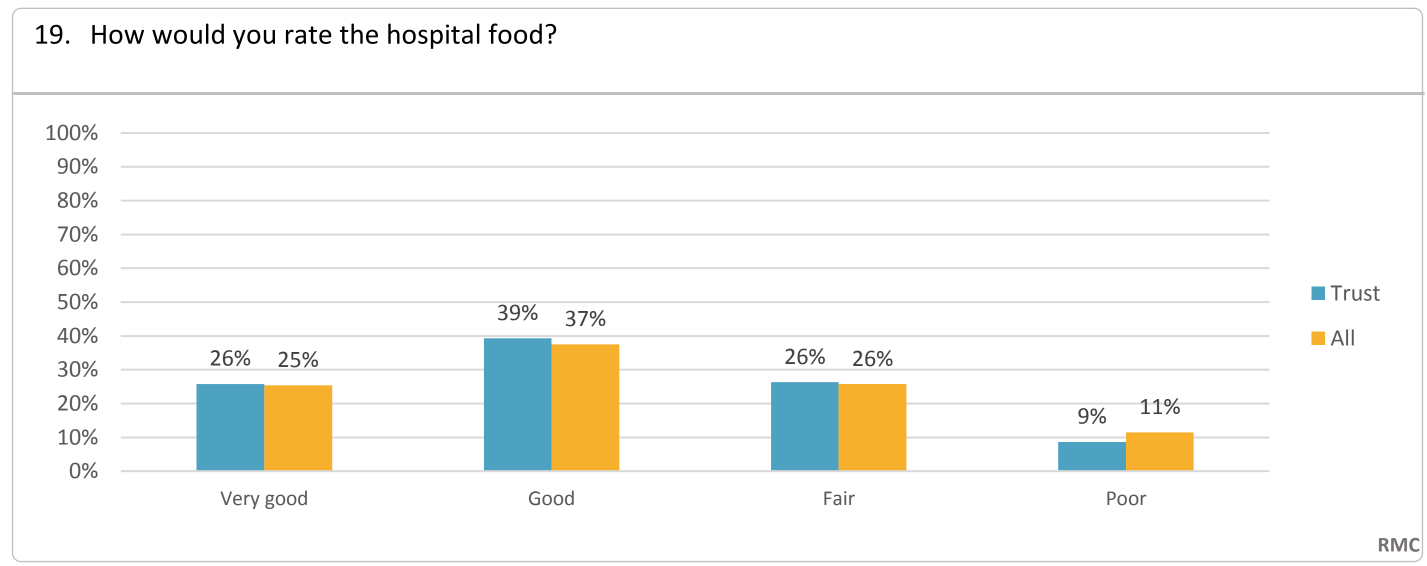


The Hospital & Ward - Compositional Charts (continued)

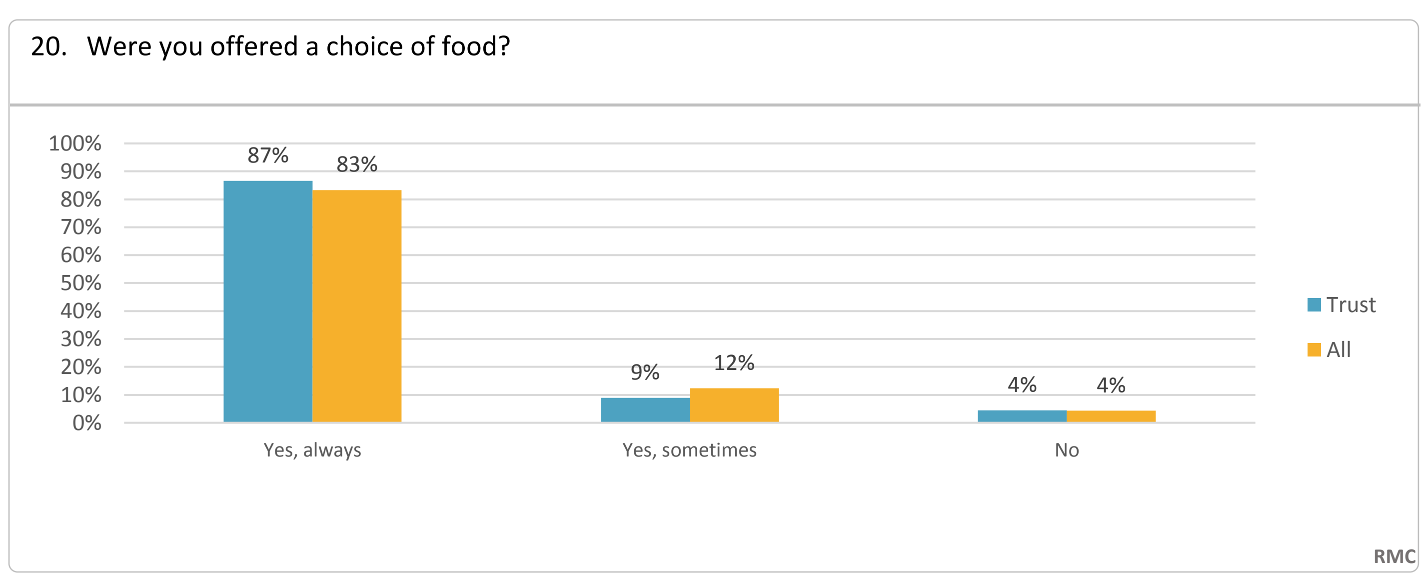
18. If you brought your own medication with you to hospital, were you able to take it when you needed to?



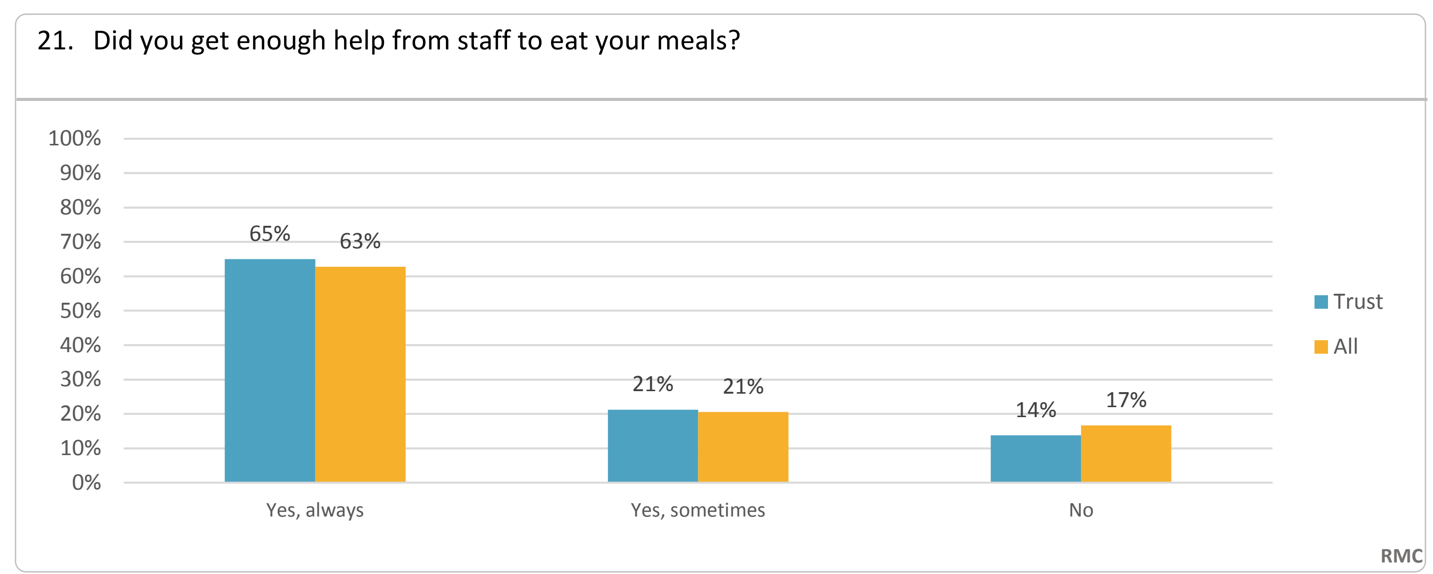
19. How would you rate the hospital food?

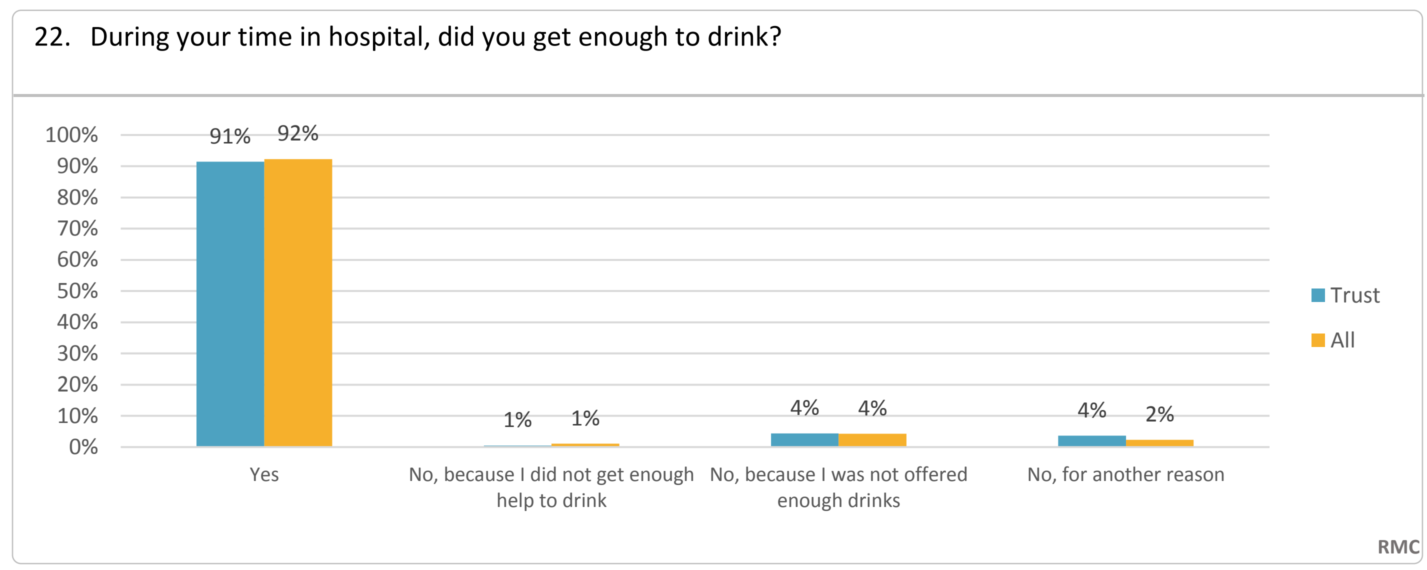


20. Were you offered a choice of food?

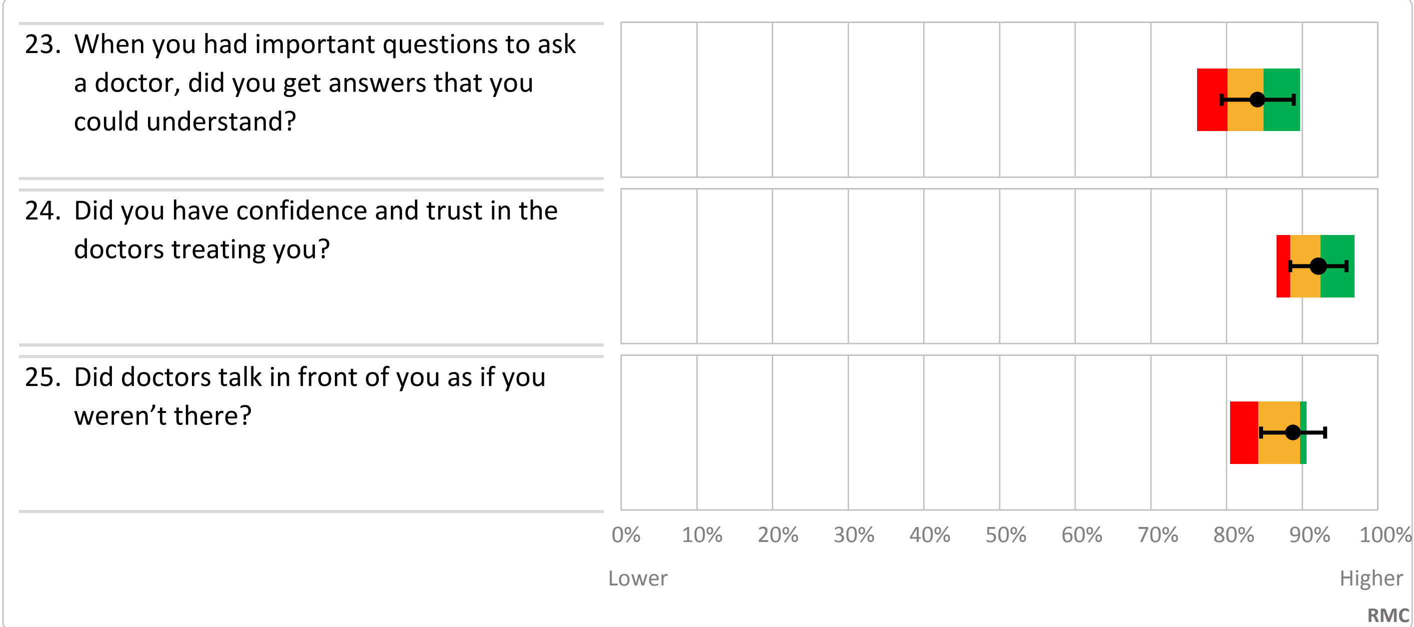


The Hospital & Ward - Compositional Charts (continued)



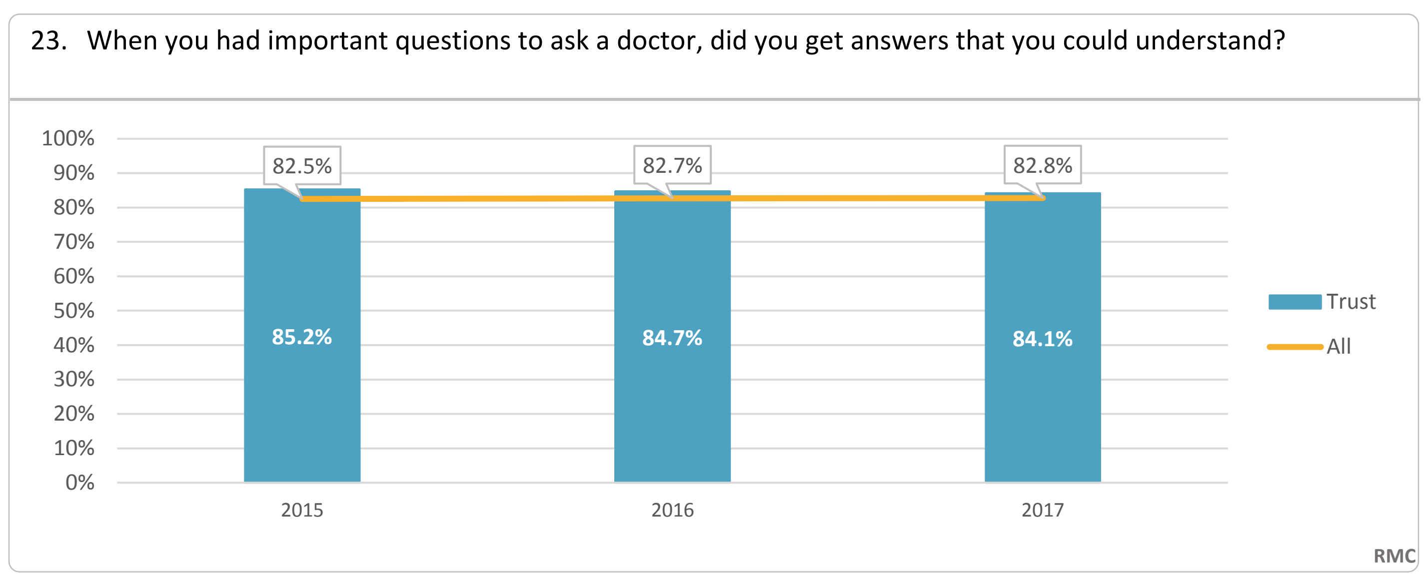


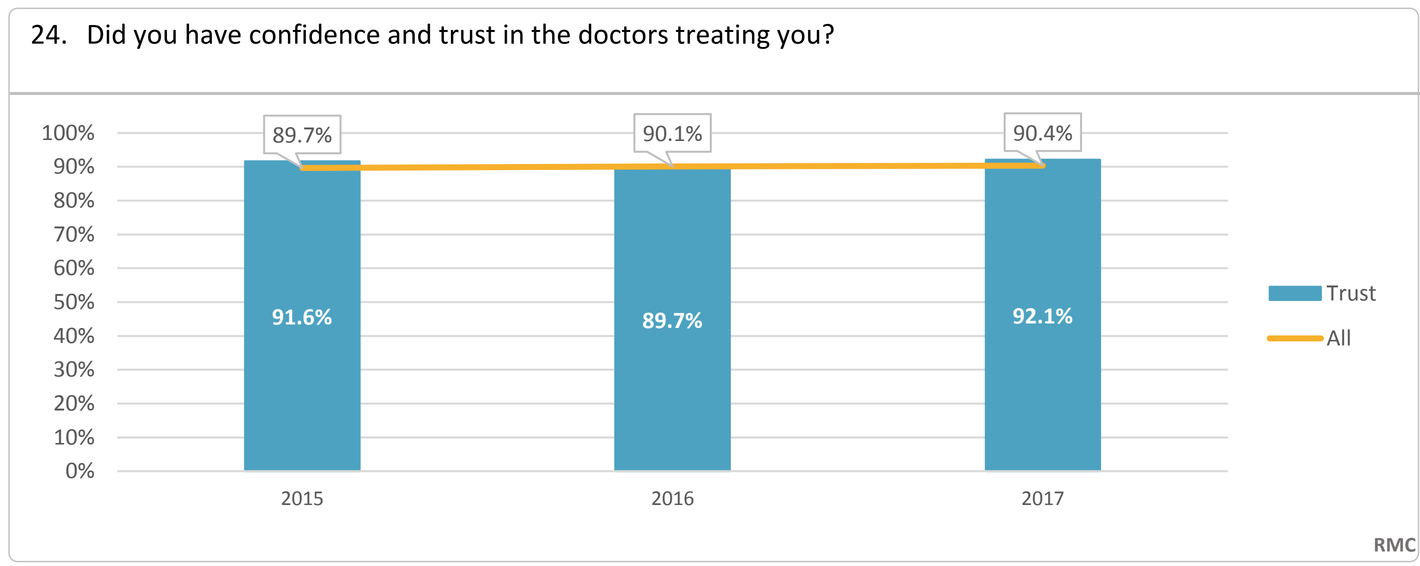
Doctors - Benchmark Charts and Tables

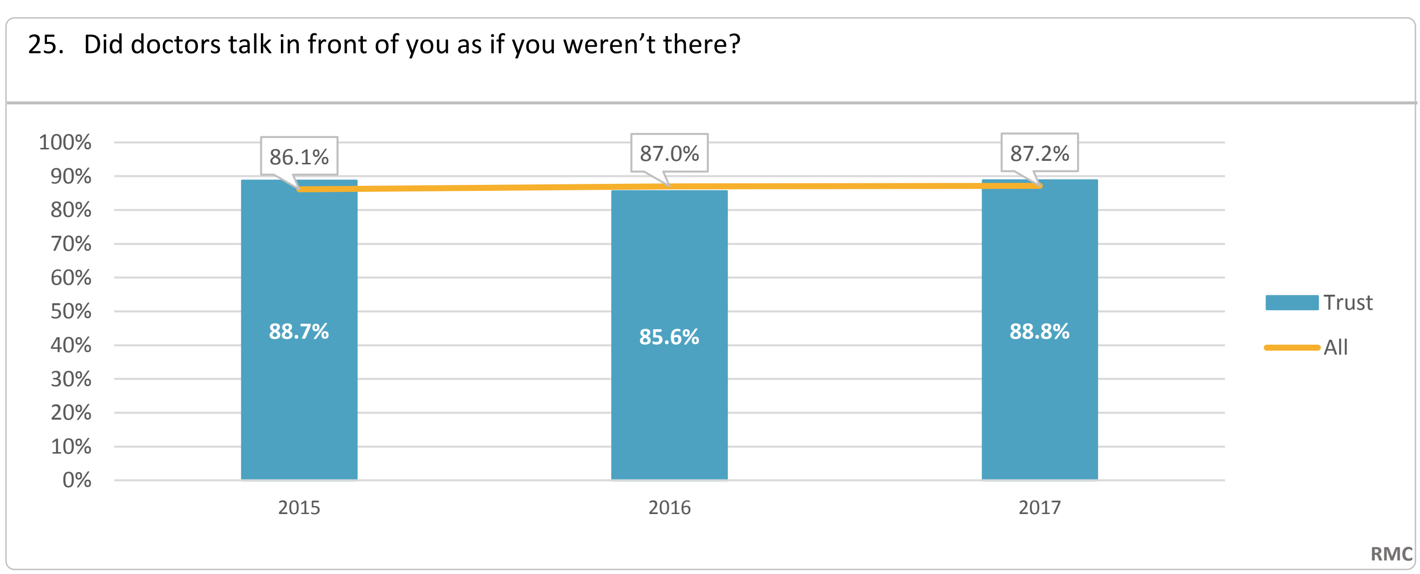


	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
23. When you had important questions to ask a doctor, did you get answers that you could understand?	76.1%	80.2%	84.9%	89.7%	342	84.1%	●
24. Did you have confidence and trust in the doctors treating you?	86.6%	88.4%	92.5%	96.9%	386	92.1%	●
25. Did doctors talk in front of you as if you weren't there?	80.5%	84.2%	89.8%	90.6%	382	88.8%	●

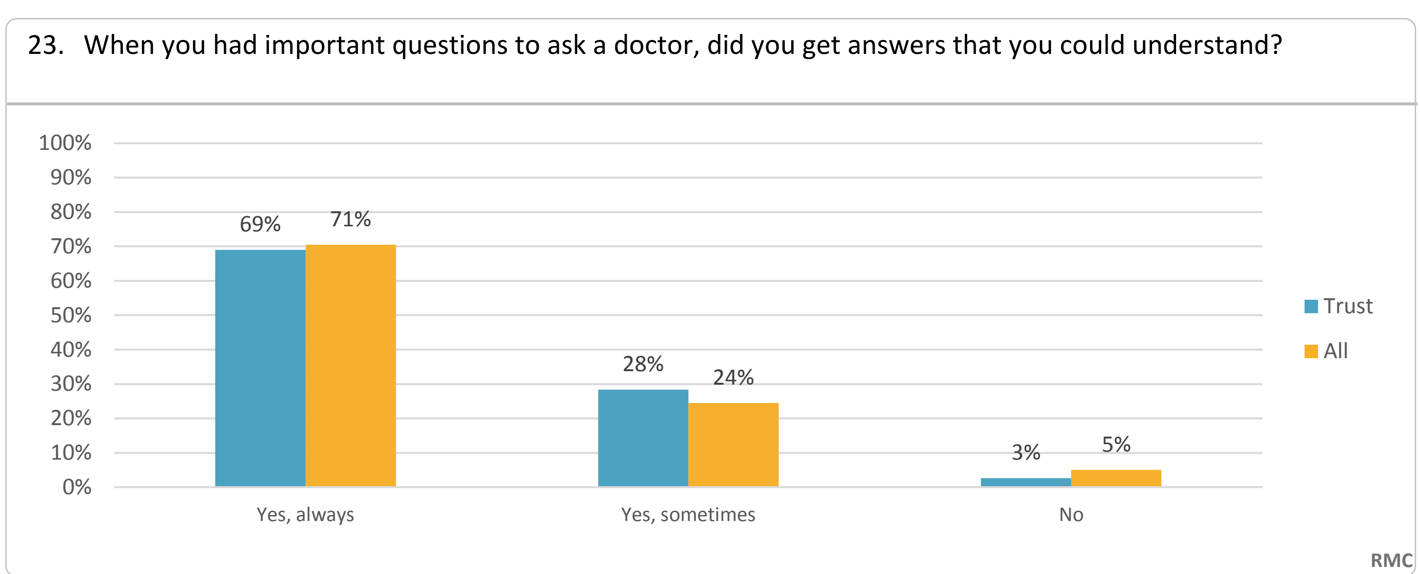
Doctors - Longitudinal Charts

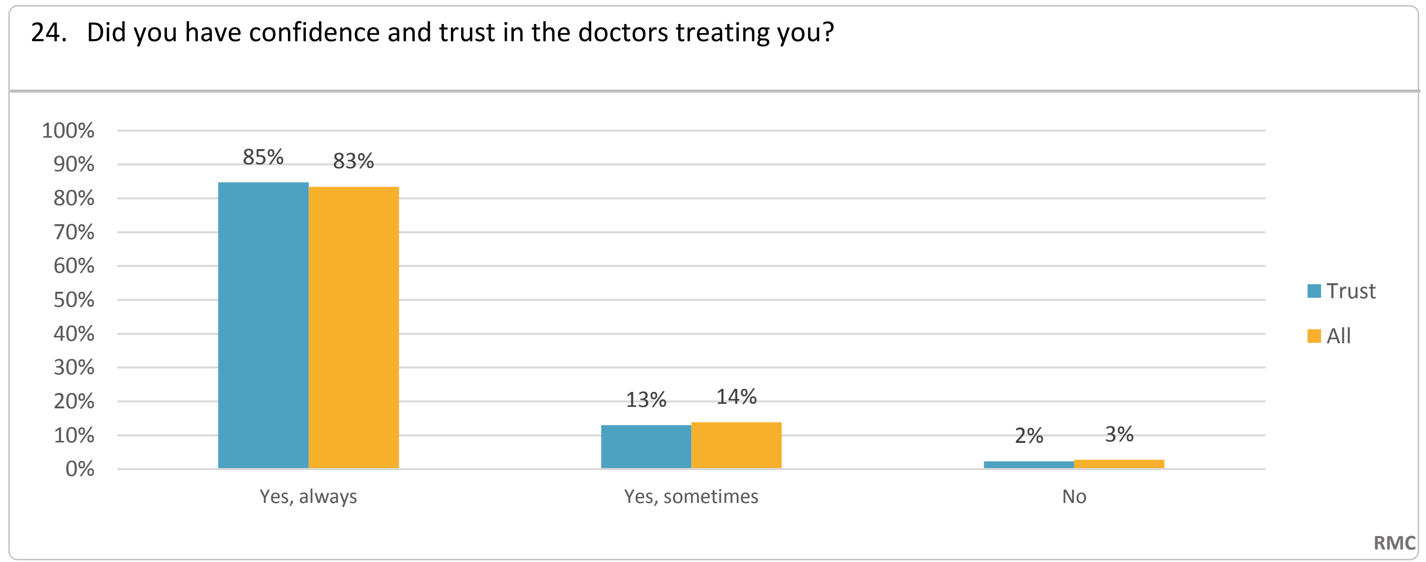


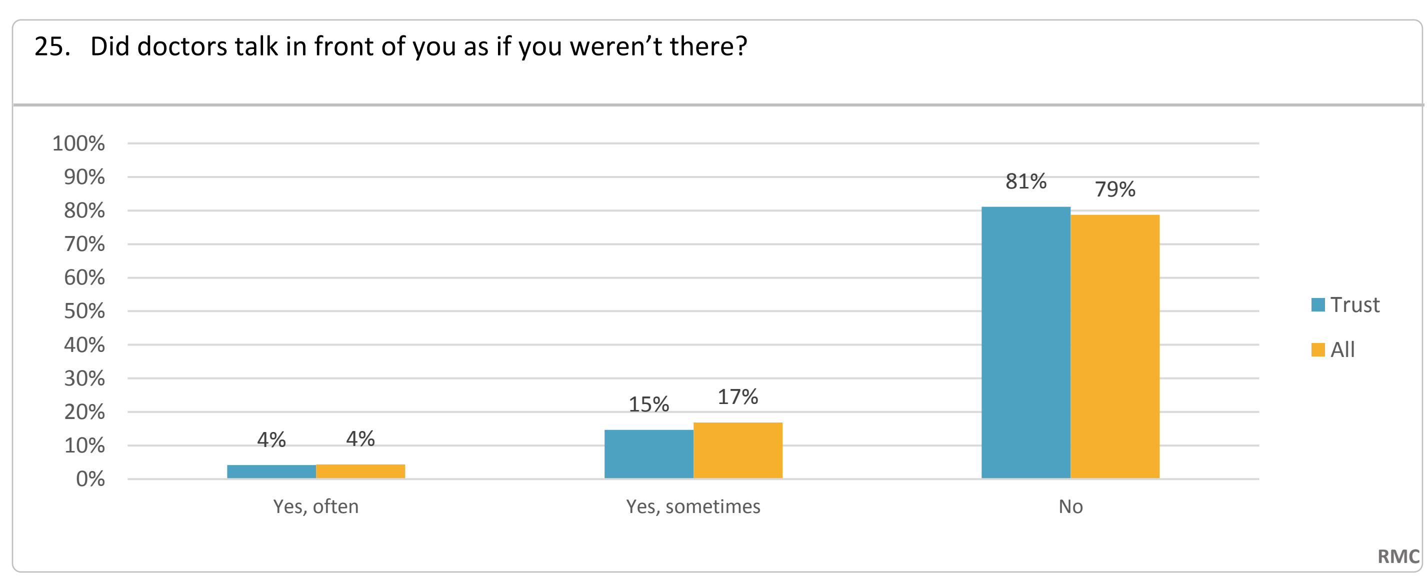




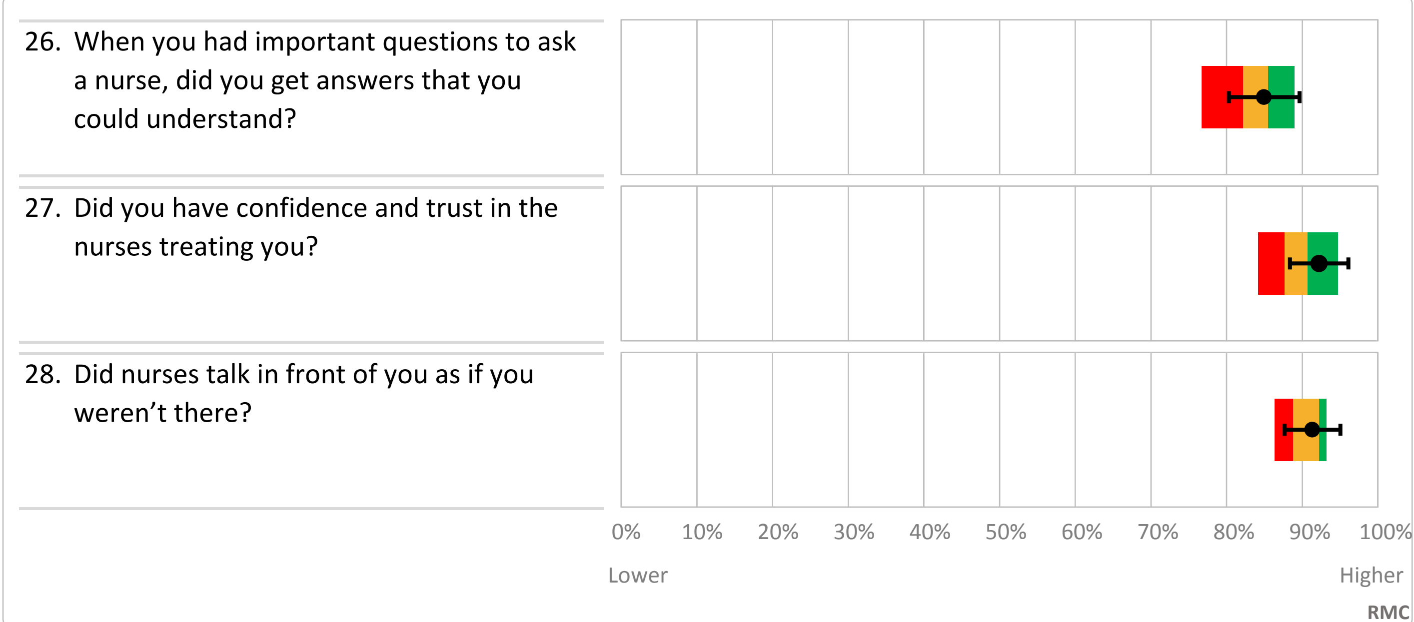
Doctors - Compositional Charts





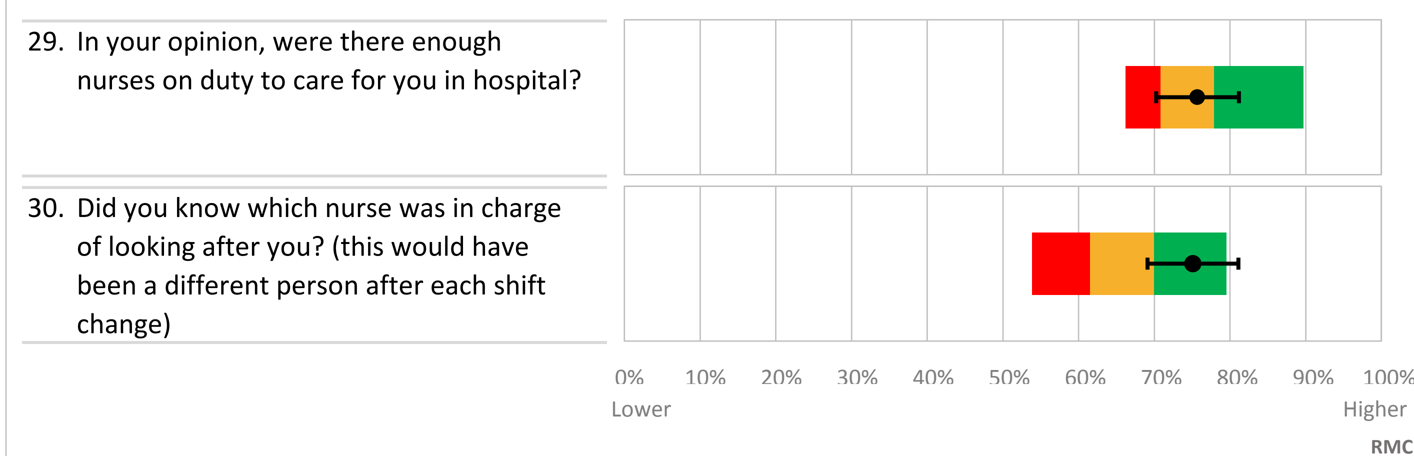


Nurses - Benchmark Charts and Tables



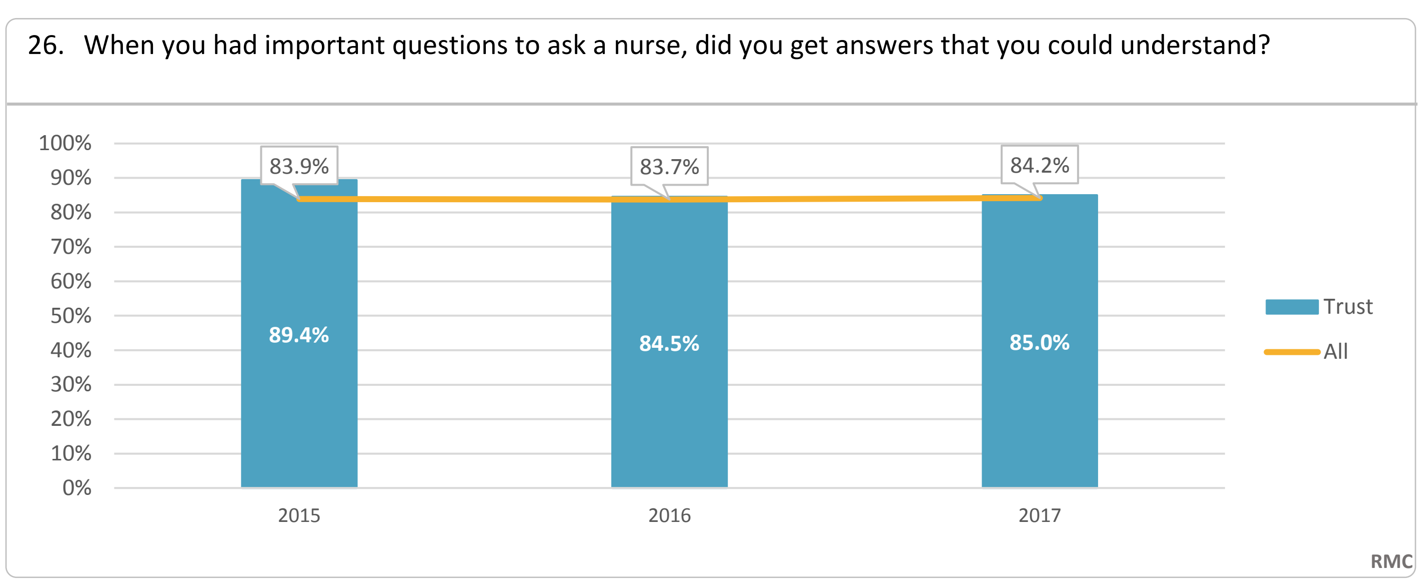
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
26. When you had important questions to ask a nurse, did you get answers that you could understand?	76.7%	82.2%	85.5%	88.9%	325	85.0%	● (amber)
27. Did you have confidence and trust in the nurses treating you?	84.2%	87.7%	90.8%	94.8%	386	92.2%	● (green)
28. Did nurses talk in front of you as if you weren't there?	86.4%	88.8%	92.2%	93.2%	385	91.4%	● (amber)

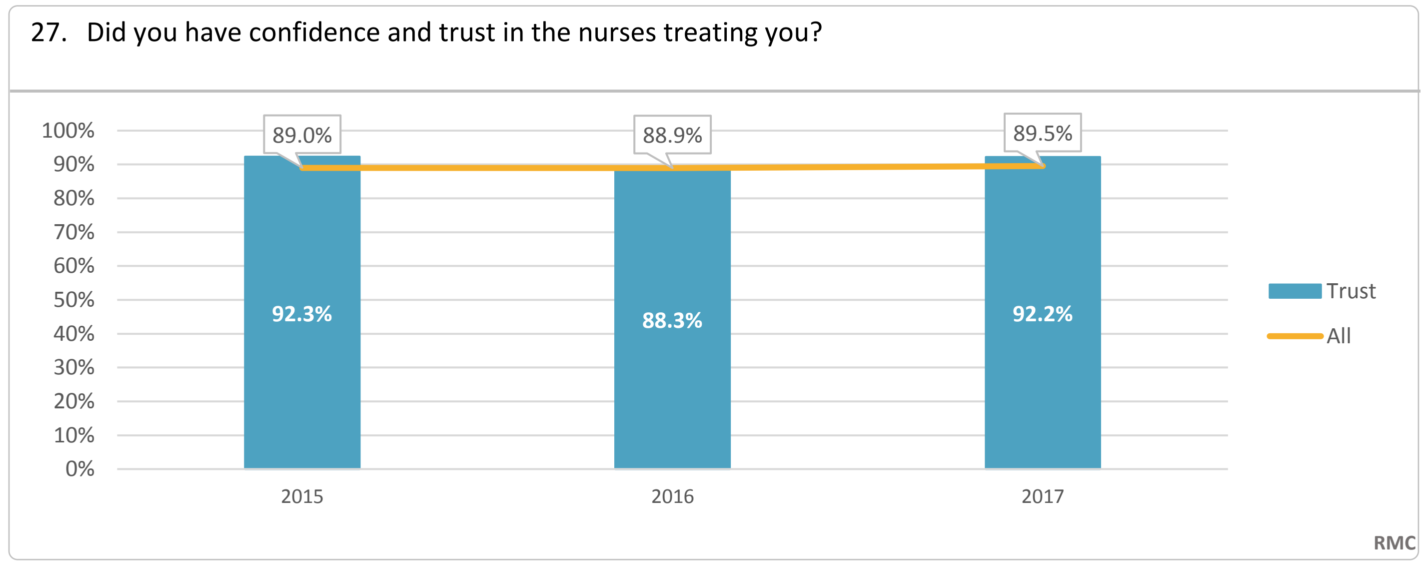
Nurses - Benchmark Charts and Tables (continued)

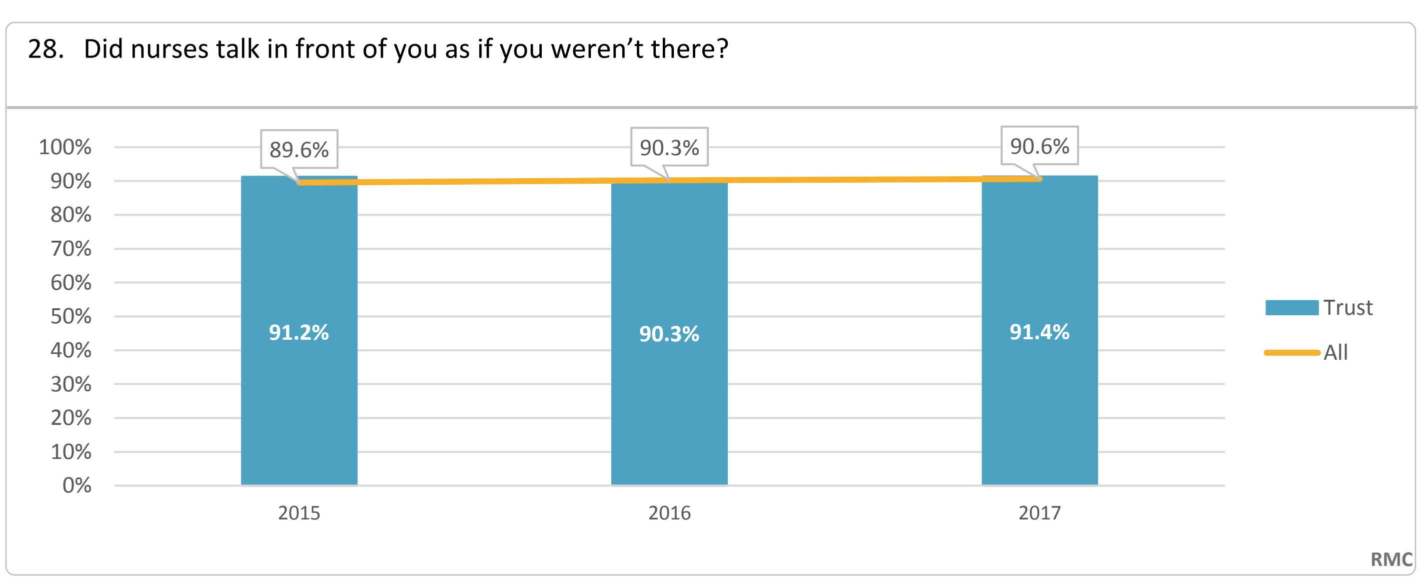


	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
29. In your opinion, were there enough nurses on duty to care for you in hospital?	66.2%	70.8%	77.9%	89.7%	385	75.7%	● (amber)
30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	53.9%	61.5%	70.0%	79.5%	383	75.1%	● (green)

Nurses - Longitudinal Charts

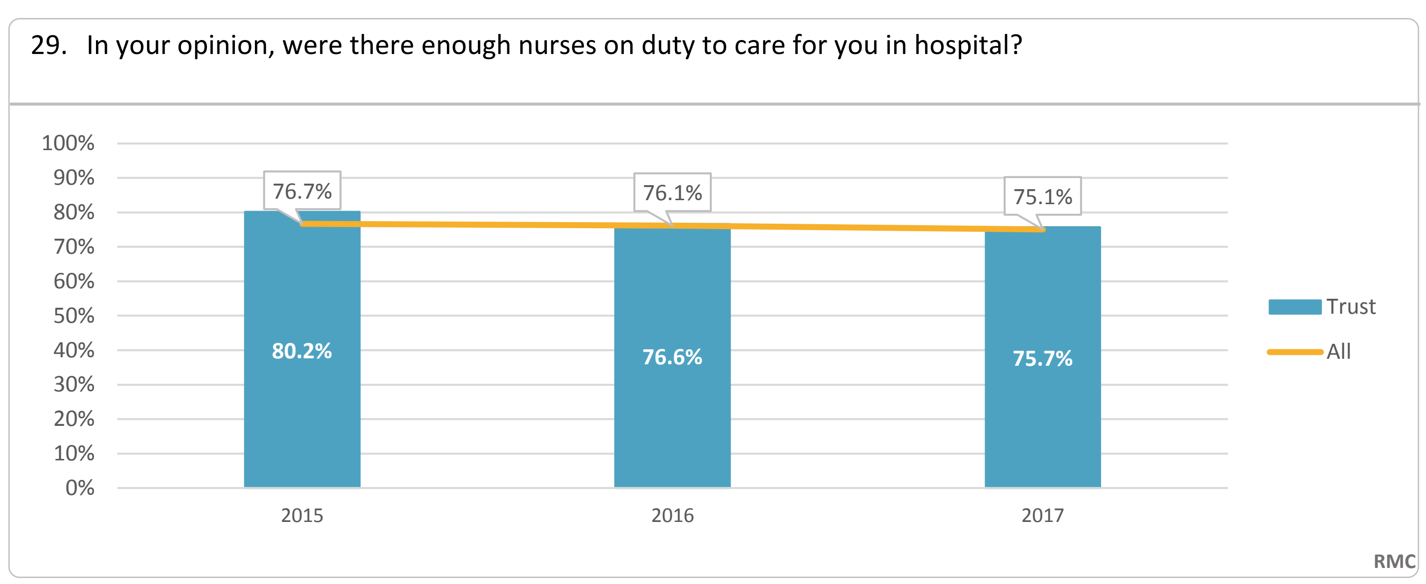




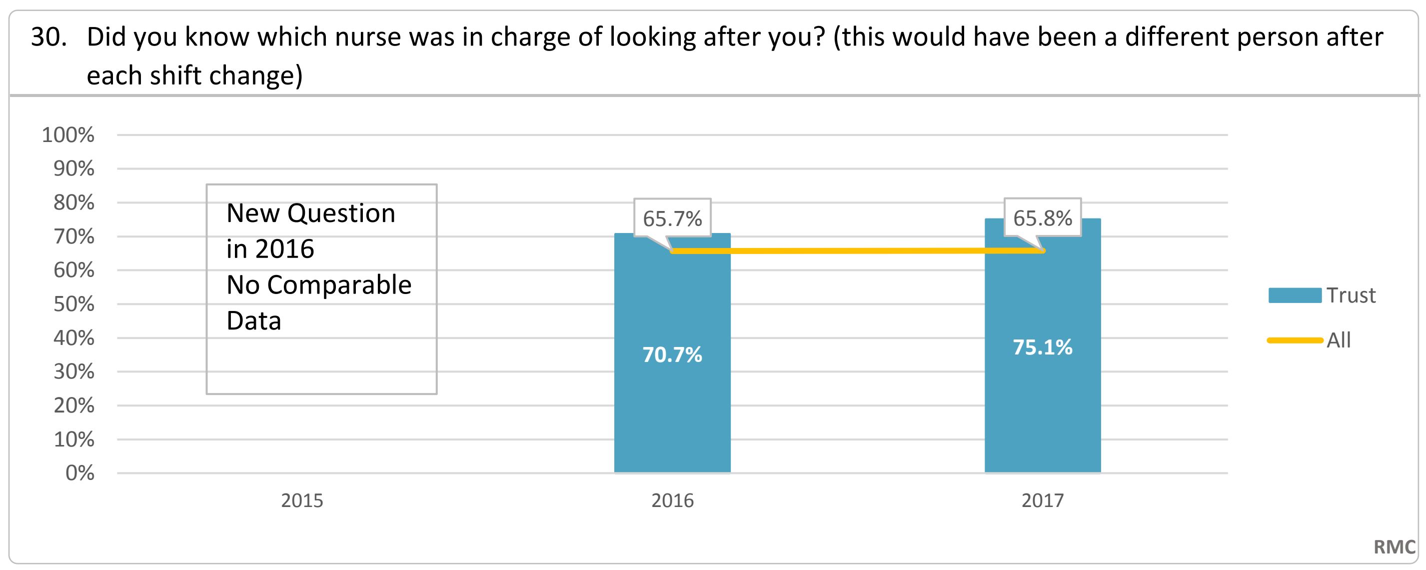


Nurses - Longitudinal Charts (continued)

29. In your opinion, were there enough nurses on duty to care for you in hospital?

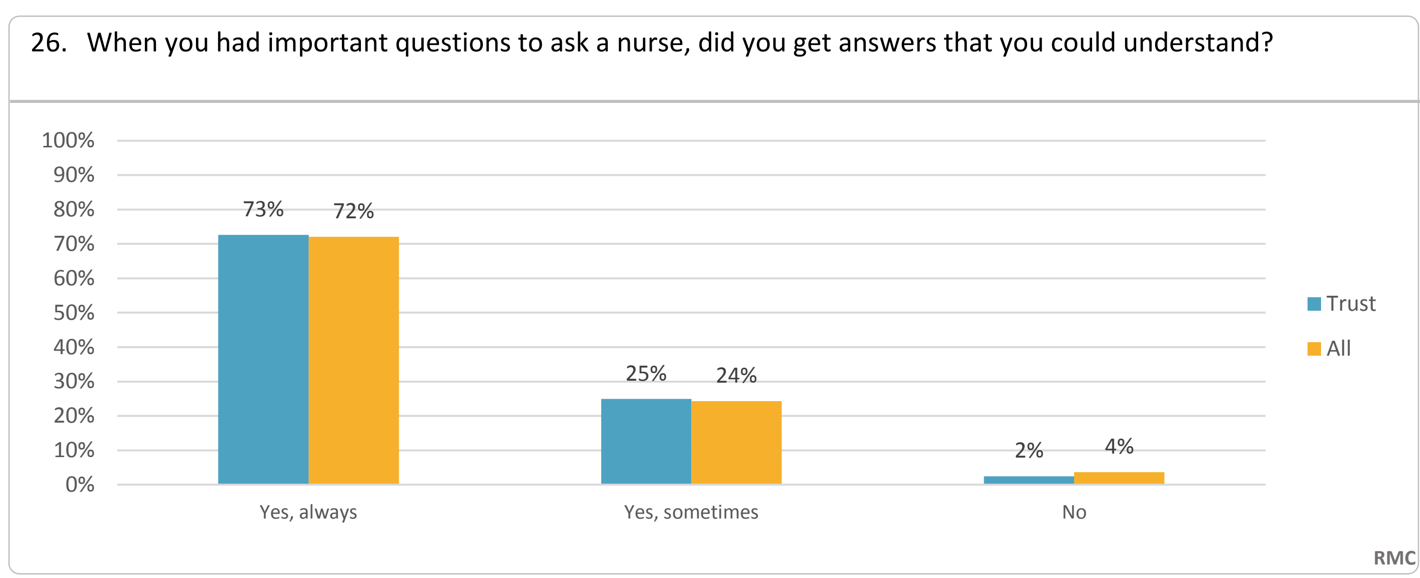


30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)

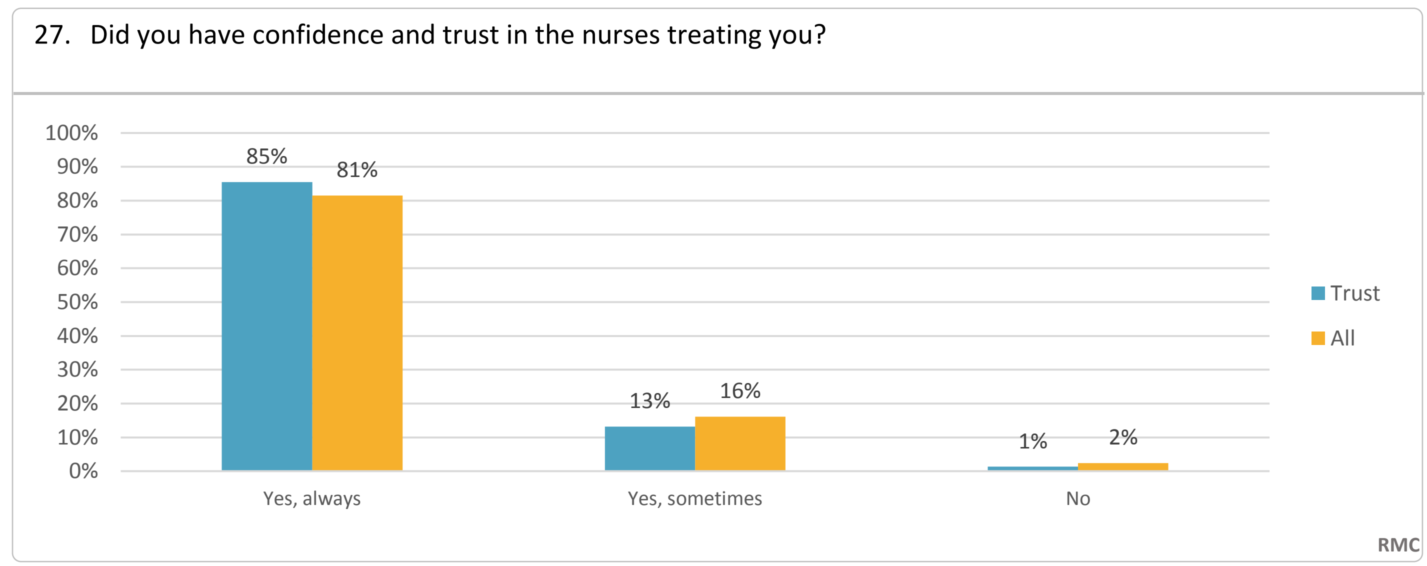


Nurses - Compositional Charts

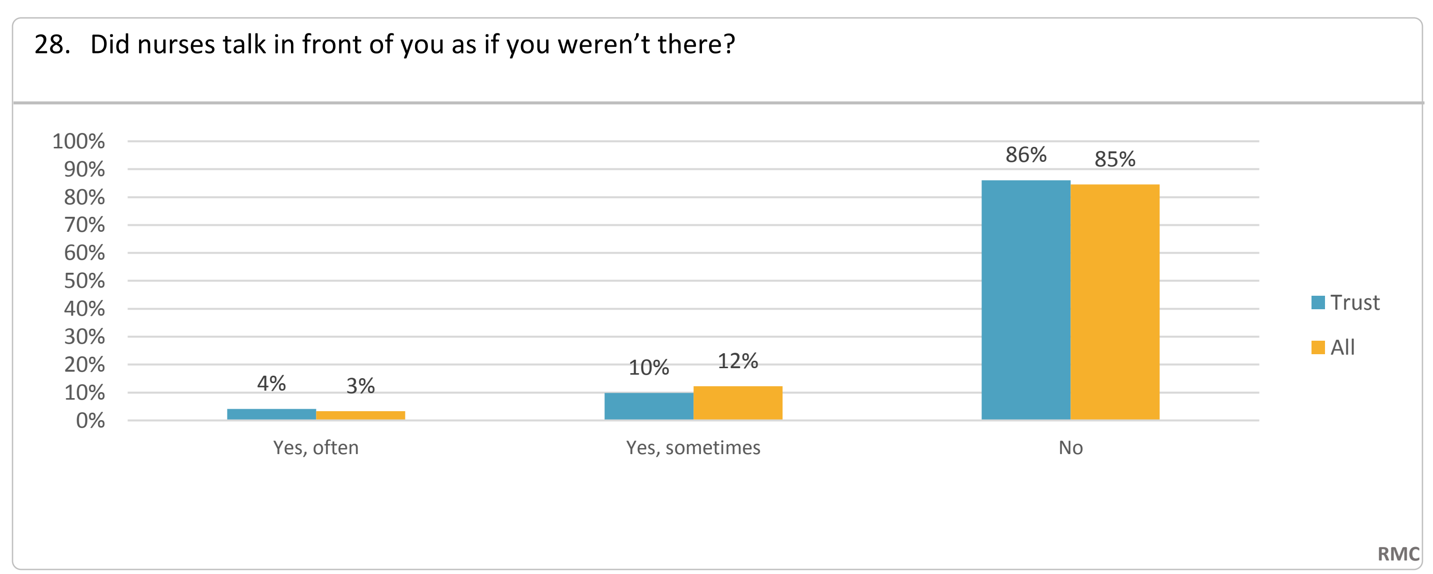
26. When you had important questions to ask a nurse, did you get answers that you could understand?



27. Did you have confidence and trust in the nurses treating you?

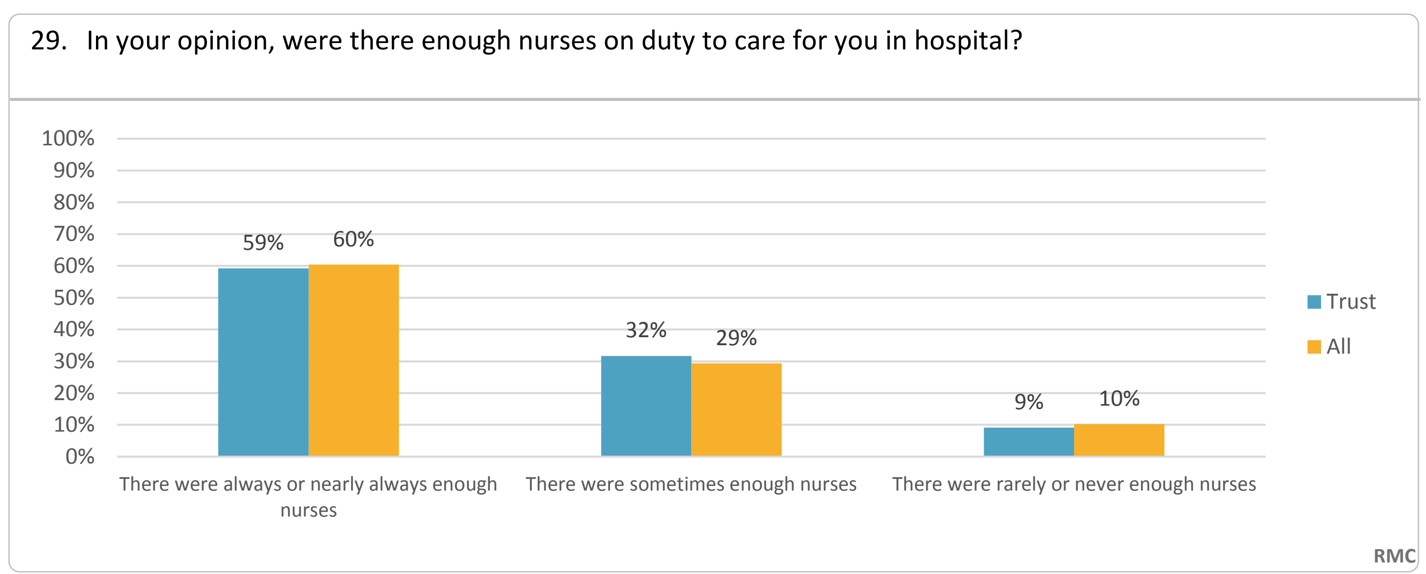


28. Did nurses talk in front of you as if you weren't there?

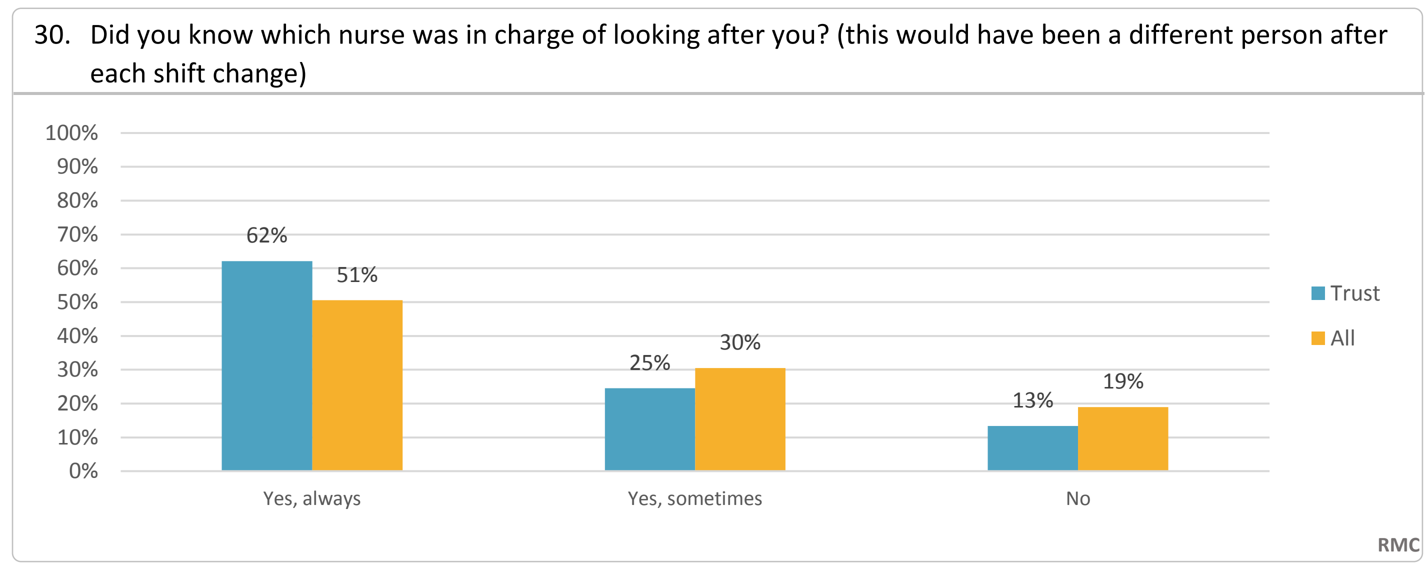


Nurses - Compositional Charts (continued)

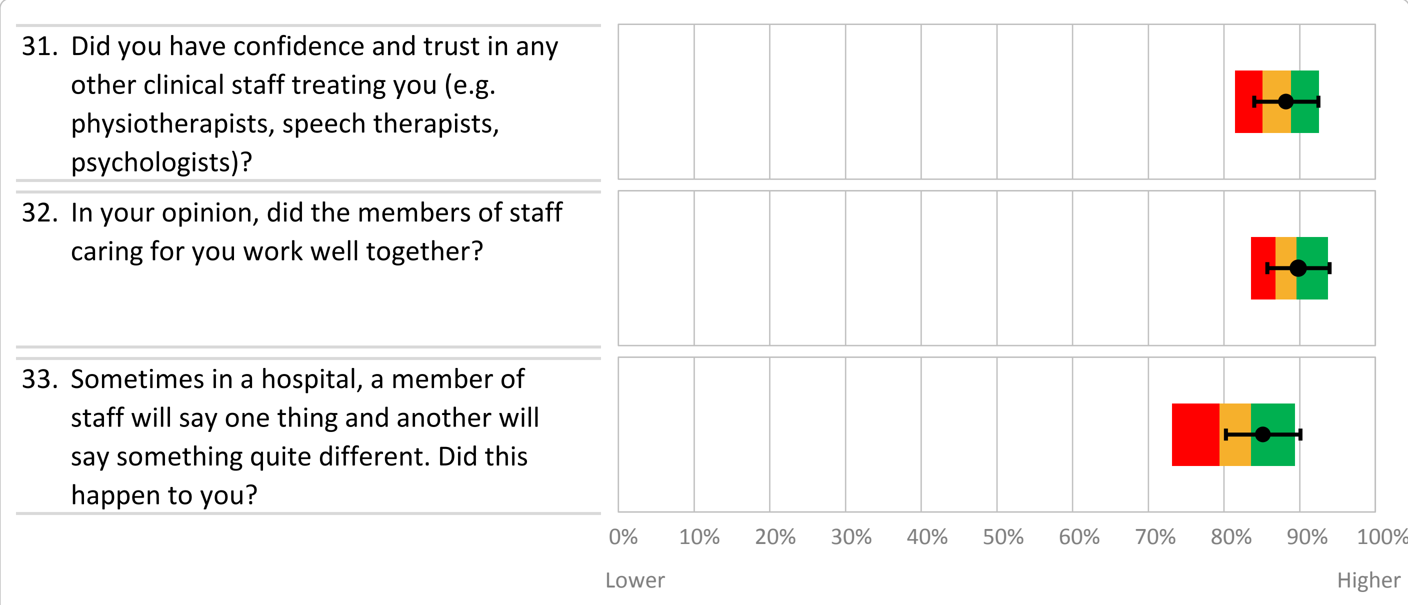
29. In your opinion, were there enough nurses on duty to care for you in hospital?



30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)

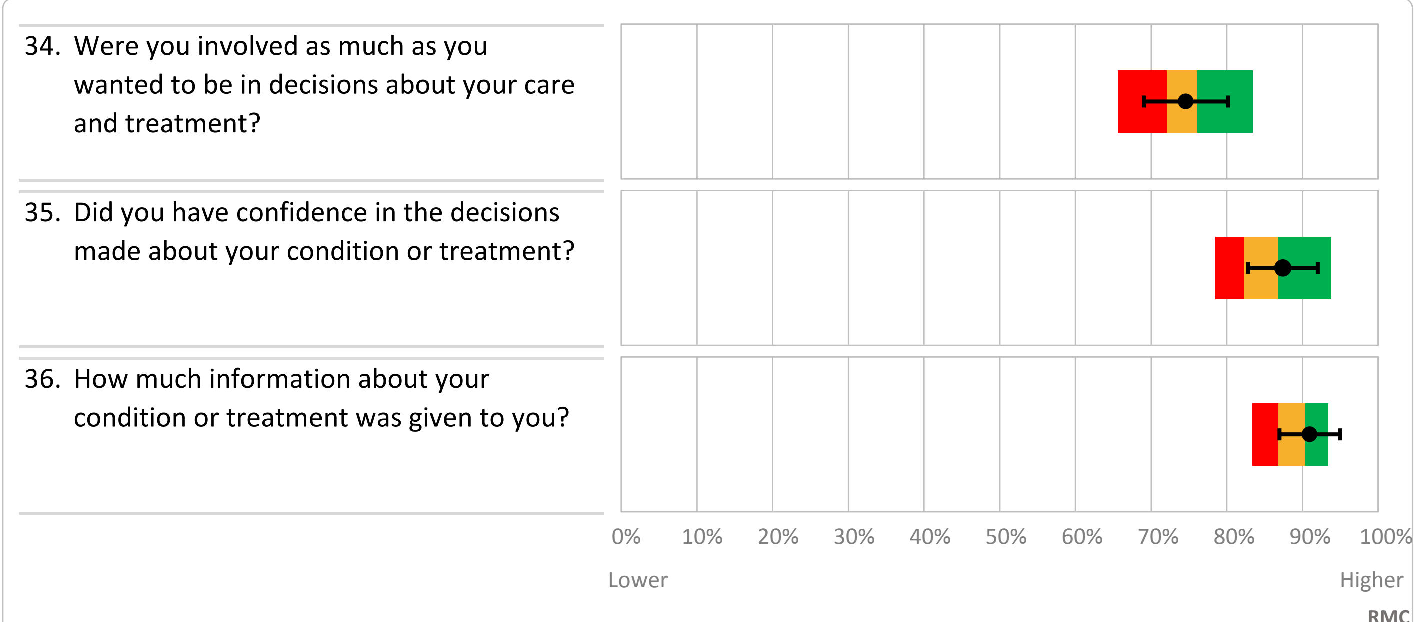


Your Care & Treatment - Benchmark Charts and Tables



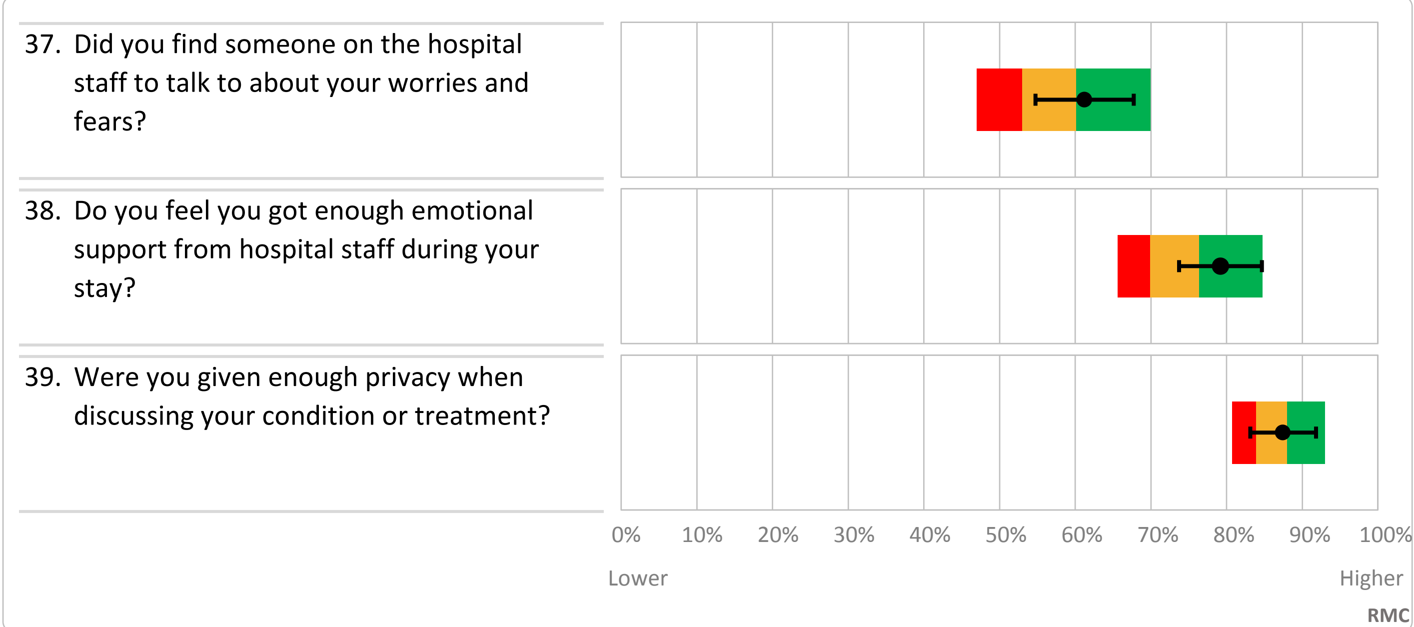
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	Score	RAG Rating
31. Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	81.5%	85.1%	88.9%	92.6%	242	88.2%	● (amber)
32. In your opinion, did the members of staff caring for you work well together?	83.6%	86.8%	89.6%	93.7%	360	89.8%	● (green)
33. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	73.1%	79.5%	83.6%	89.4%	383	85.2%	● (green)

Your Care & Treatment - Benchmark Charts and Tables (continued)



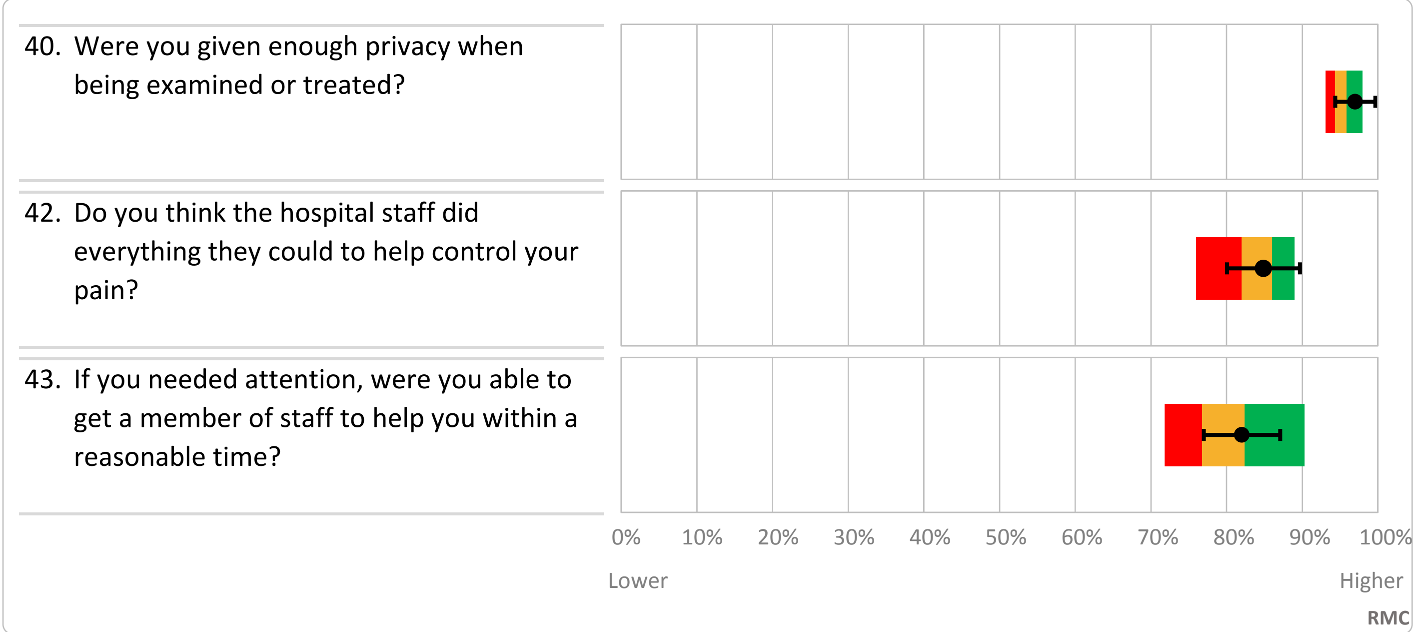
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
34. Were you involved as much as you wanted to be in decisions about your care and treatment?	65.6%	72.2%	76.1%	83.4%	380	74.6%	●
35. Did you have confidence in the decisions made about your condition or treatment?	78.5%	82.2%	86.8%	93.8%	382	87.4%	●
36. How much information about your condition or treatment was given to you?	83.4%	86.8%	90.4%	93.4%	376	91.0%	●

Your Care & Treatment - Benchmark Charts and Tables (continued)



	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
37. Did you find someone on the hospital staff to talk to about your worries and fears?	47.0%	53.0%	60.2%	70.0%	217	61.2%	●
38. Do you feel you got enough emotional support from hospital staff during your stay?	65.7%	69.9%	76.4%	84.8%	247	79.2%	●
39. Were you given enough privacy when discussing your condition or treatment?	80.7%	83.9%	88.0%	93.0%	382	87.5%	●

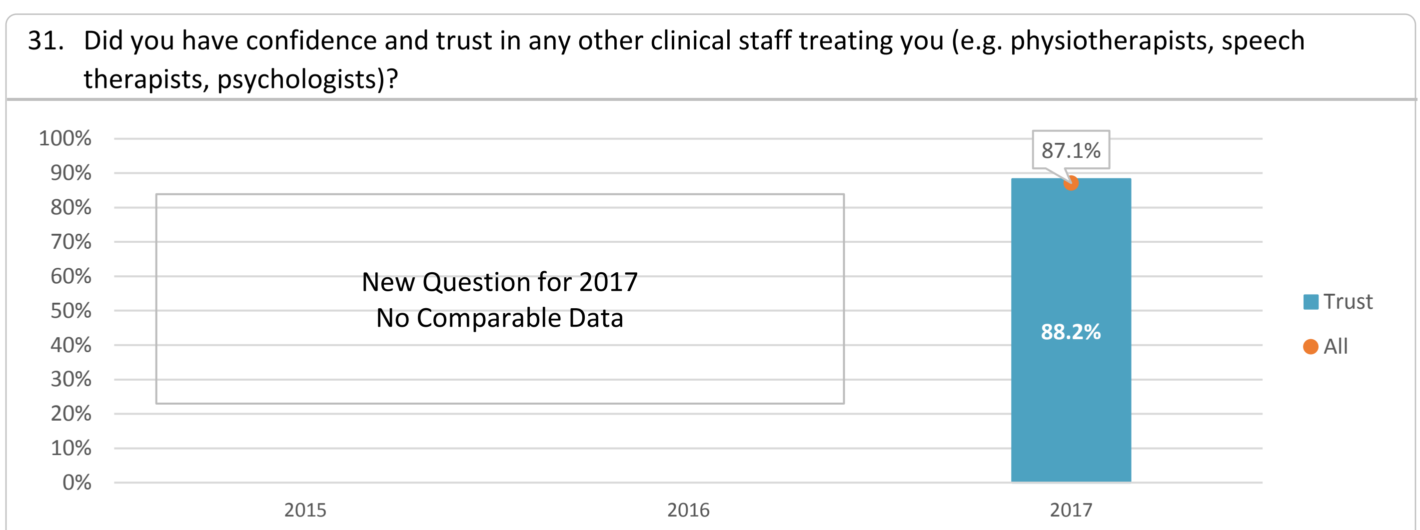
Your Care & Treatment - Benchmark Charts and Tables (continued)



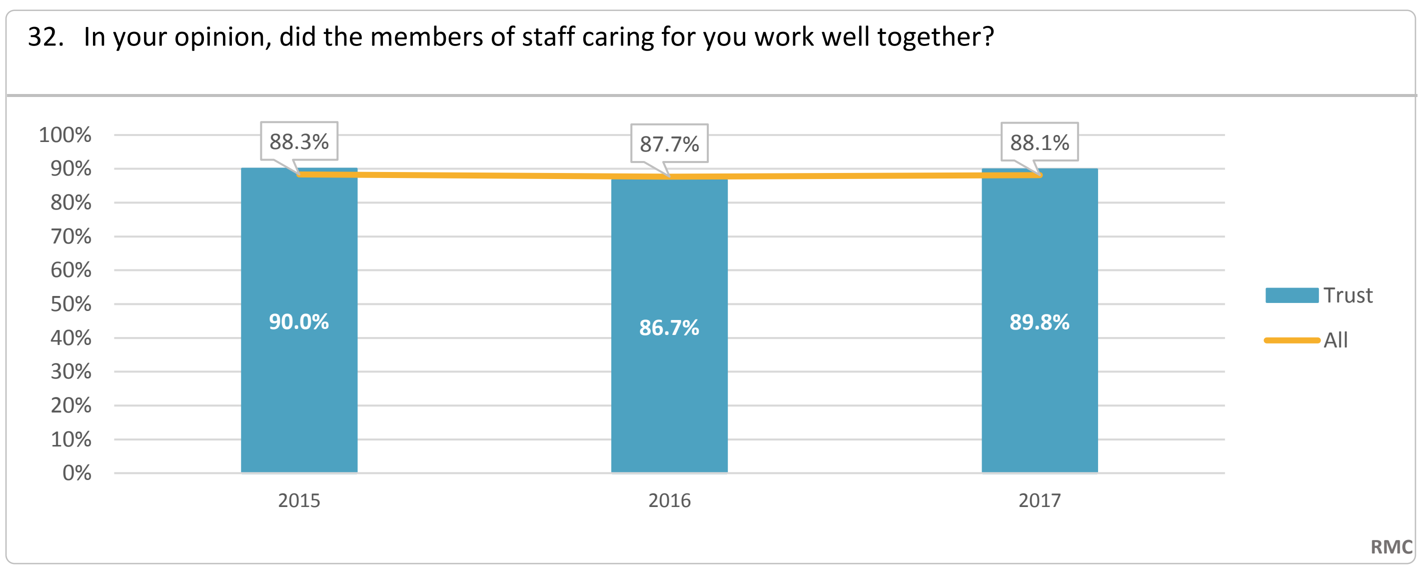
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
40. Were you given enough privacy when being examined or treated?	93.1%	94.4%	95.9%	98.0%	384	97.0%	● (green)
42. Do you think the hospital staff did everything they could to help control your pain?	76.0%	82.0%	86.1%	89.0%	223	84.9%	● (amber)
43. If you needed attention, were you able to get a member of staff to help you within a reasonable time?	71.9%	76.8%	82.4%	90.3%	354	82.0%	● (amber)

Your Care & Treatment - Longitudinal Charts

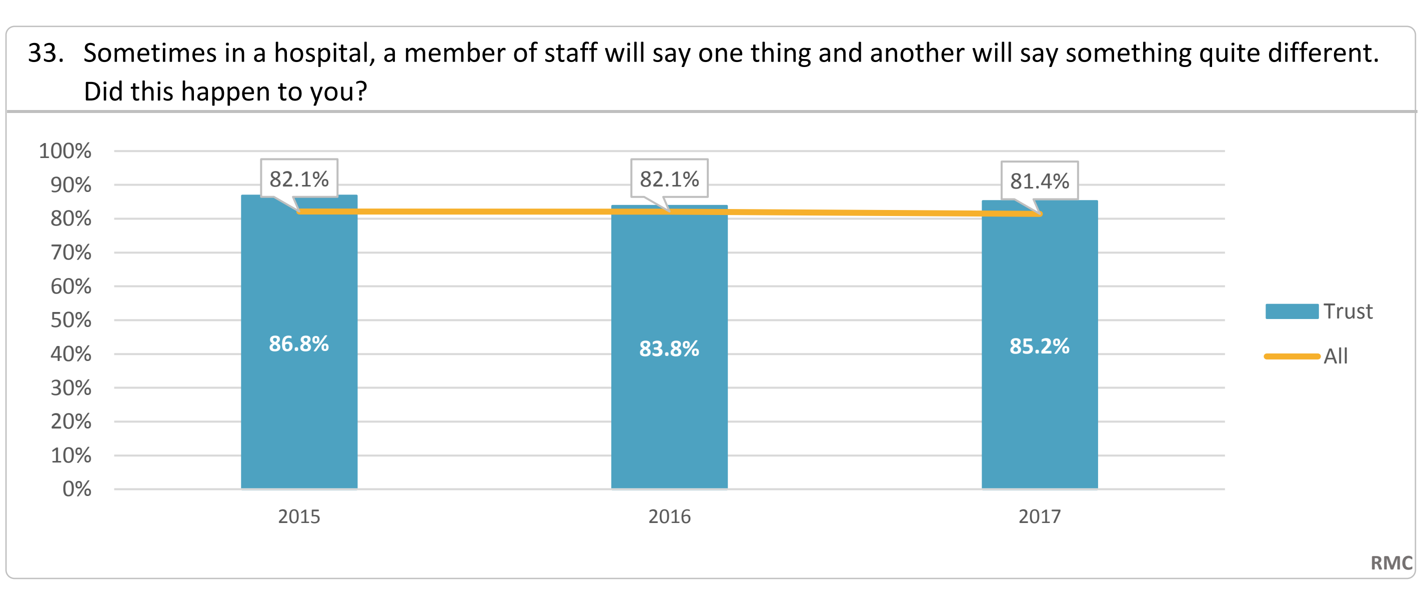
31. Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?



32. In your opinion, did the members of staff caring for you work well together?

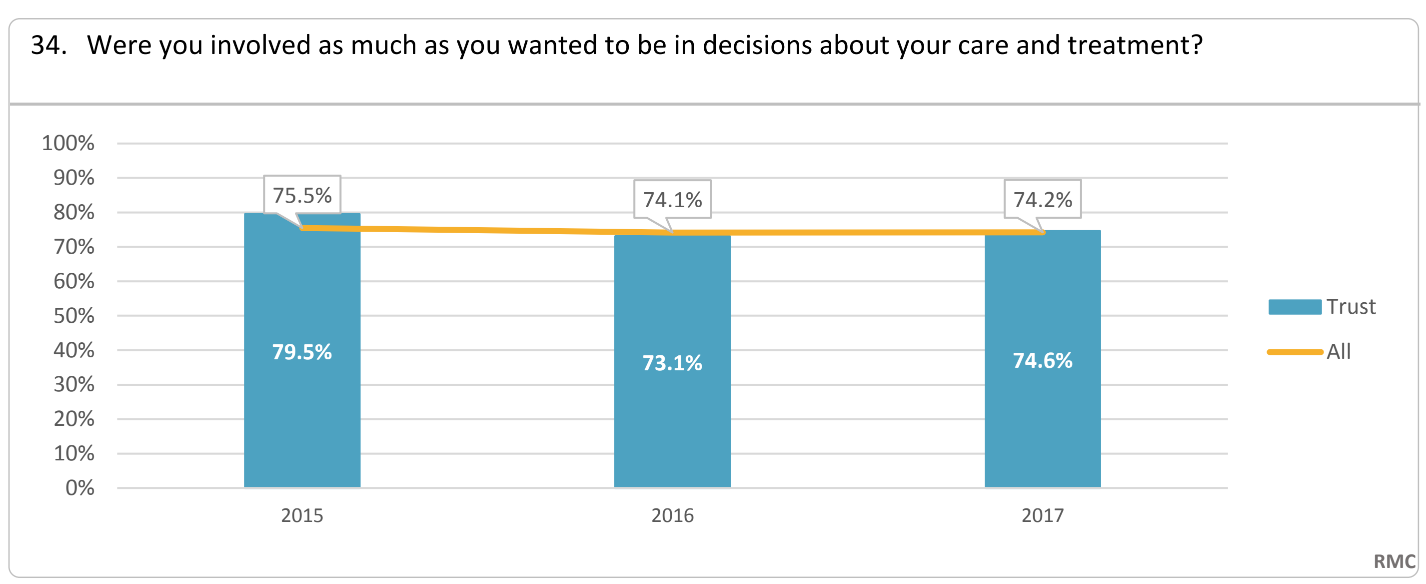


33. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

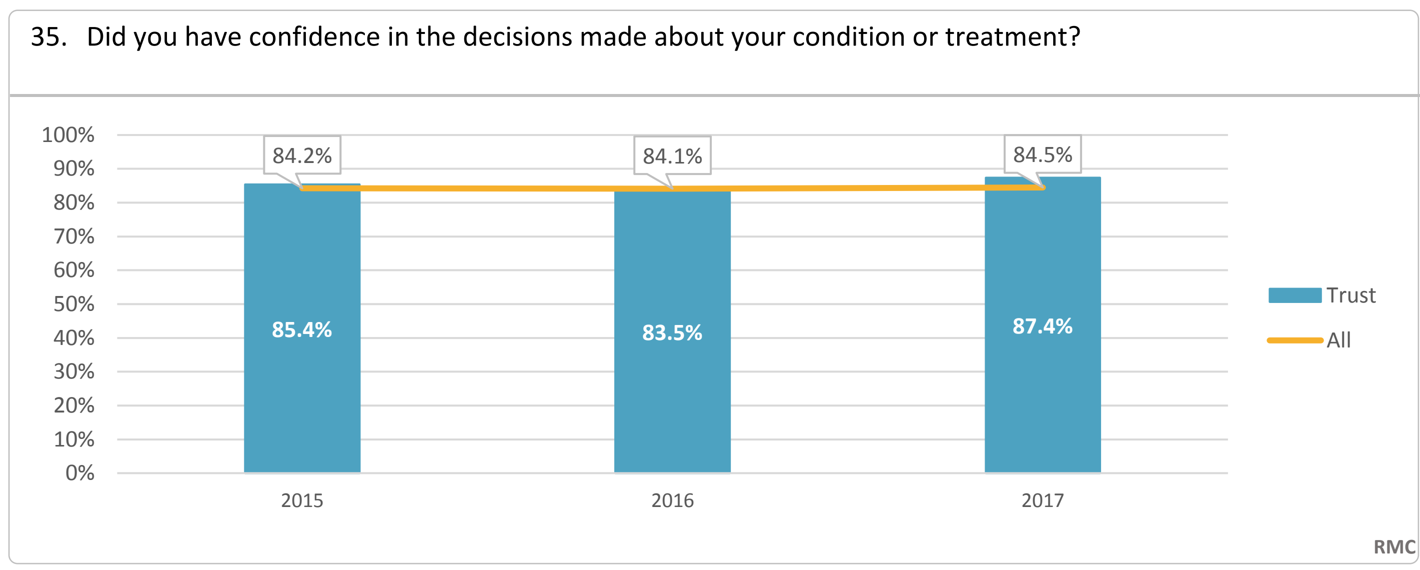


Your Care & Treatment - Longitudinal Charts (continued)

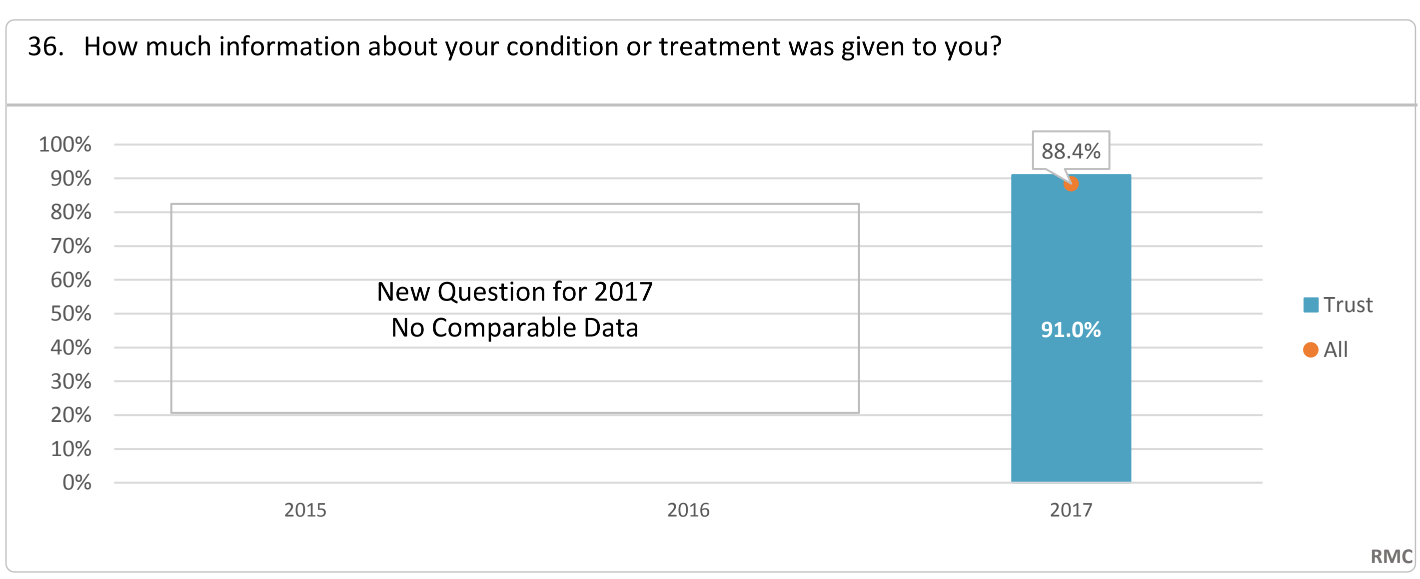
34. Were you involved as much as you wanted to be in decisions about your care and treatment?



35. Did you have confidence in the decisions made about your condition or treatment?

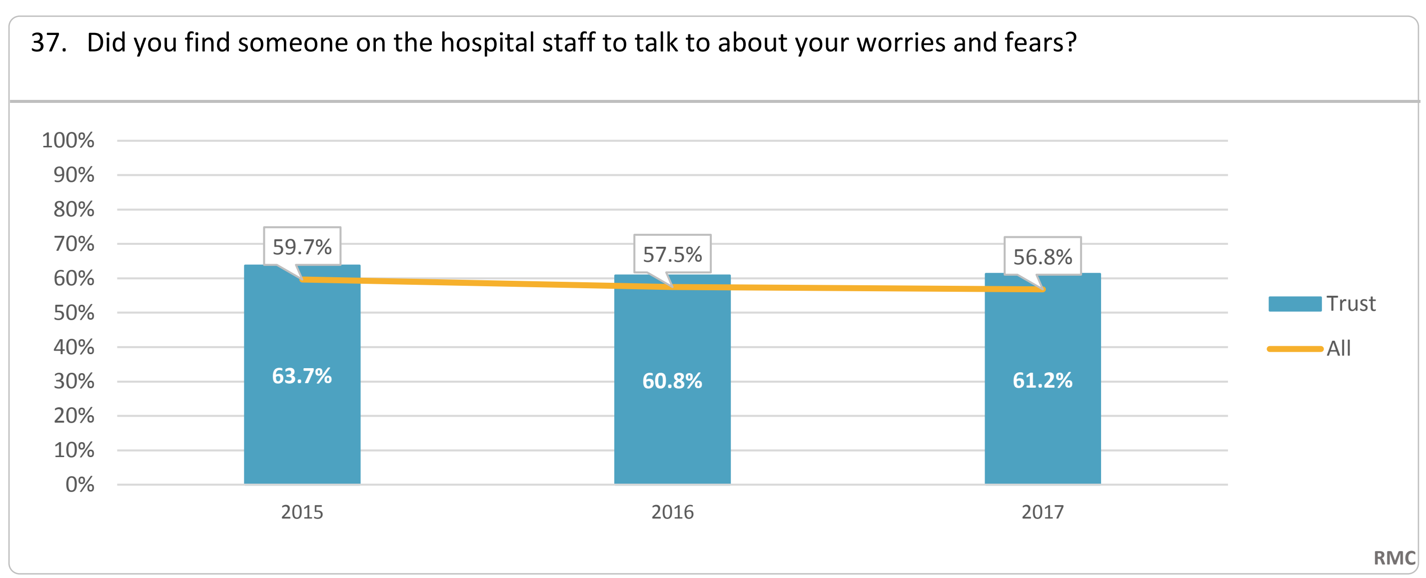


36. How much information about your condition or treatment was given to you?

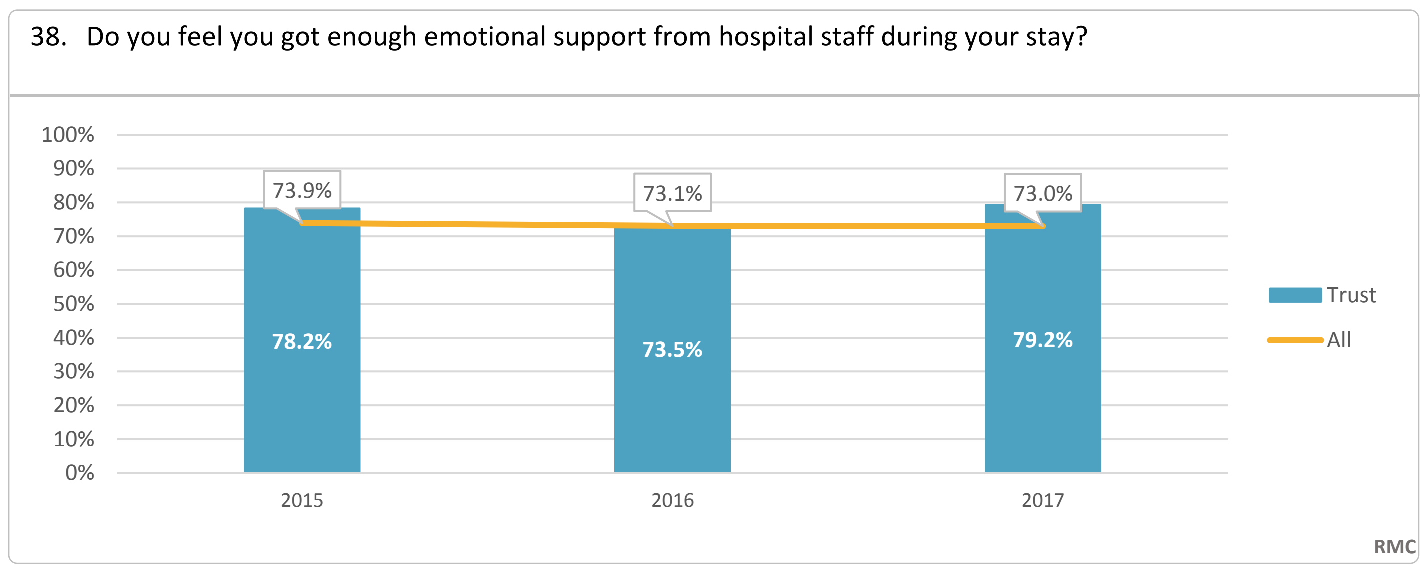


Your Care & Treatment - Longitudinal Charts (continued)

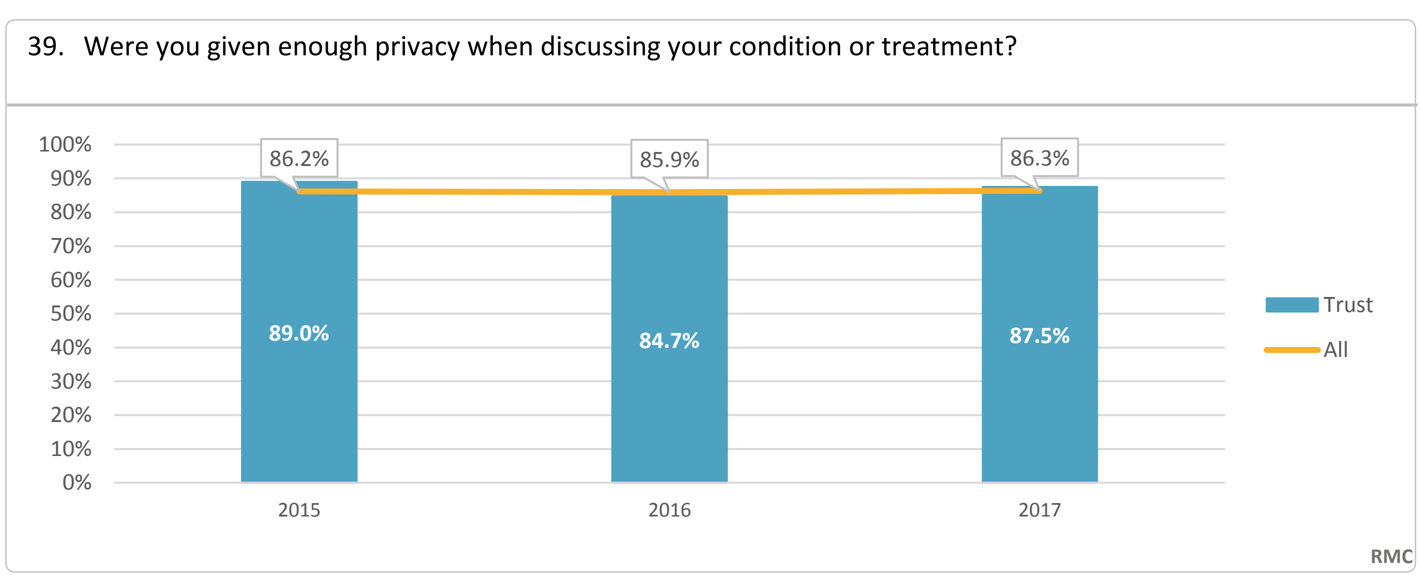
37. Did you find someone on the hospital staff to talk to about your worries and fears?



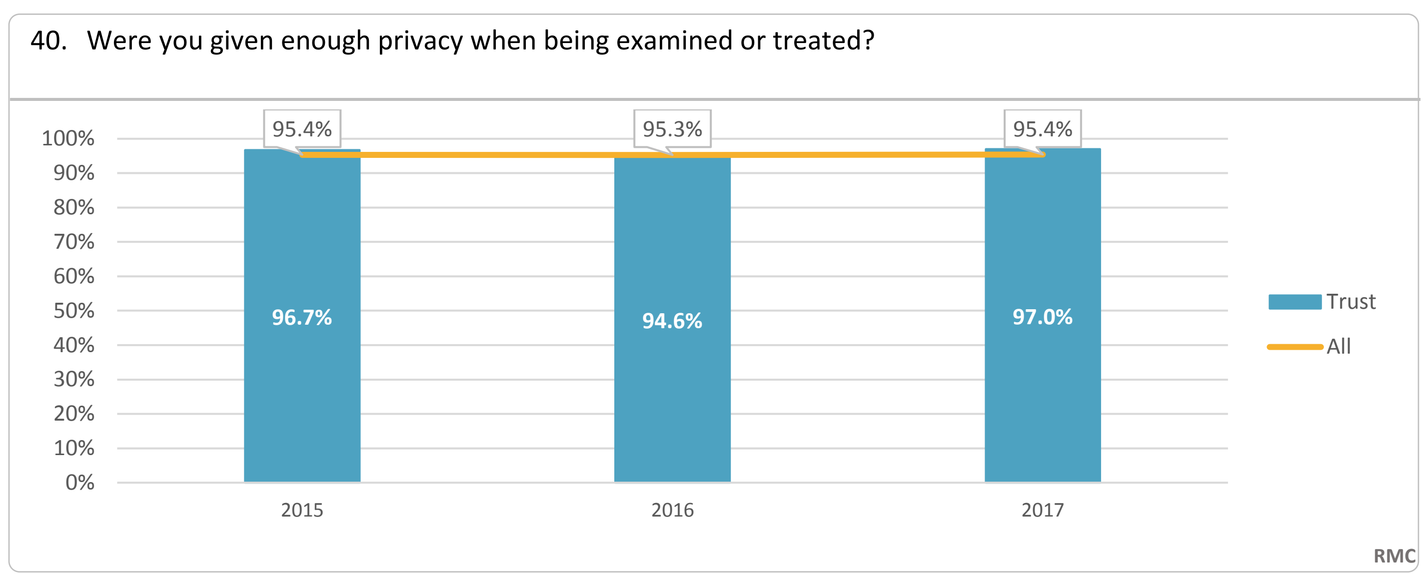
38. Do you feel you got enough emotional support from hospital staff during your stay?

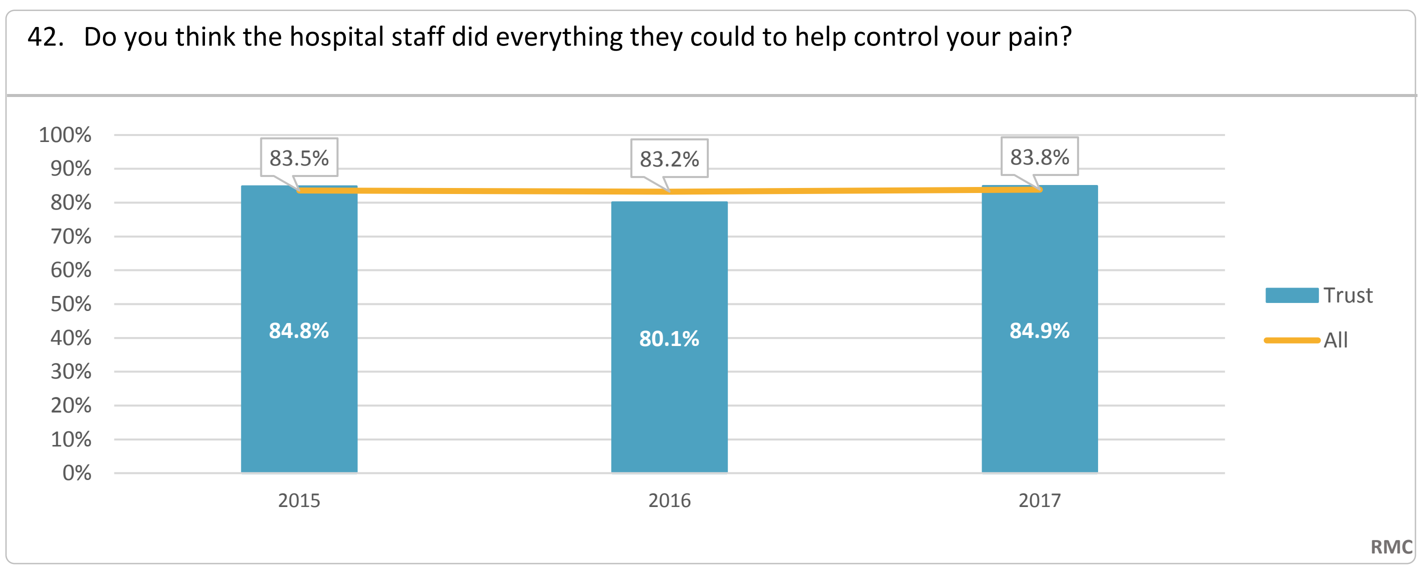


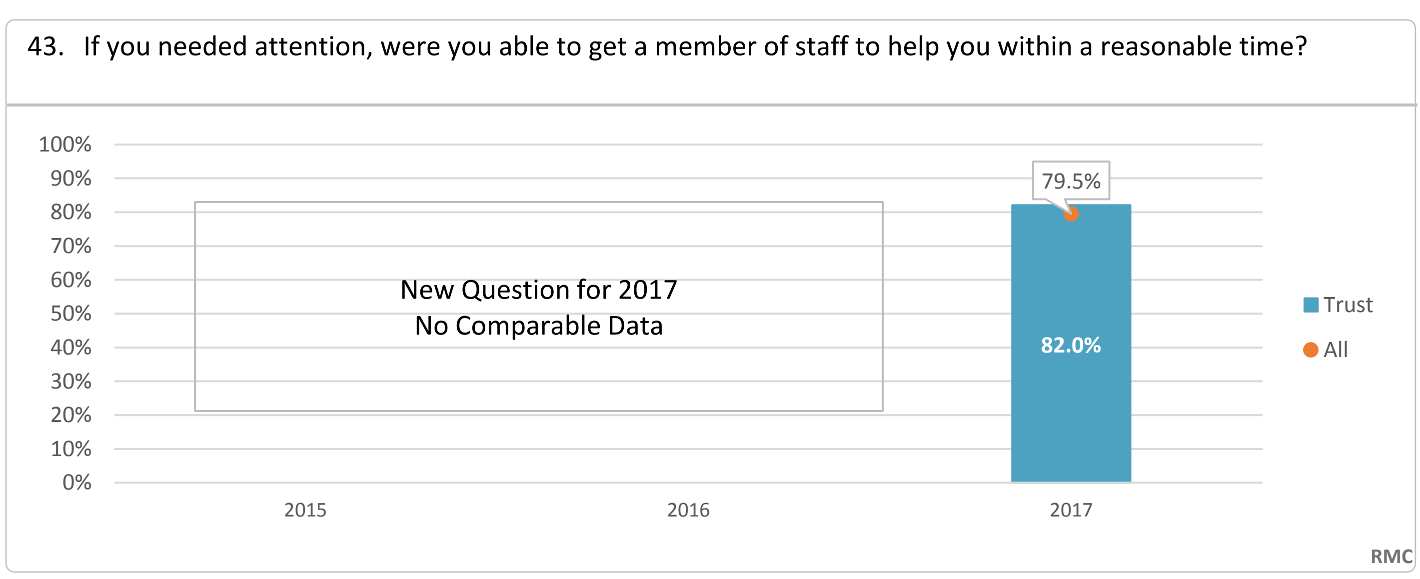
39. Were you given enough privacy when discussing your condition or treatment?



Your Care & Treatment - Longitudinal Charts (continued)

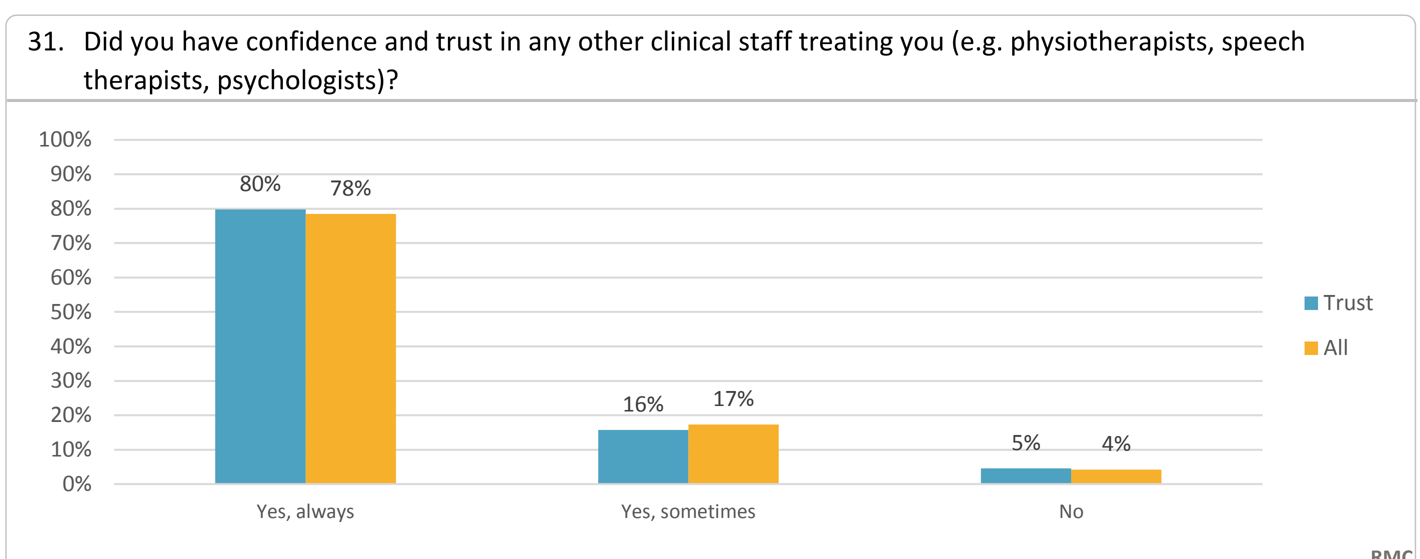




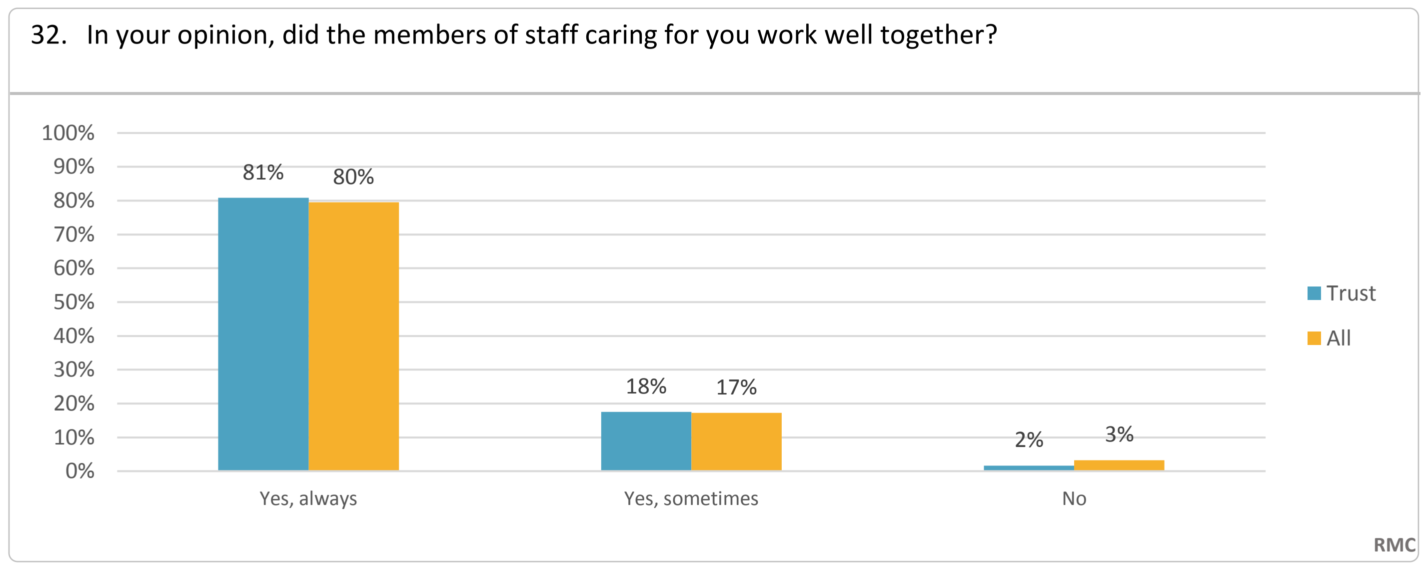


Your Care & Treatment - Compositional Charts

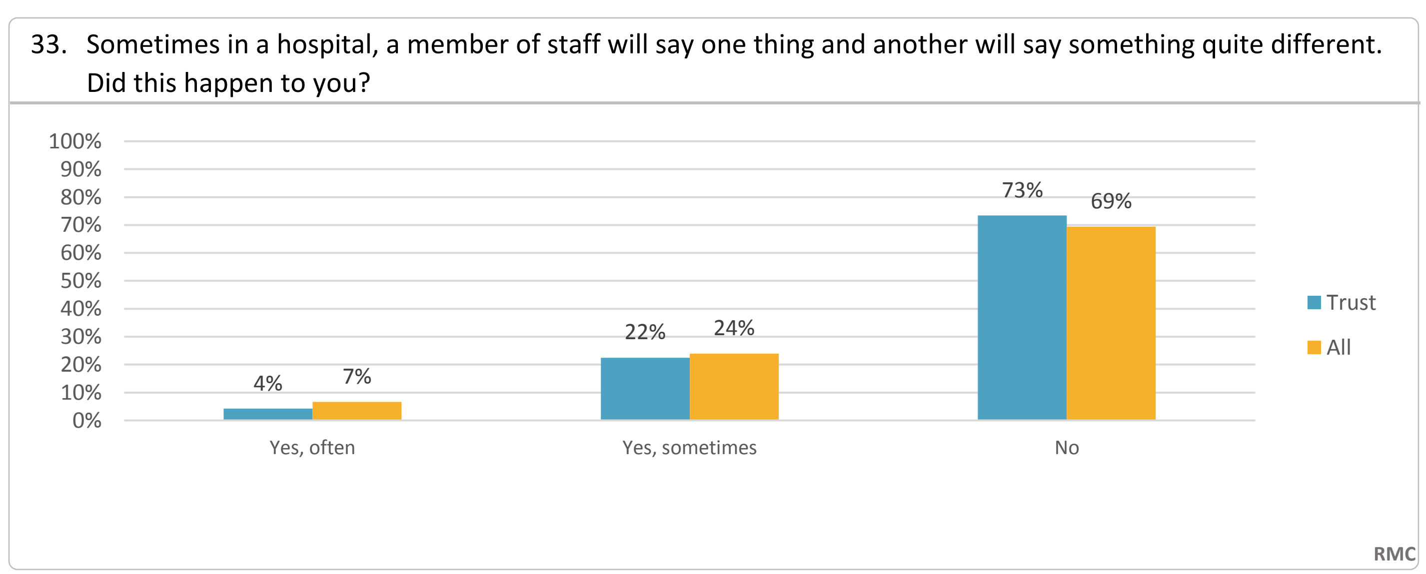
31. Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?



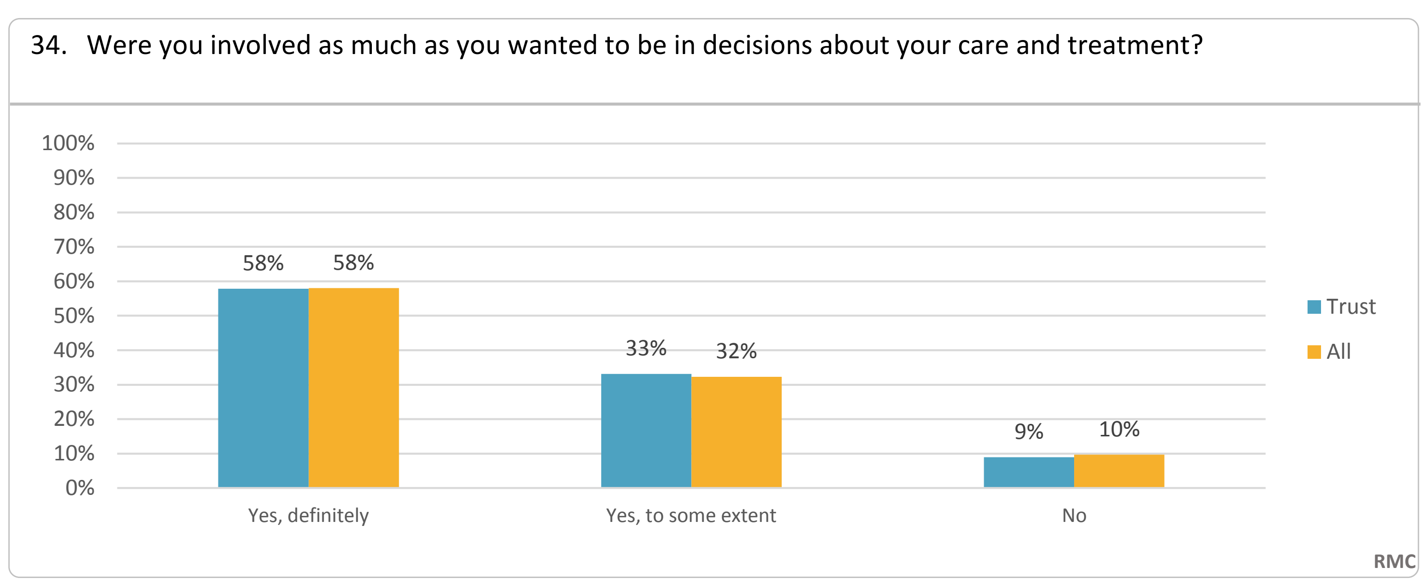
32. In your opinion, did the members of staff caring for you work well together?

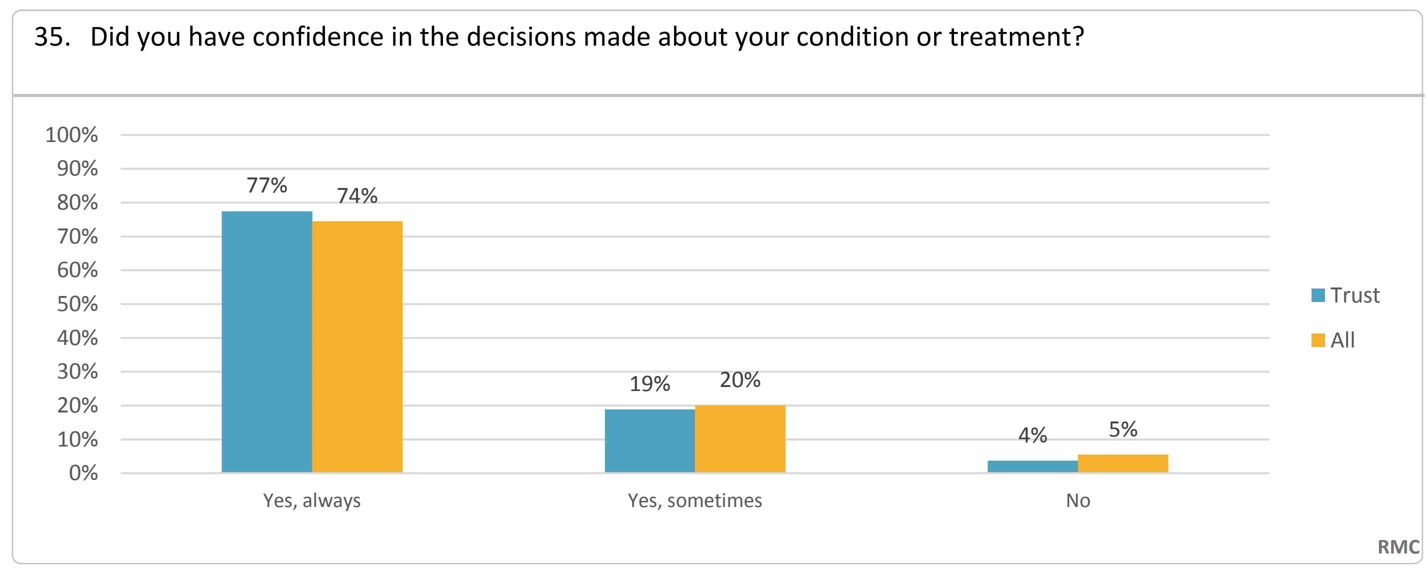


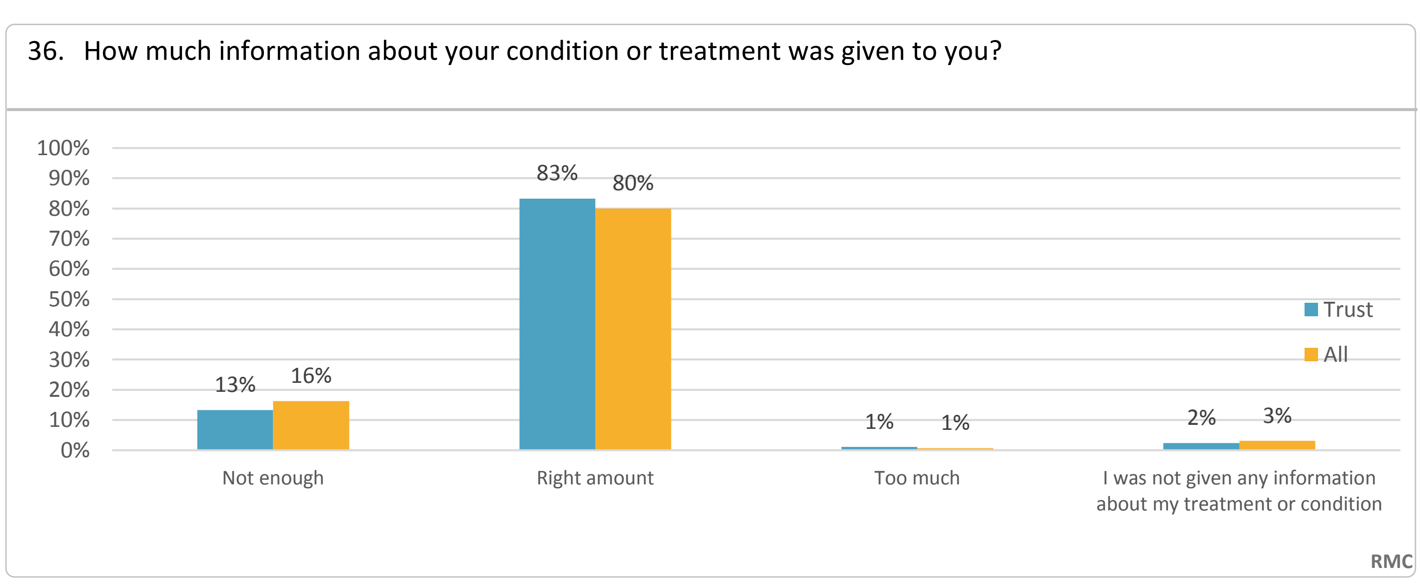
33. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?



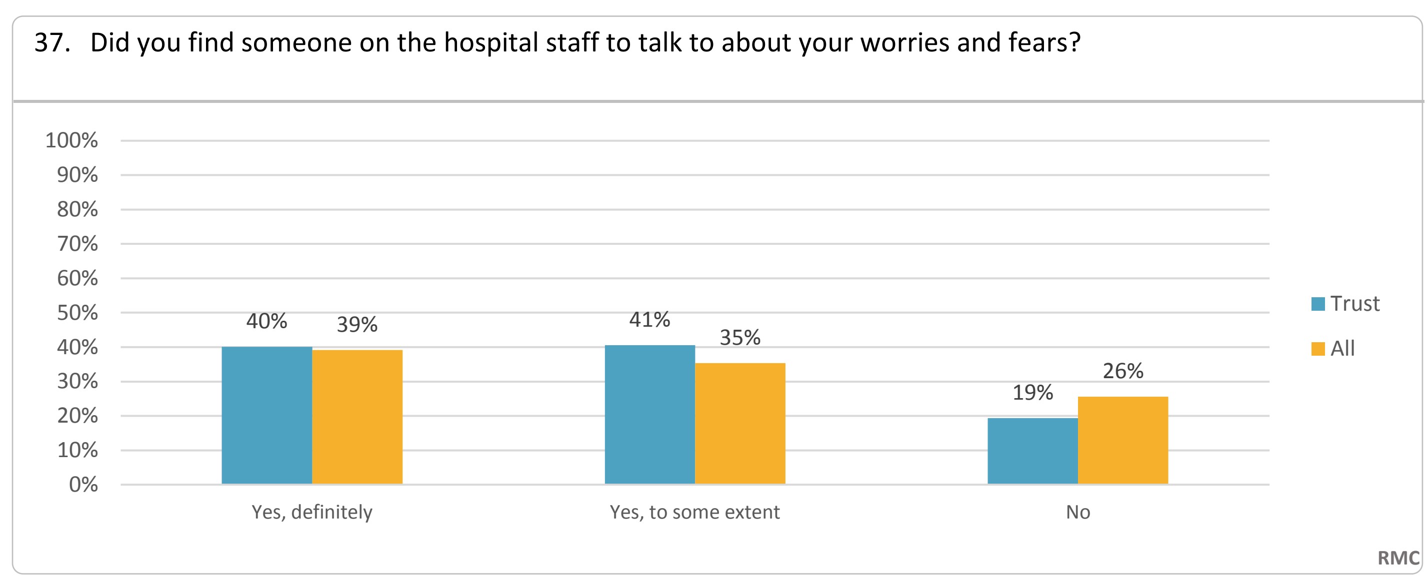
Your Care & Treatment - Compositional Charts (continued)

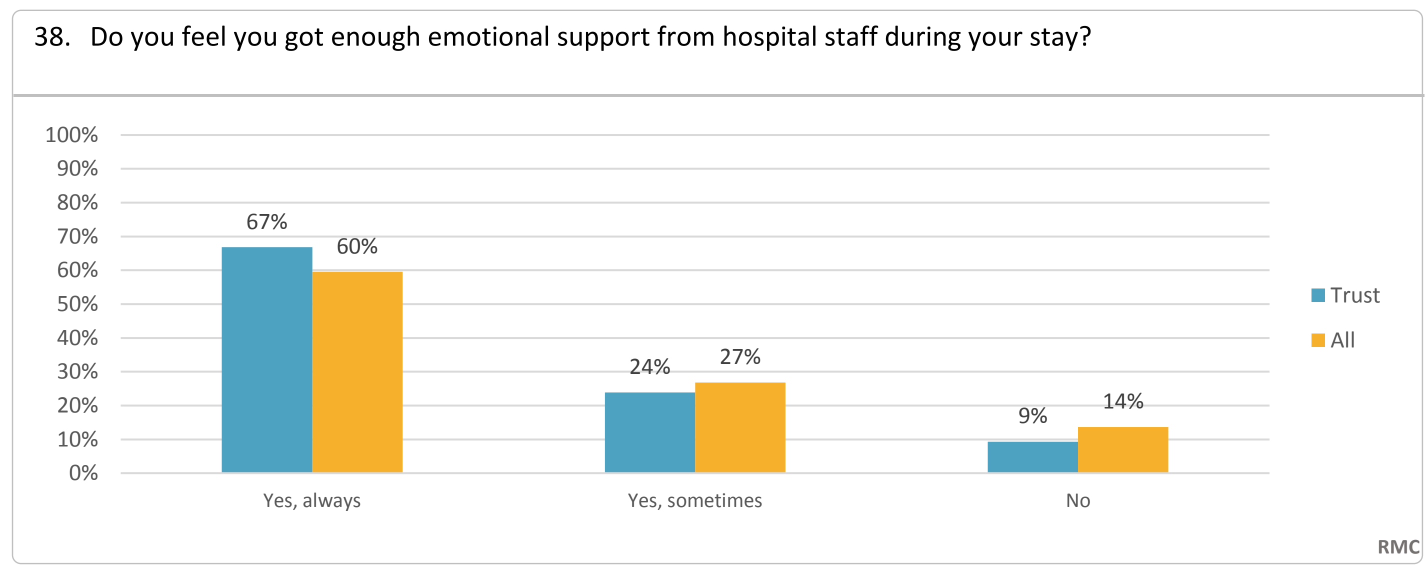


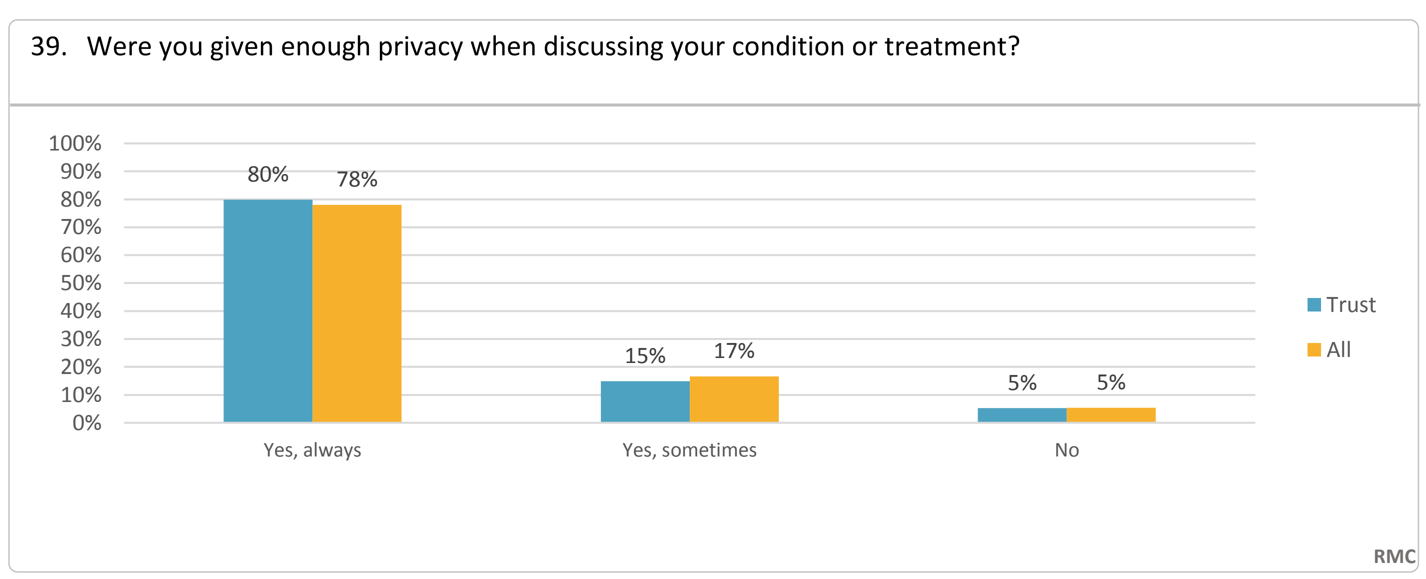




Your Care & Treatment - Compositional Charts (continued)

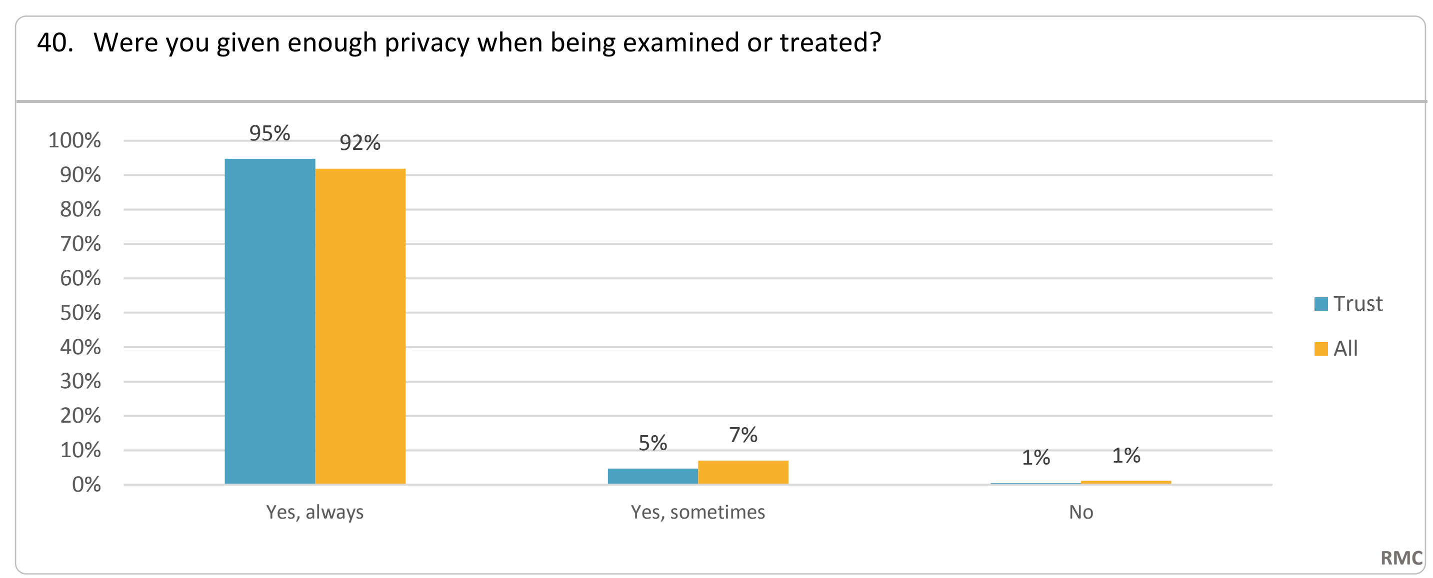




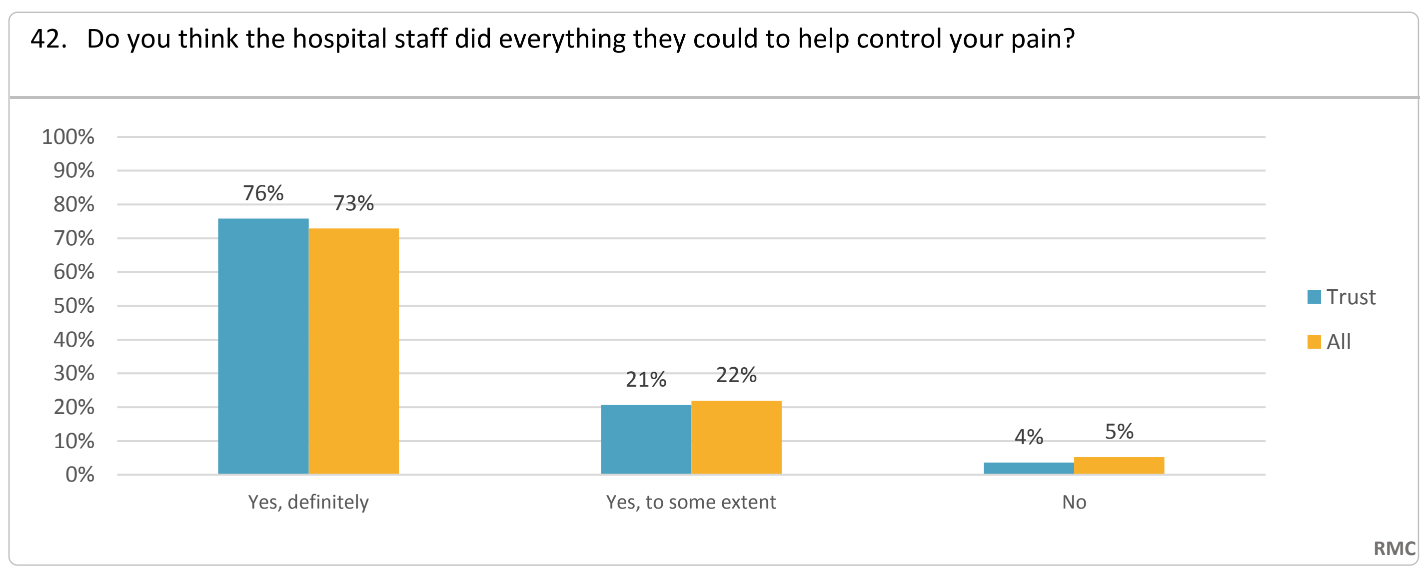


Your Care & Treatment - Compositional Charts (continued)

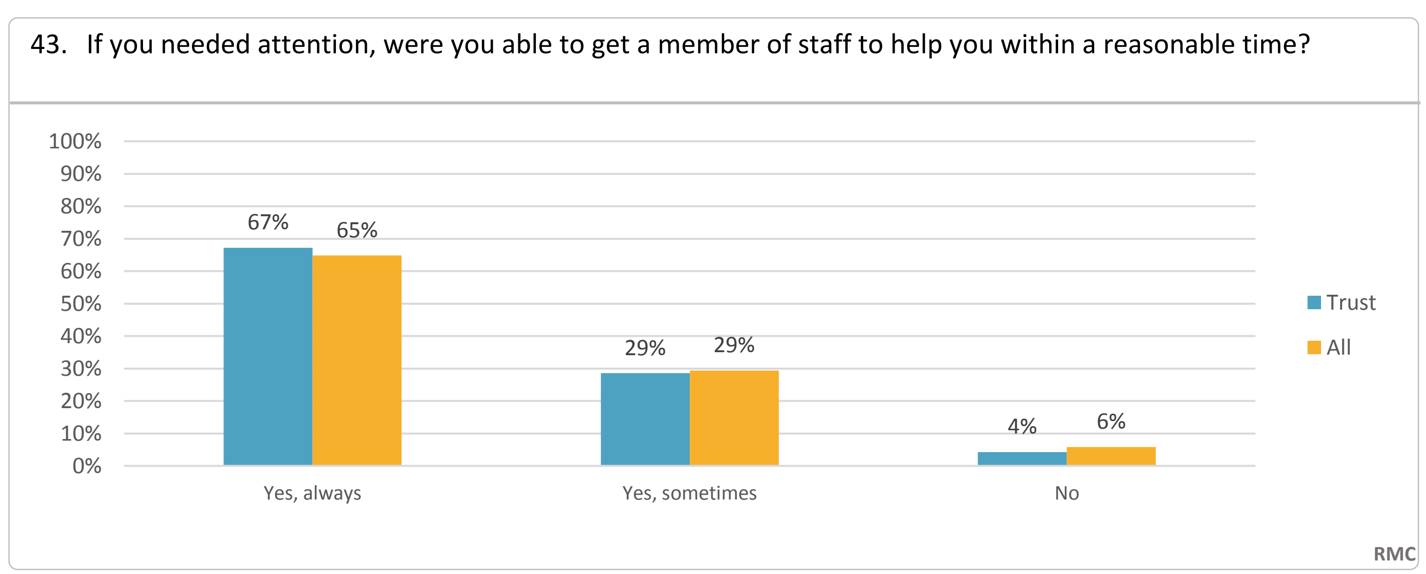
40. Were you given enough privacy when being examined or treated?



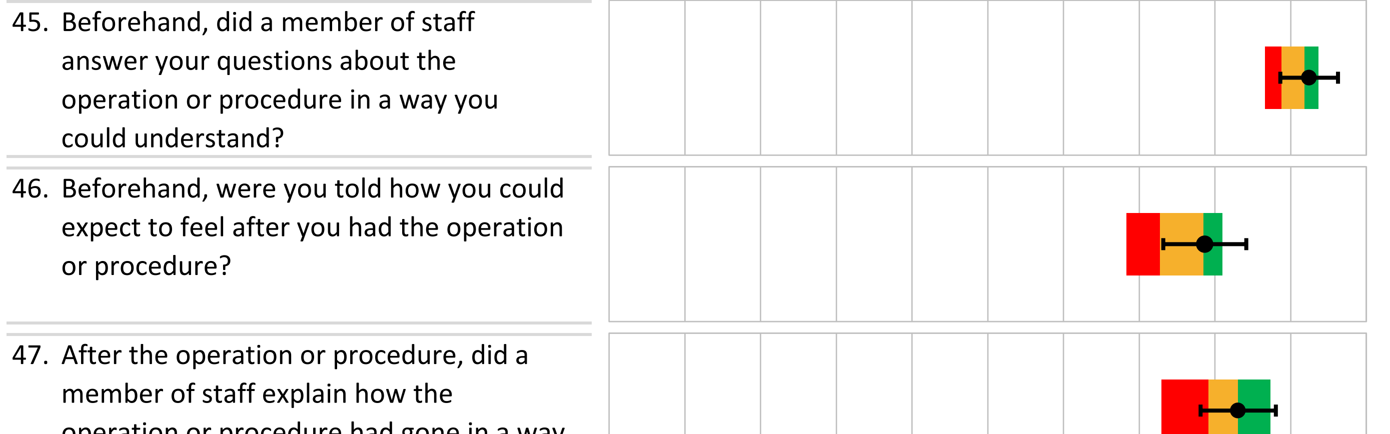
42. Do you think the hospital staff did everything they could to help control your pain?



43. If you needed attention, were you able to get a member of staff to help you within a reasonable time?



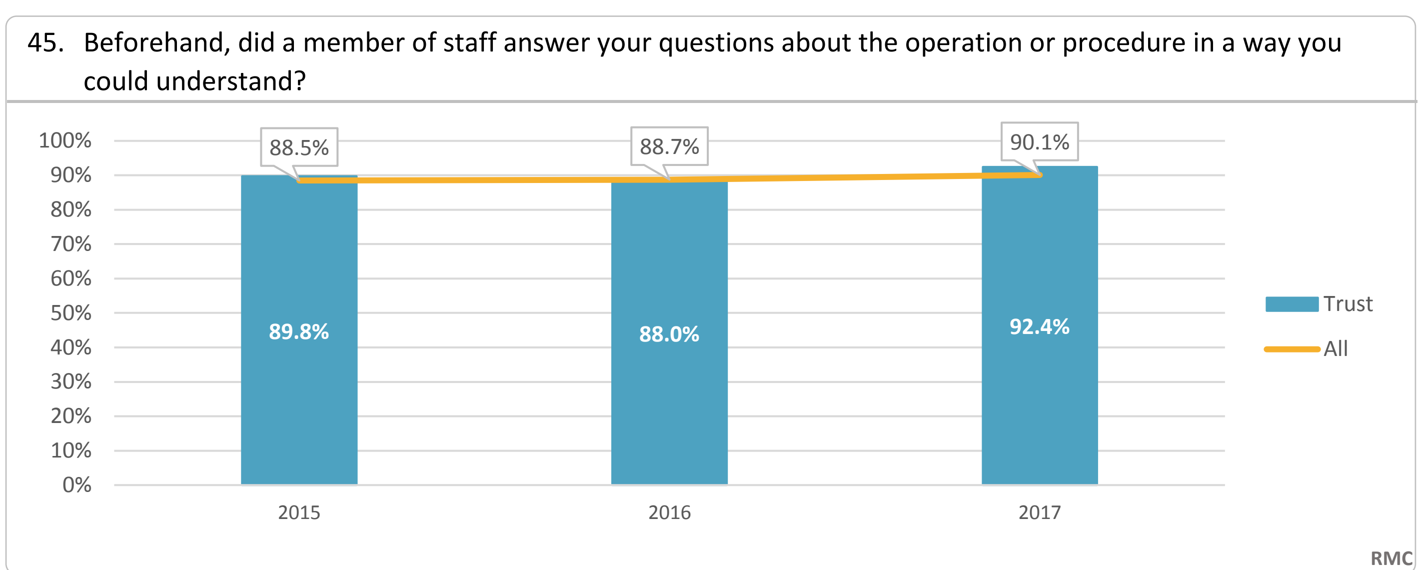
Operations & Procedures - Benchmark Charts and Tables



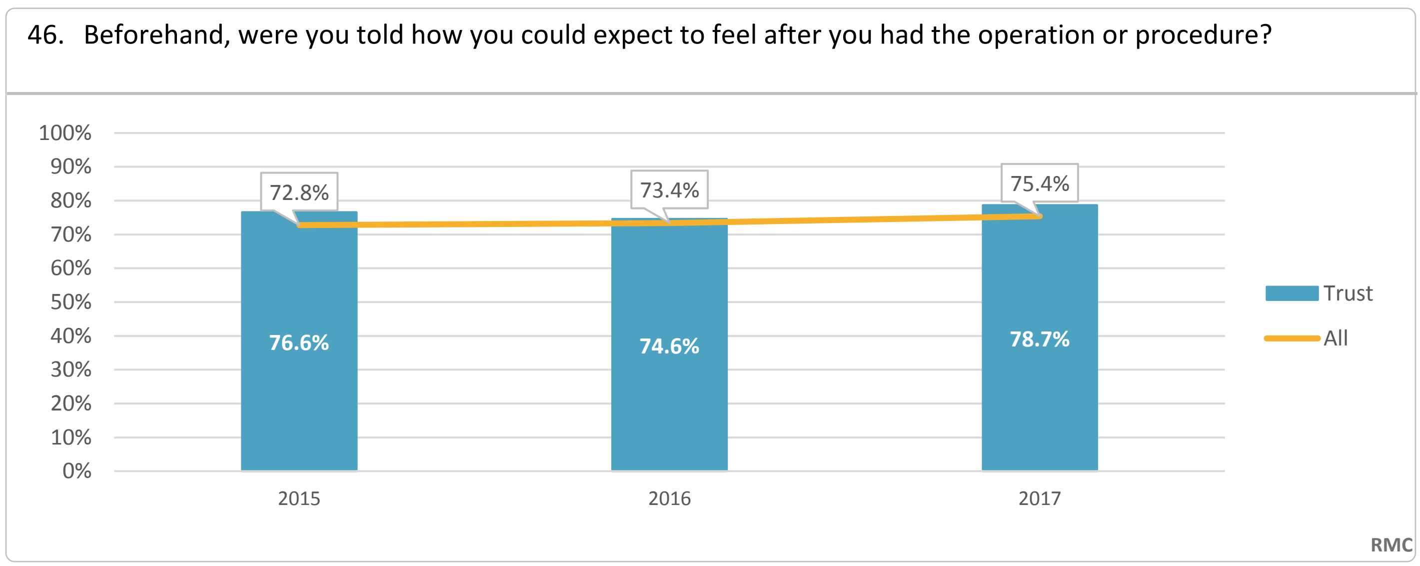
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	86.6%	88.8%	91.8%	93.6%	199	92.4%	●
46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	68.3%	72.8%	78.5%	81.0%	213	78.7%	●
47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	73.0%	79.2%	83.0%	87.3%	211	83.1%	●

Operations & Procedures - Longitudinal Charts

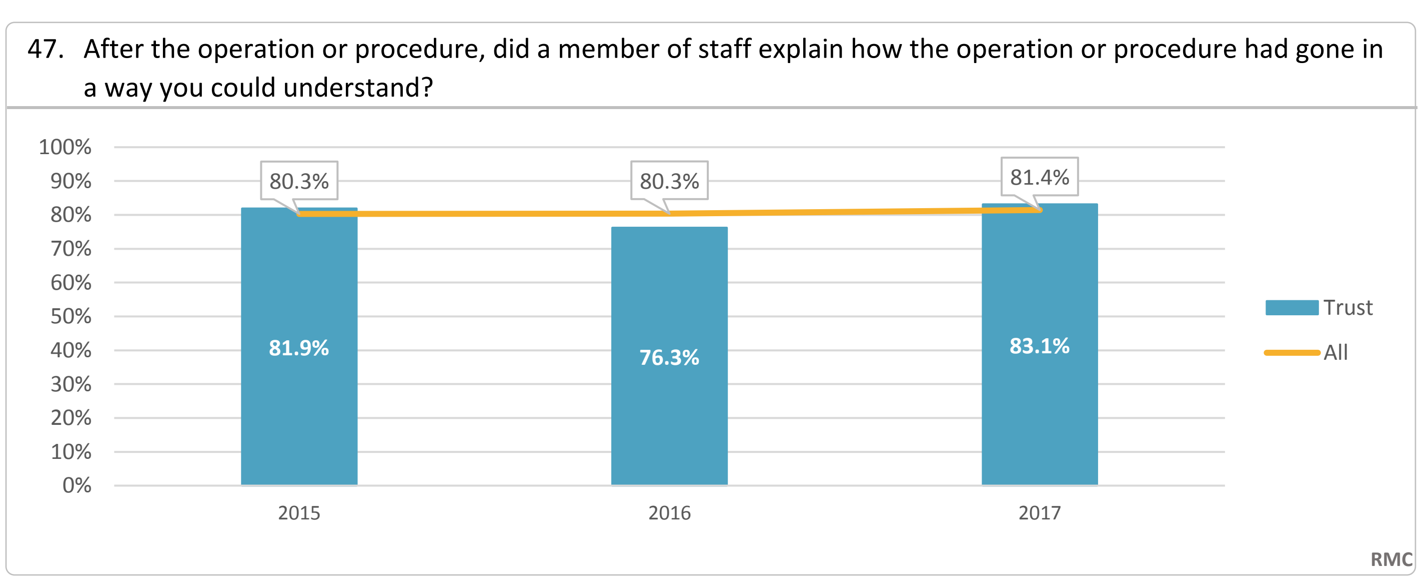
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?



46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?

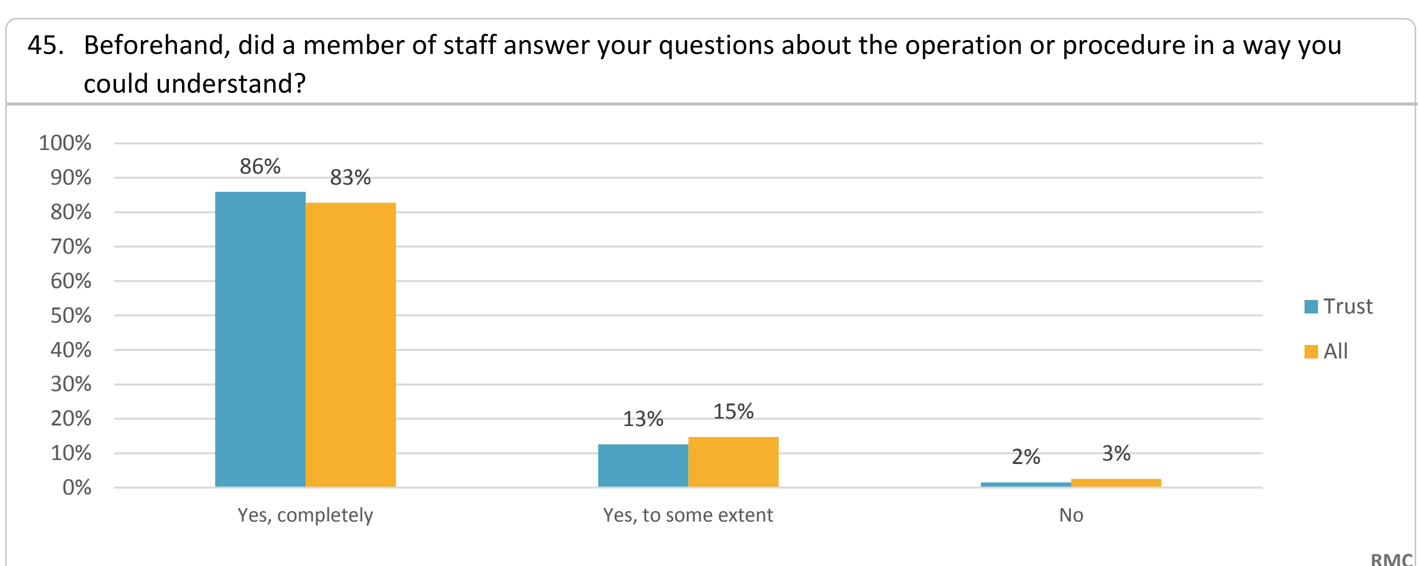


47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

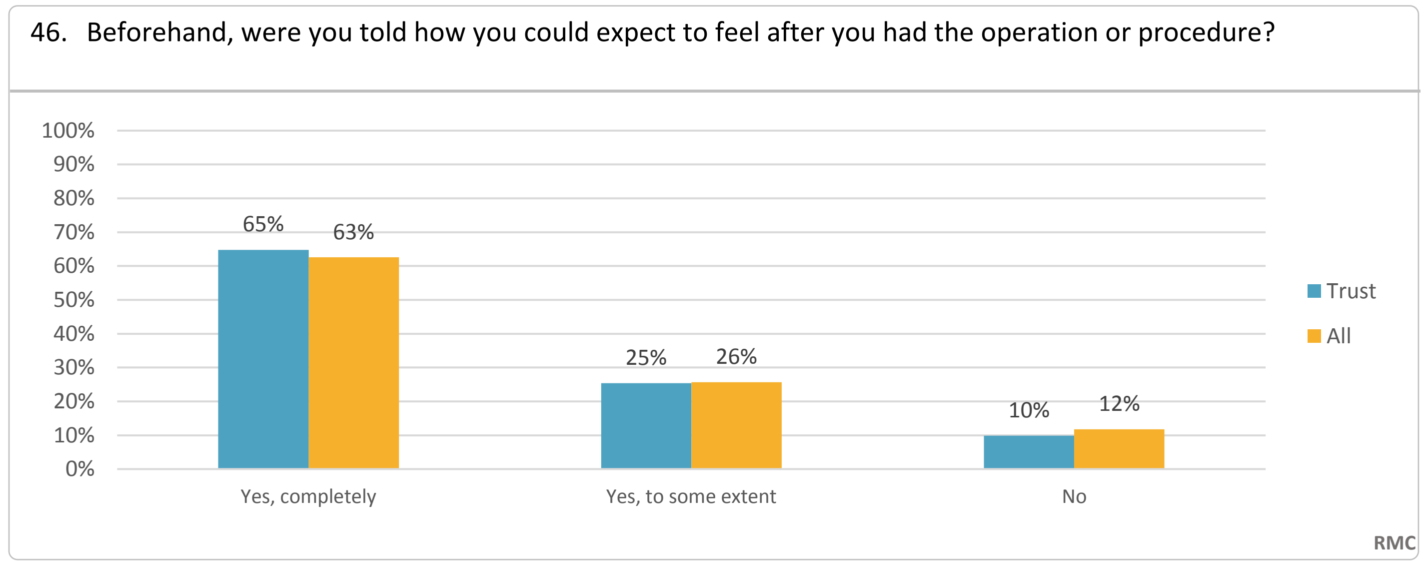


Operations & Procedures - Compositional Charts

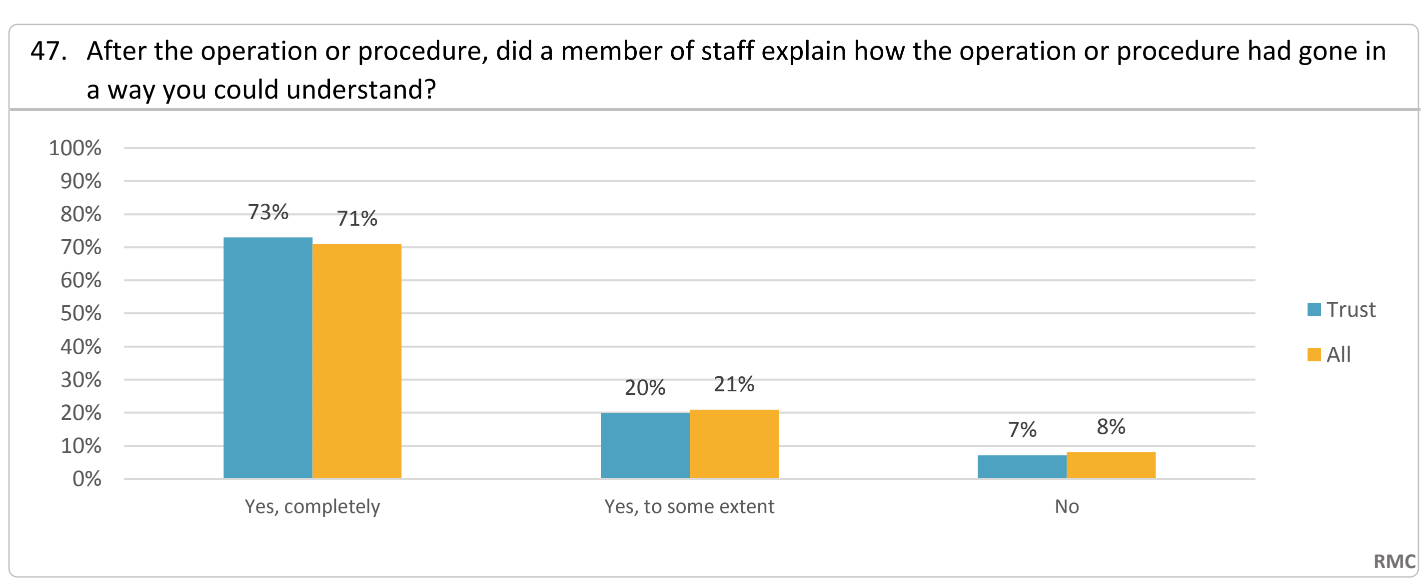
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?



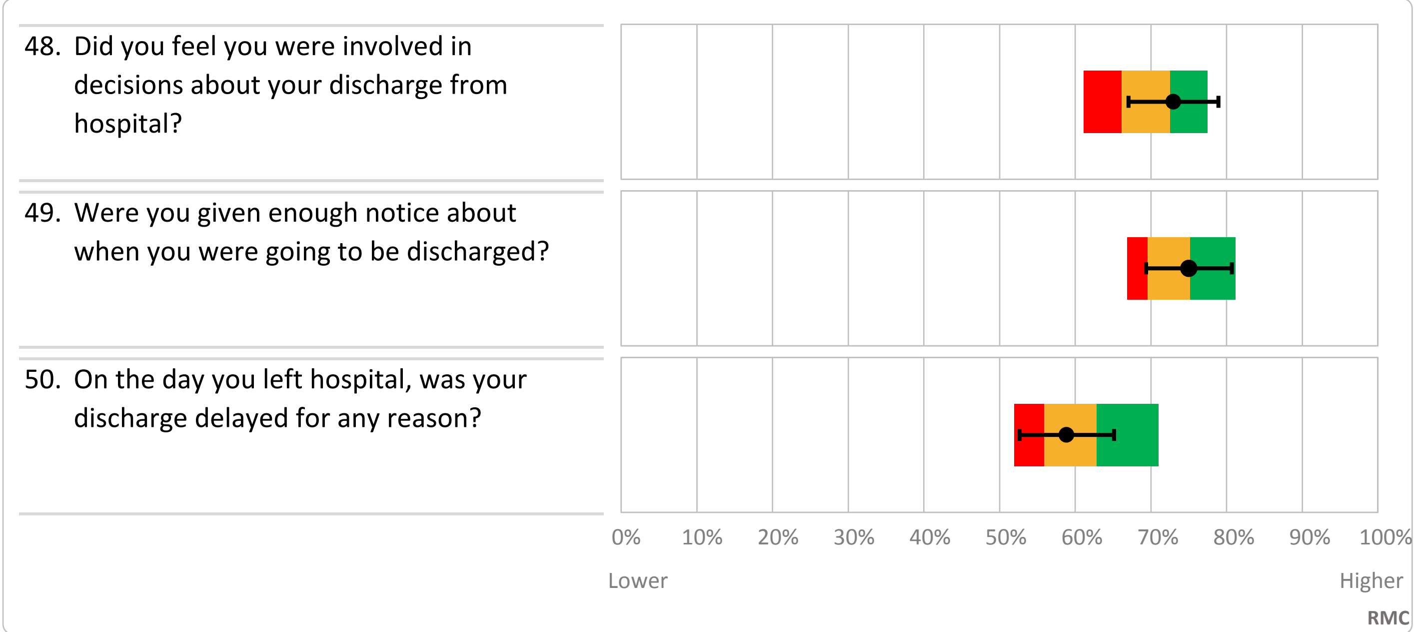
46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?



47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

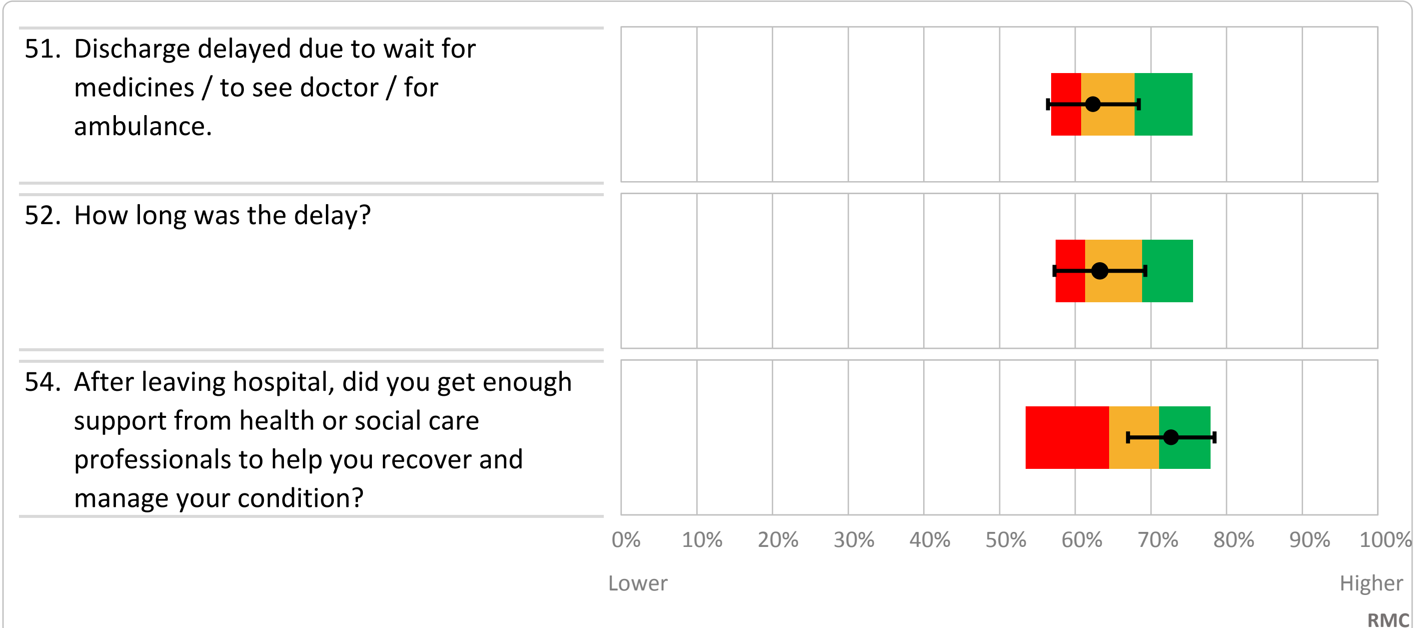


Leaving Hospital - Benchmark Charts and Tables



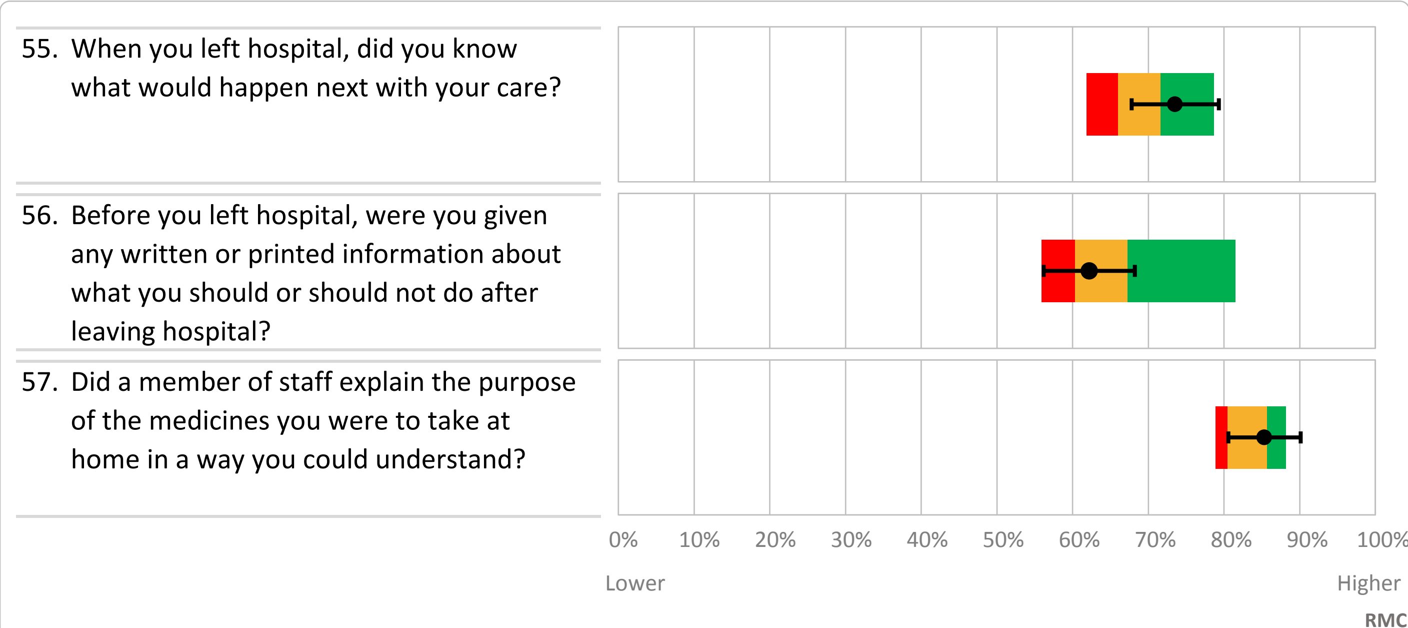
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
48. Did you feel you were involved in decisions about your discharge from hospital?	61.1%	66.2%	72.5%	77.5%	354	73.0%	● (green)
49. Were you given enough notice about when you were going to be discharged?	66.9%	69.6%	75.2%	81.2%	385	75.0%	● (amber)
50. On the day you left hospital, was your discharge delayed for any reason?	52.0%	55.9%	62.8%	71.0%	380	58.9%	● (amber)

Leaving Hospital - Benchmark Charts and Tables (continued)



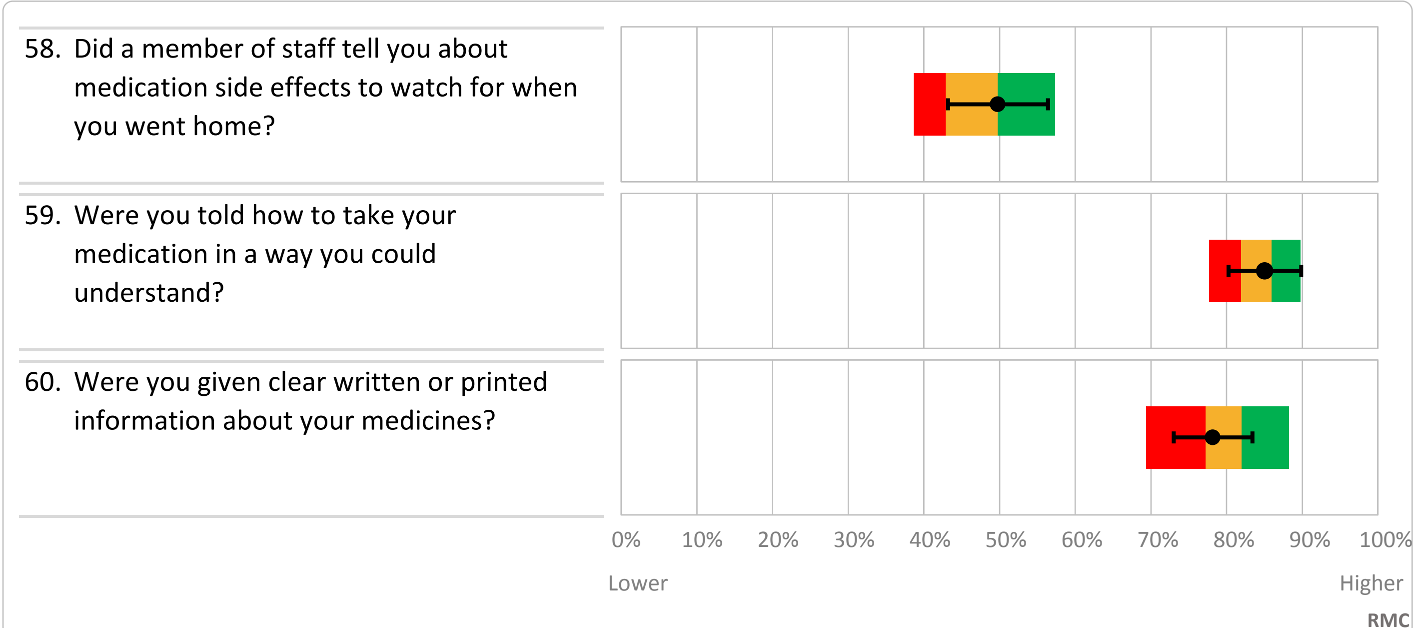
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
51. Discharge delayed due to wait for medicines / to see doctor / for ambulance.	56.8%	60.8%	67.9%	75.5%	359	62.4%	●
52. How long was the delay?	57.5%	61.3%	68.8%	75.5%	355	63.3%	●
54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	53.5%	64.5%	71.1%	77.8%	221	72.7%	●

Leaving Hospital - Benchmark Charts and Tables (continued)



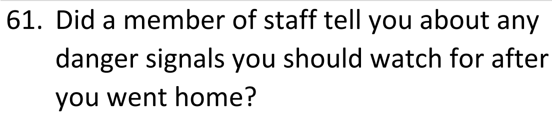
	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
55. When you left hospital, did you know what would happen next with your care?	61.8%	66.0%	71.6%	78.6%	326	73.6%	●
56. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	55.9%	60.4%	67.3%	81.5%	372	62.2%	●
57. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	78.9%	80.4%	85.7%	88.2%	263	85.4%	●

Leaving Hospital - Benchmark Charts and Tables (continued)



	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
58. Did a member of staff tell you about medication side effects to watch for when you went home?	38.7%	42.9%	49.8%	57.3%	210	49.8%	●
59. Were you told how to take your medication in a way you could understand?	77.7%	82.0%	86.0%	89.8%	226	85.1%	●
60. Were you given clear written or printed information about your medicines?	69.4%	77.3%	82.0%	88.2%	236	78.2%	●

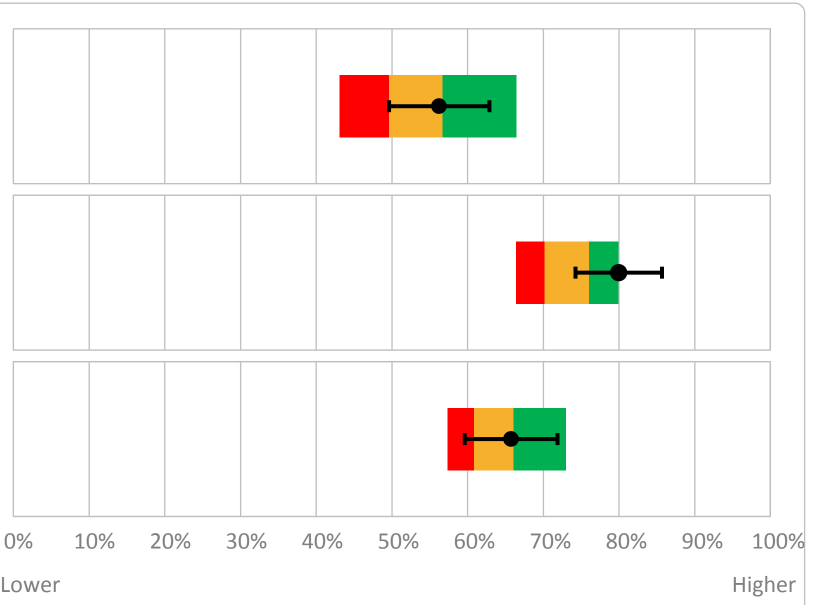
Leaving Hospital - Benchmark Charts and Tables (continued)



61. Did a member of staff tell you about any danger signals you should watch for after you went home?

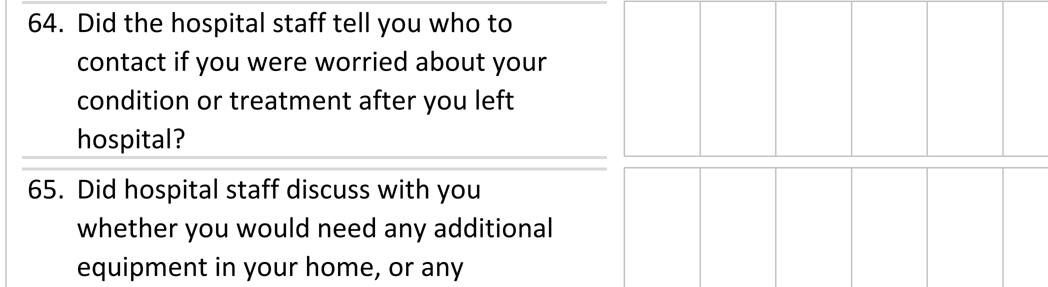
62. Did hospital staff take your family or home situation into account when planning your discharge?

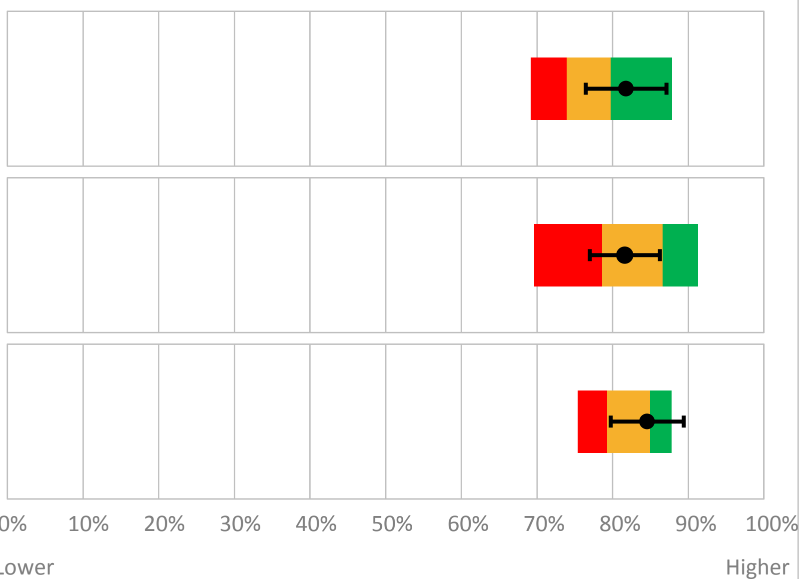
63. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?



	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	Score	RAG Rating
61. Did a member of staff tell you about any danger signals you should watch for after you went home?	43.1%	49.6%	56.7%	66.4%	230	56.3%	● (amber)
62. Did hospital staff take your family or home situation into account when planning your discharge?	66.4%	70.2%	76.1%	80.0%	235	80.0%	● (green)
63. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	57.4%	60.9%	66.0%	73.0%	245	65.8%	● (amber)

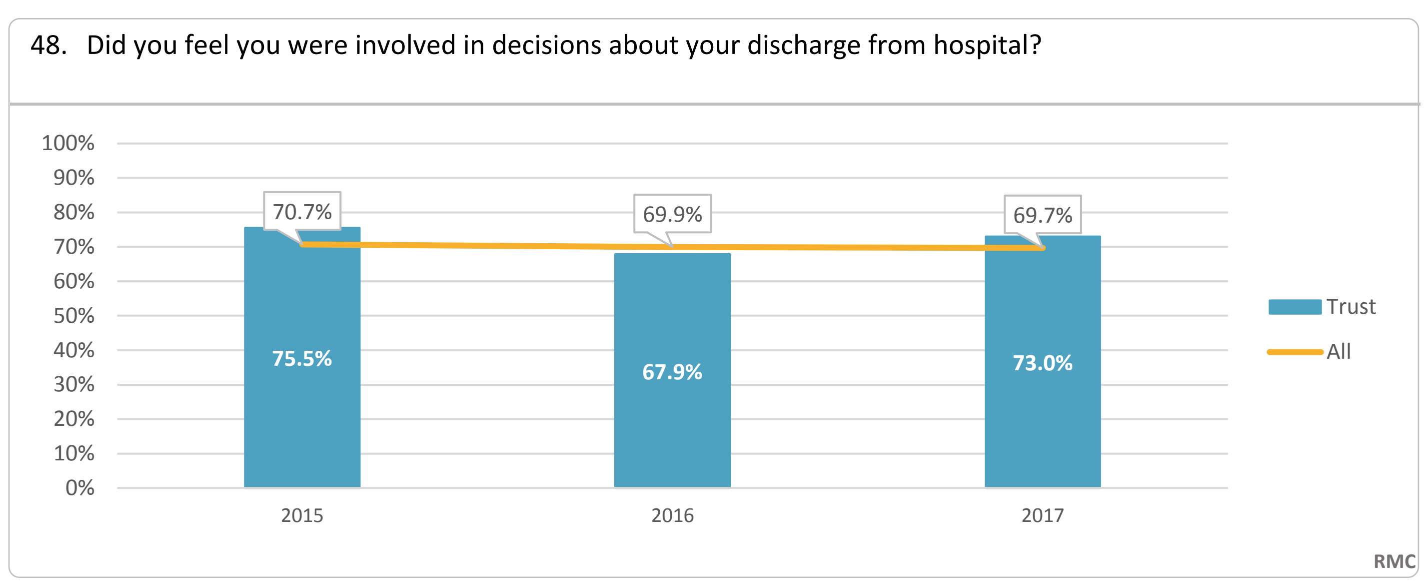
Leaving Hospital - Benchmark Charts and Tables (continued)

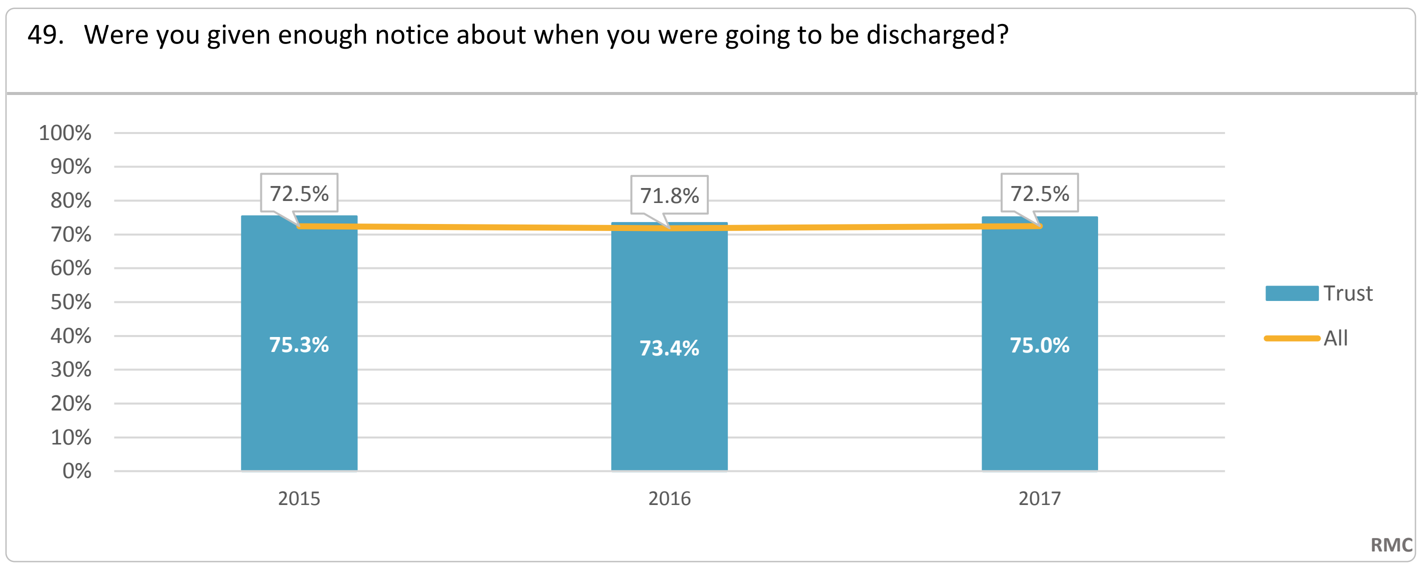


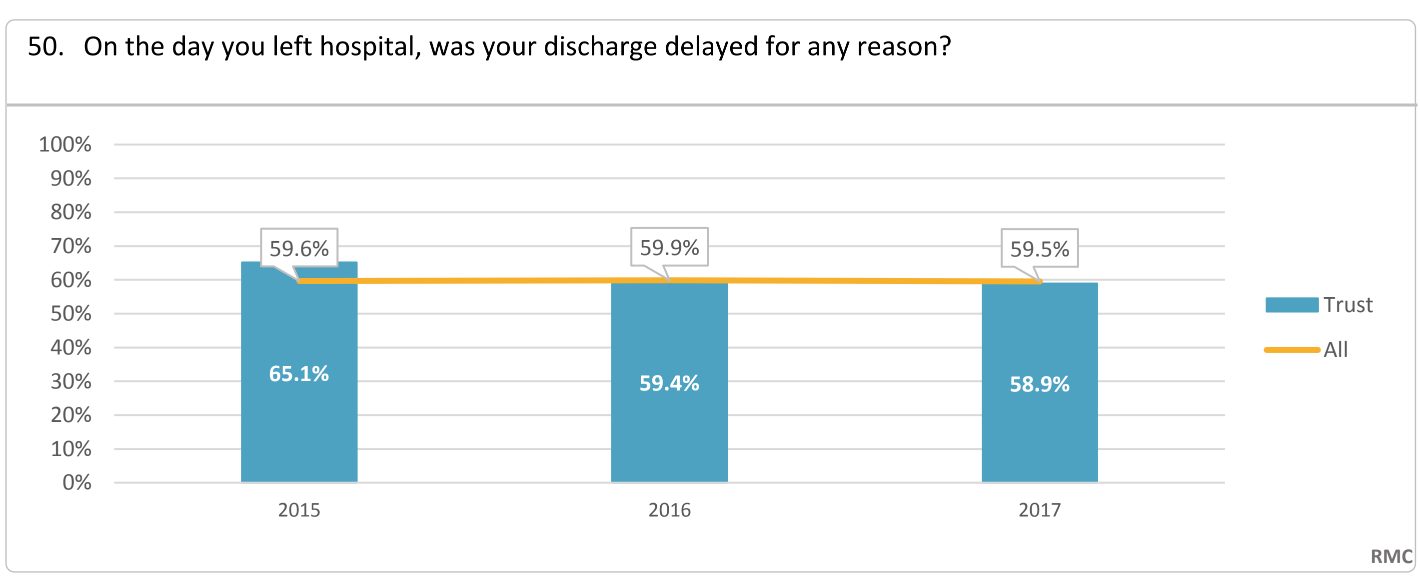


	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017		
					Number of Respondents	Score	RAG Rating
64. Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	69.2%	74.0%	79.8%	87.9%	342	81.8%	● (green)
65. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home?	69.7%	78.6%	86.6%	91.3%	134	81.6%	● (amber)
66. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	75.4%	79.3%	85.0%	87.8%	202	84.6%	● (amber)

Leaving Hospital - Longitudinal Charts

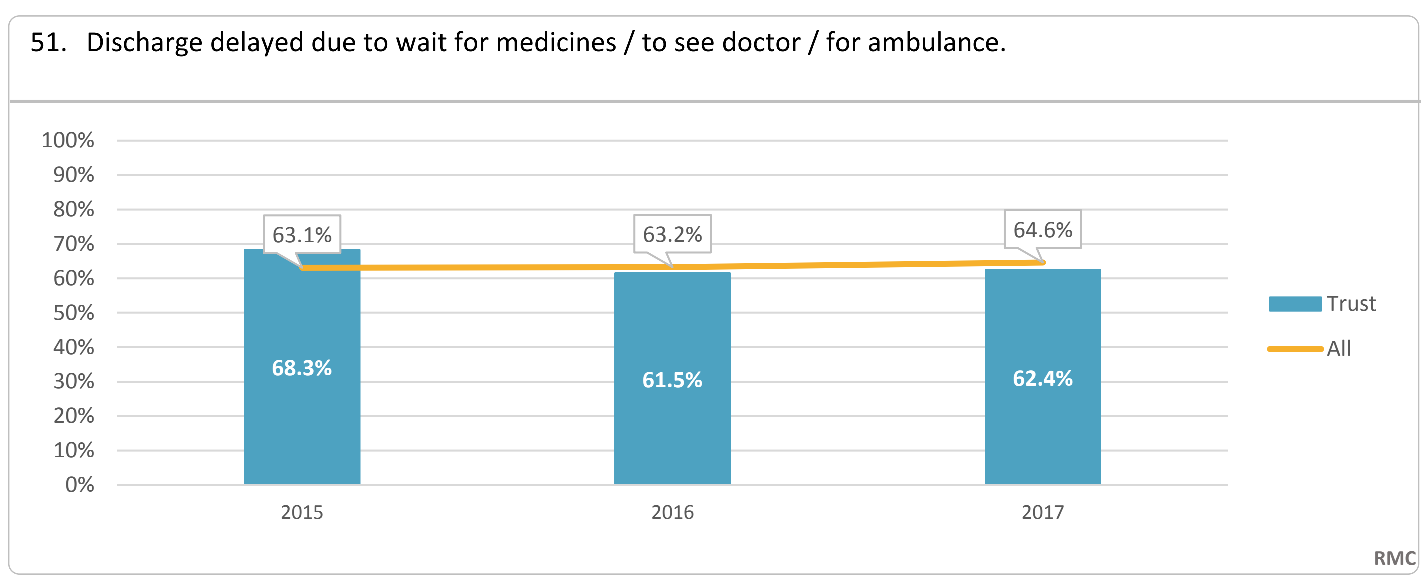




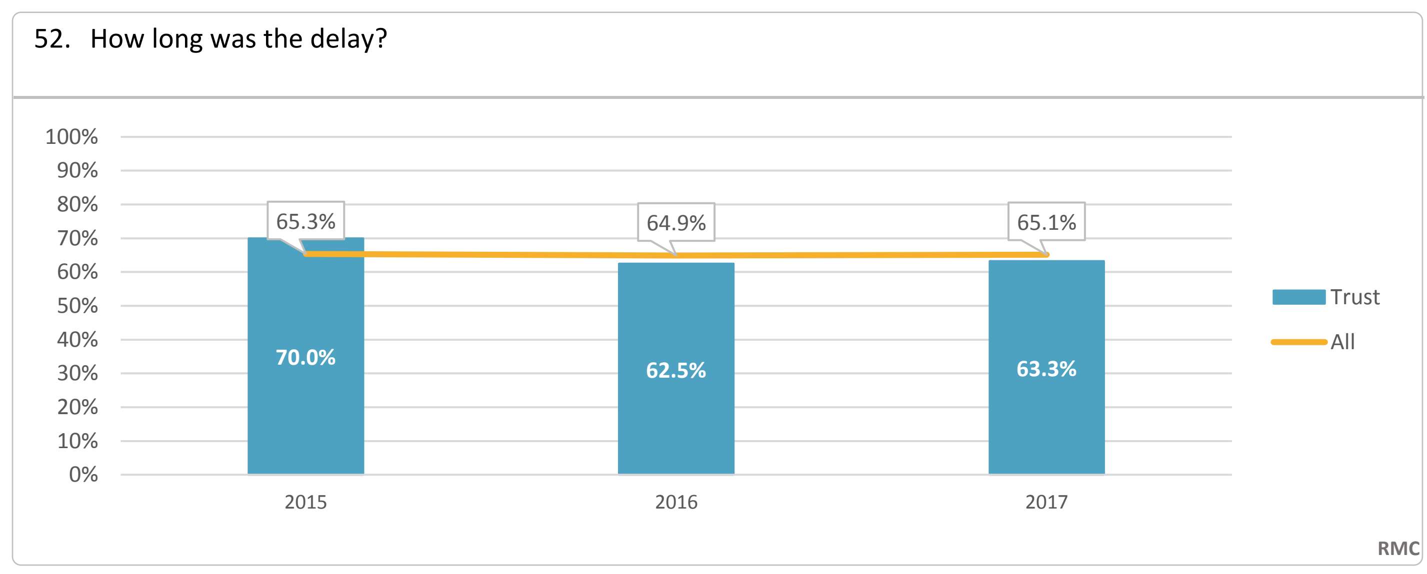


Leaving Hospital - Longitudinal Charts (continued)

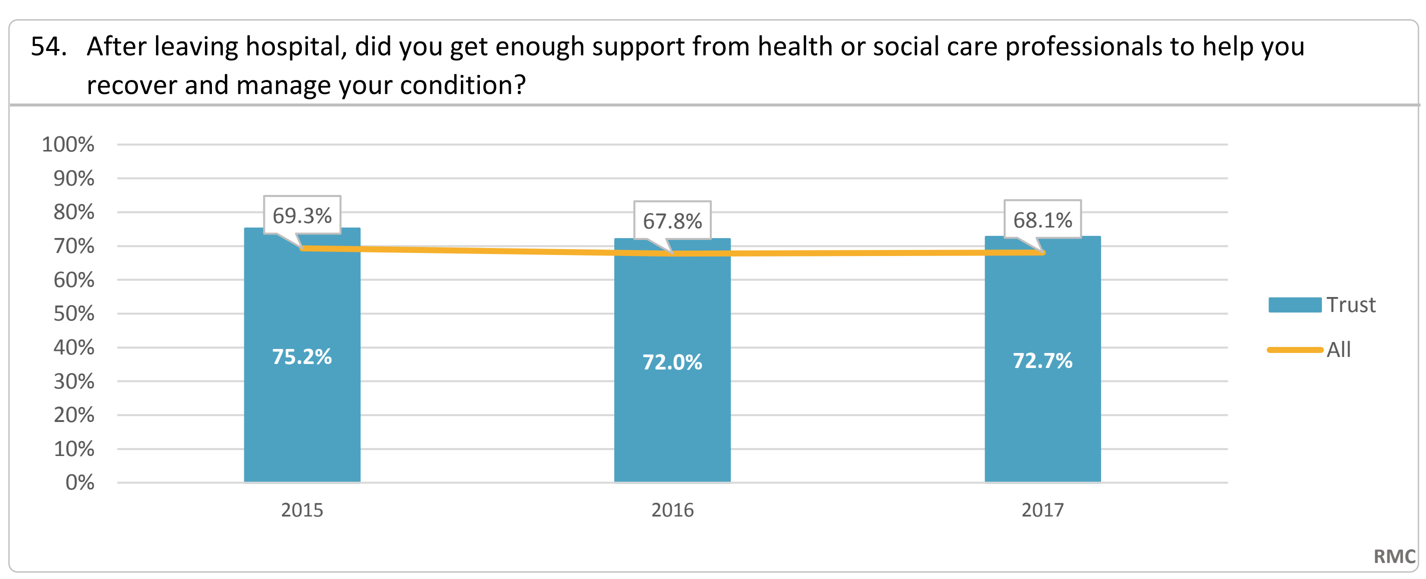
51. Discharge delayed due to wait for medicines / to see doctor / for ambulance.



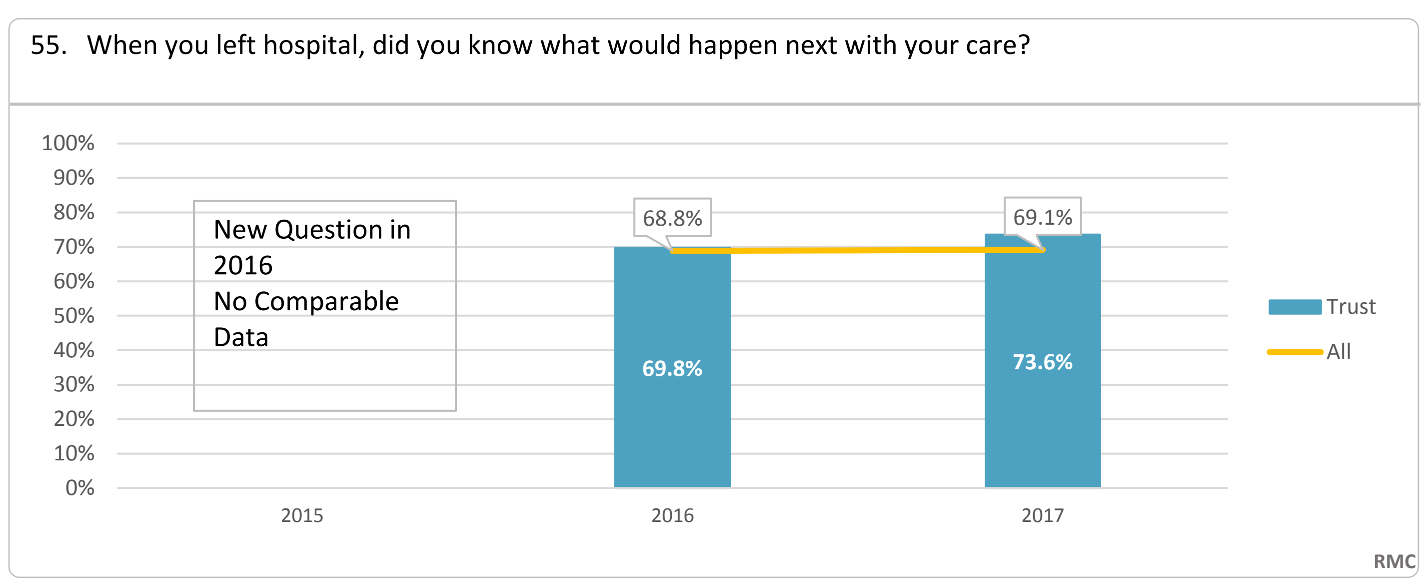
52. How long was the delay?

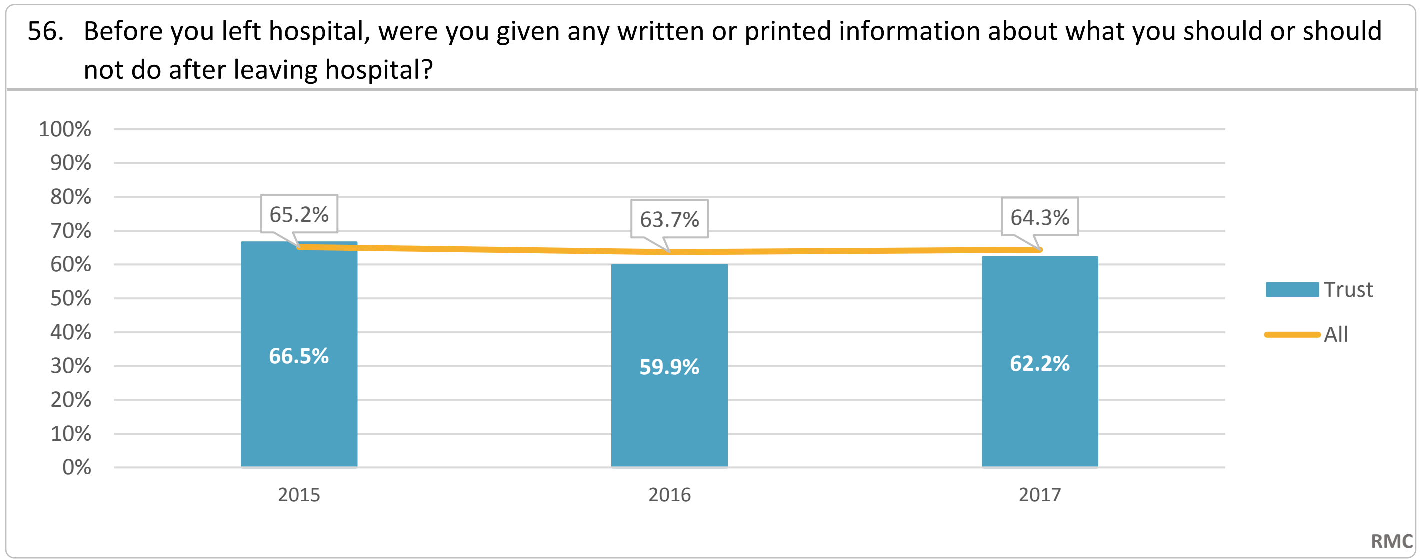


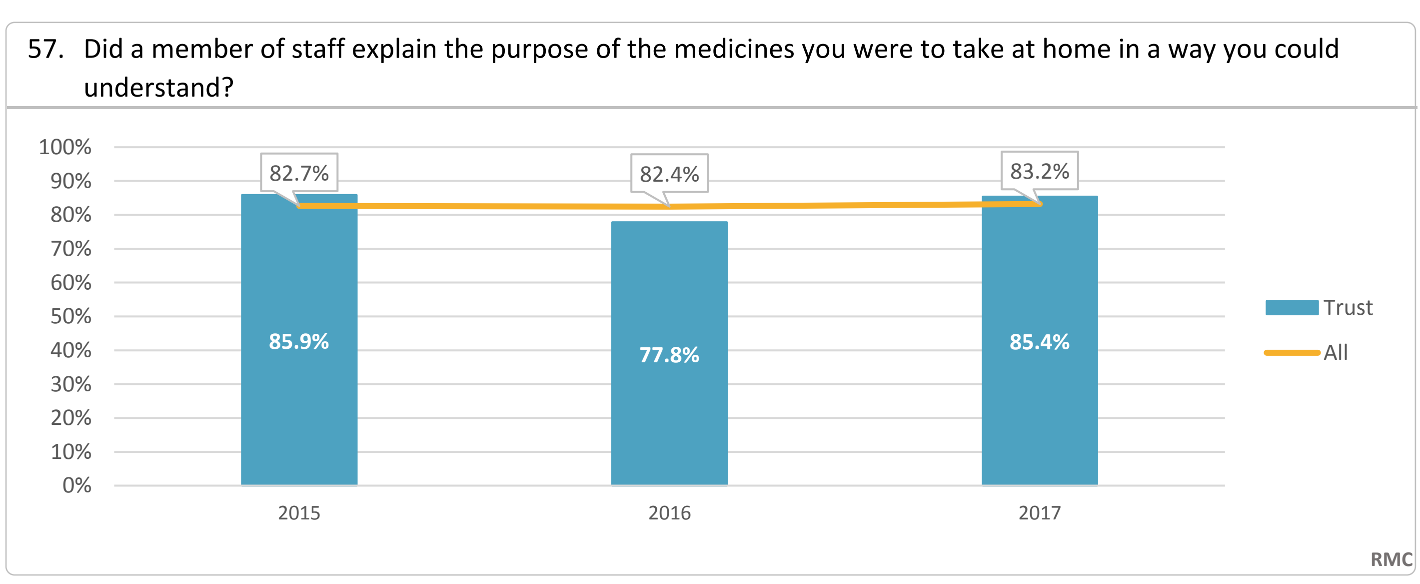
54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?



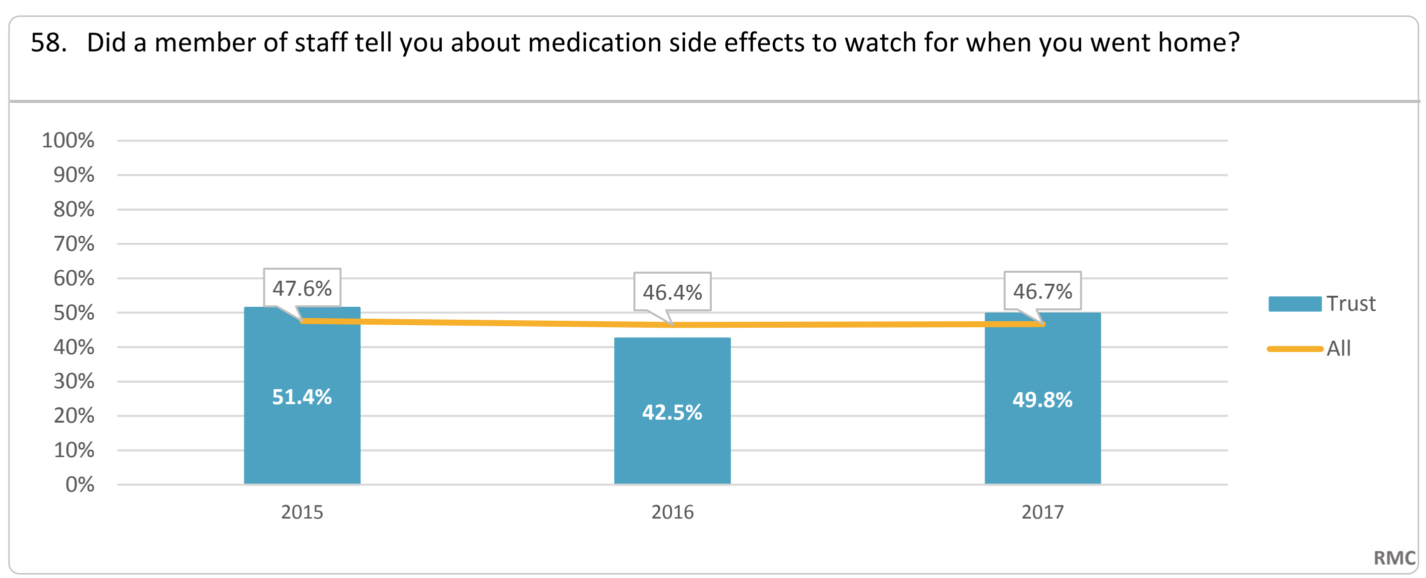
Leaving Hospital - Longitudinal Charts (continued)

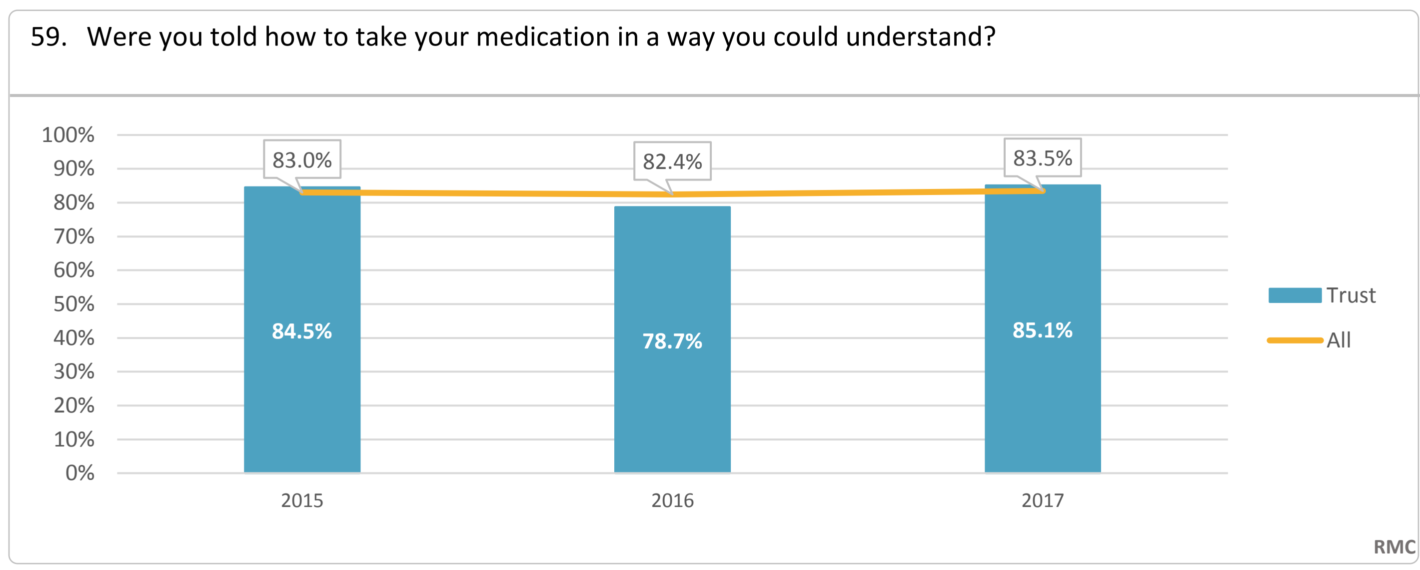


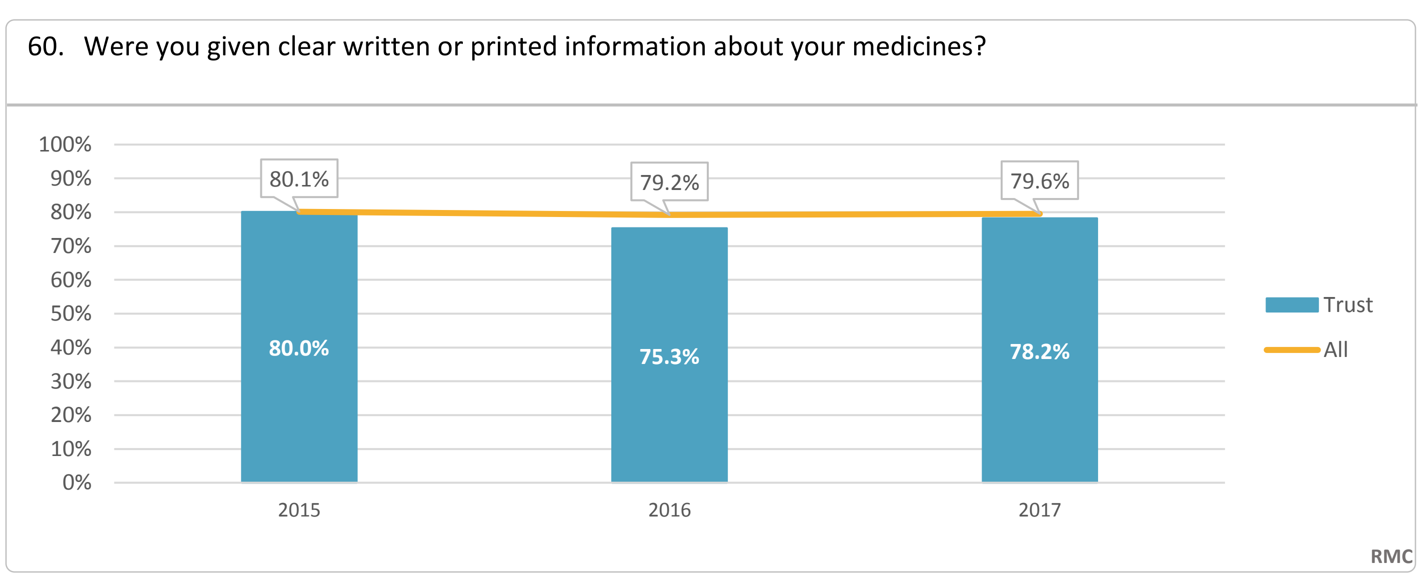




Leaving Hospital - Longitudinal Charts (continued)

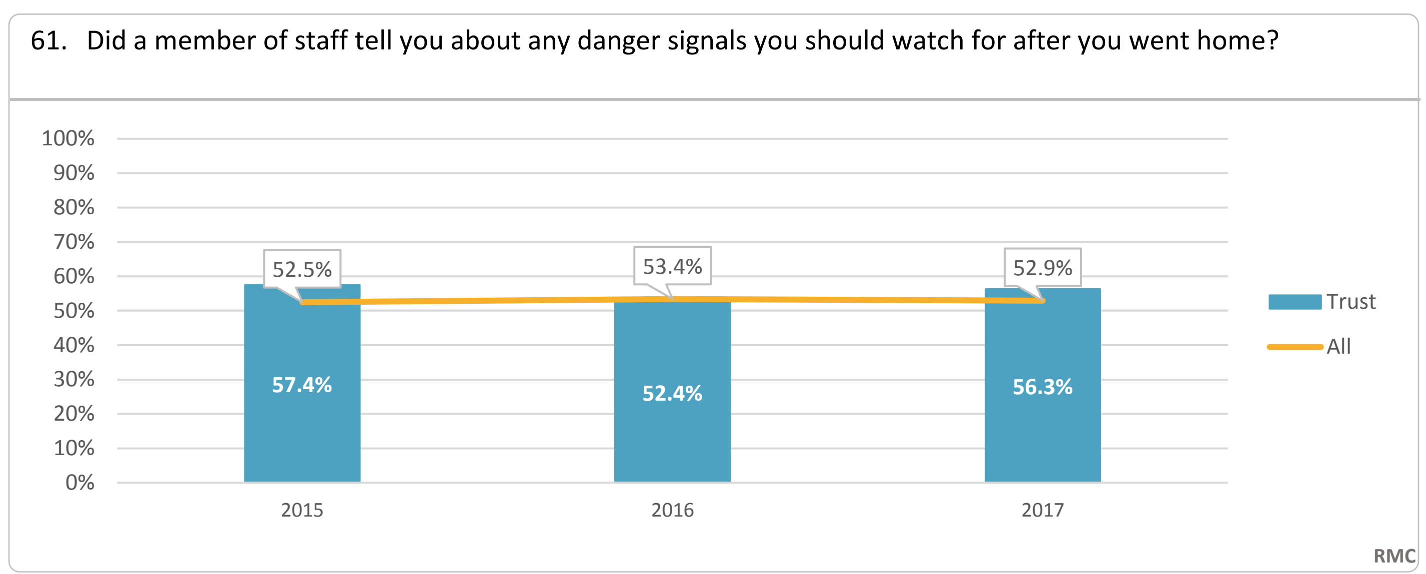




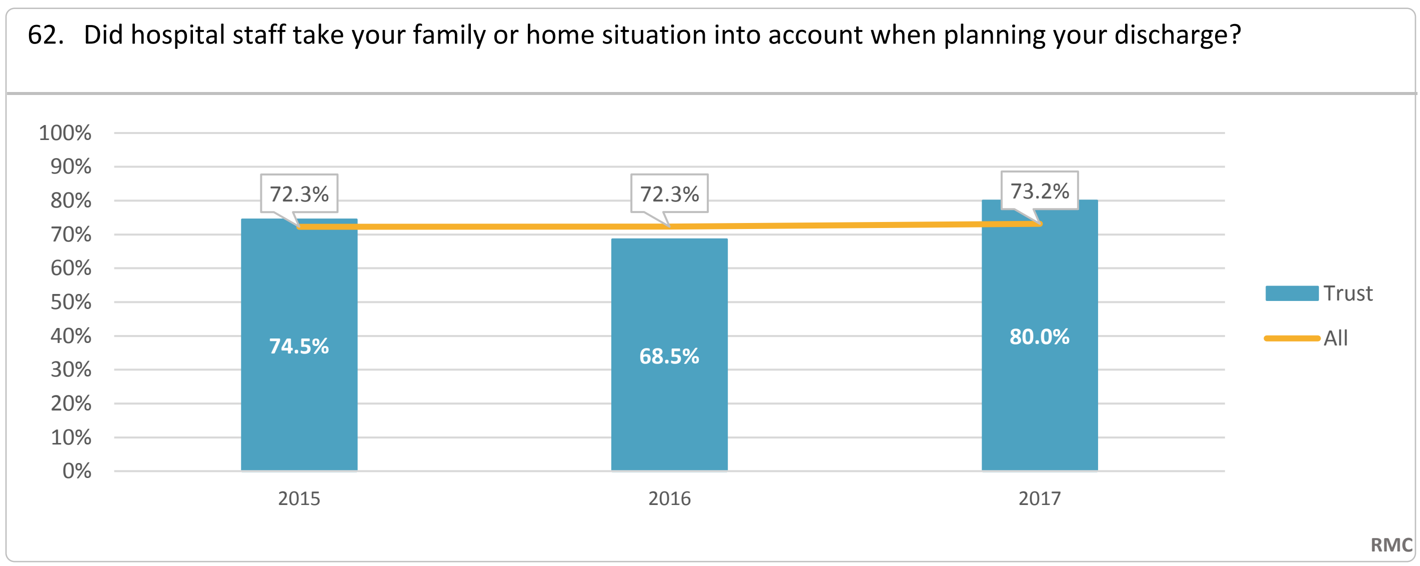


Leaving Hospital - Longitudinal Charts (continued)

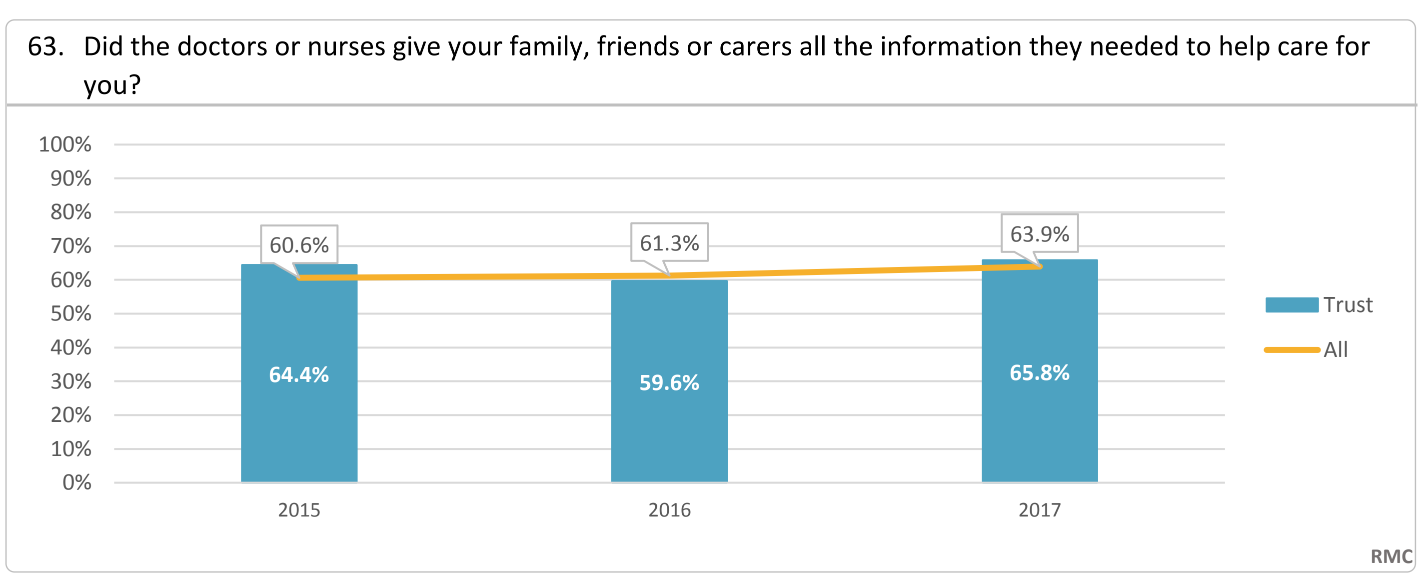
61. Did a member of staff tell you about any danger signals you should watch for after you went home?



62. Did hospital staff take your family or home situation into account when planning your discharge?

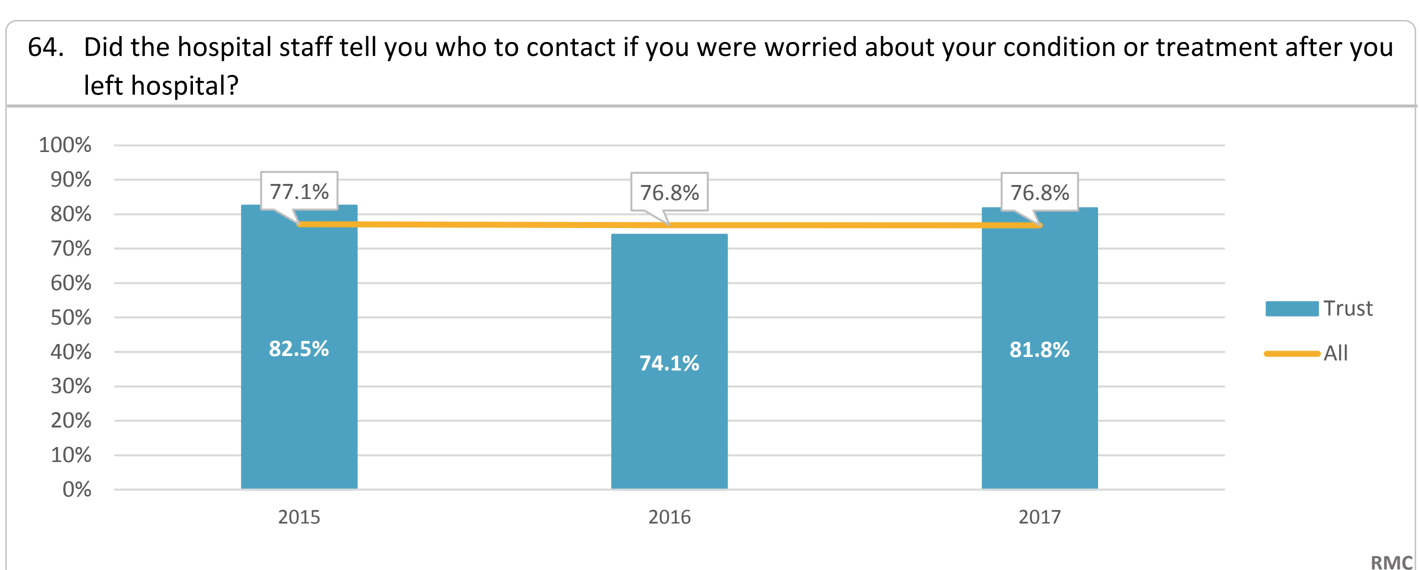


63. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?

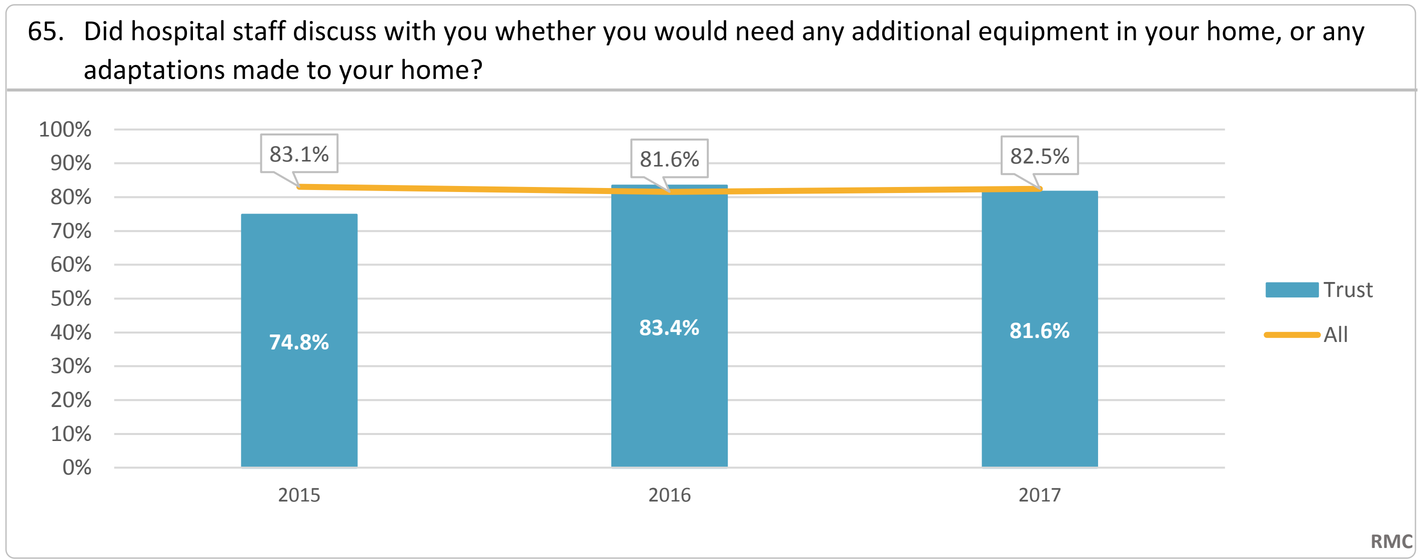


Leaving Hospital - Longitudinal Charts (continued)

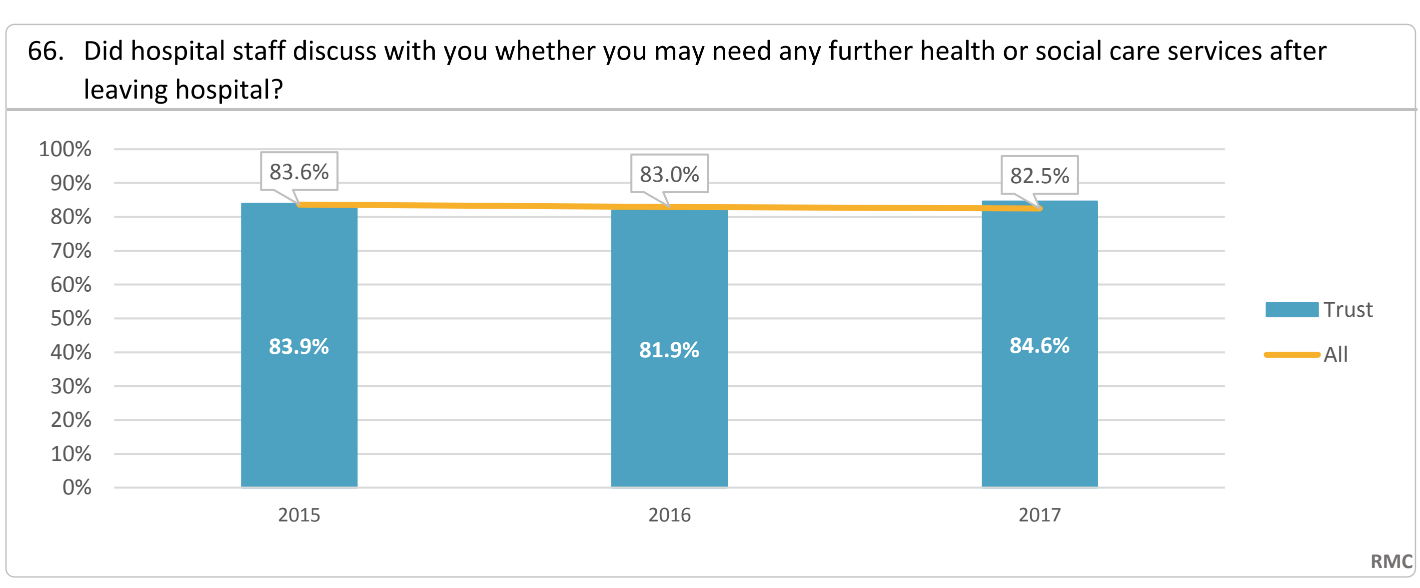
64. Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?



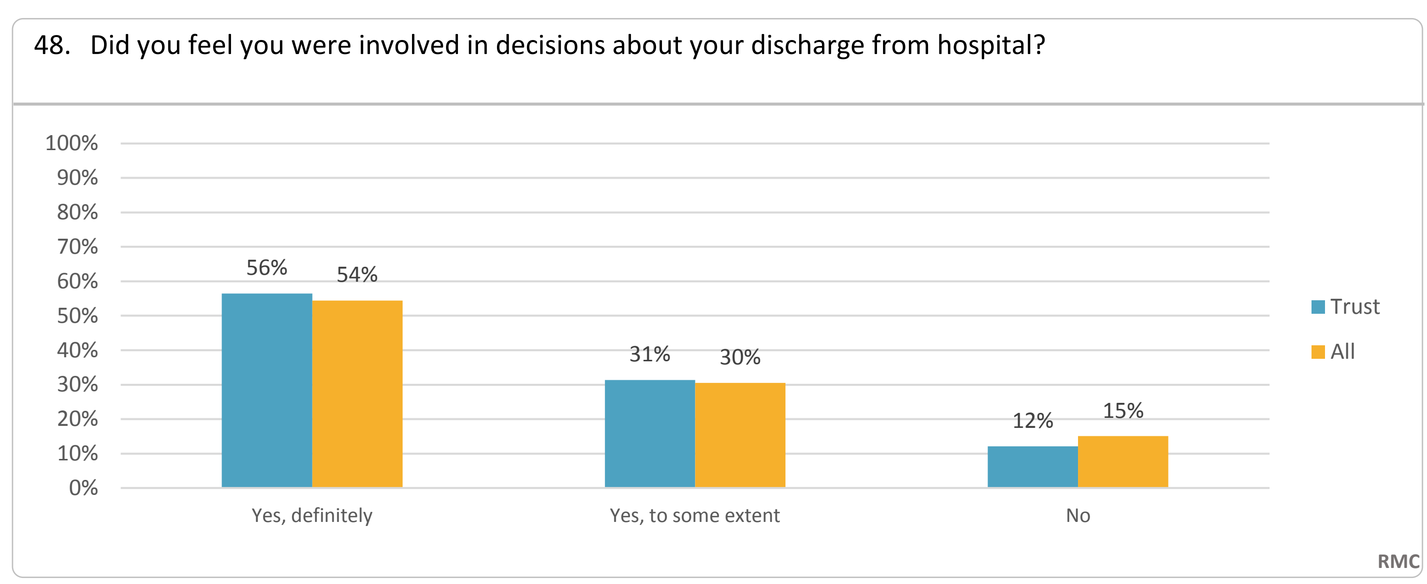
65. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home?

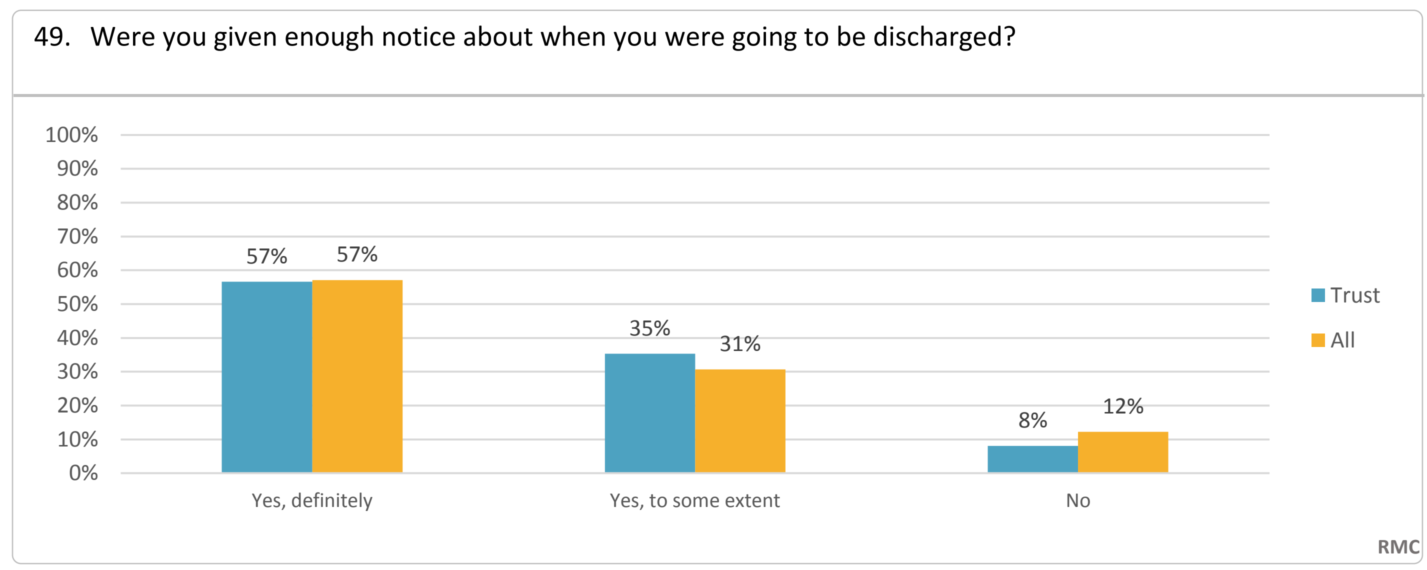


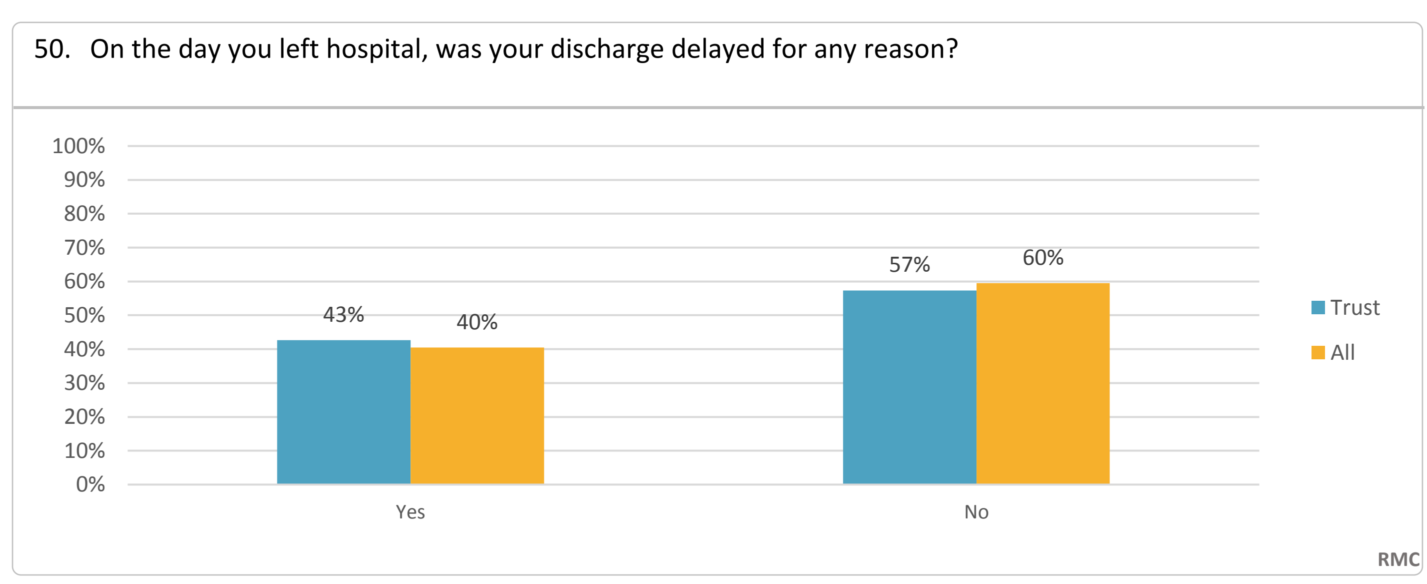
66. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



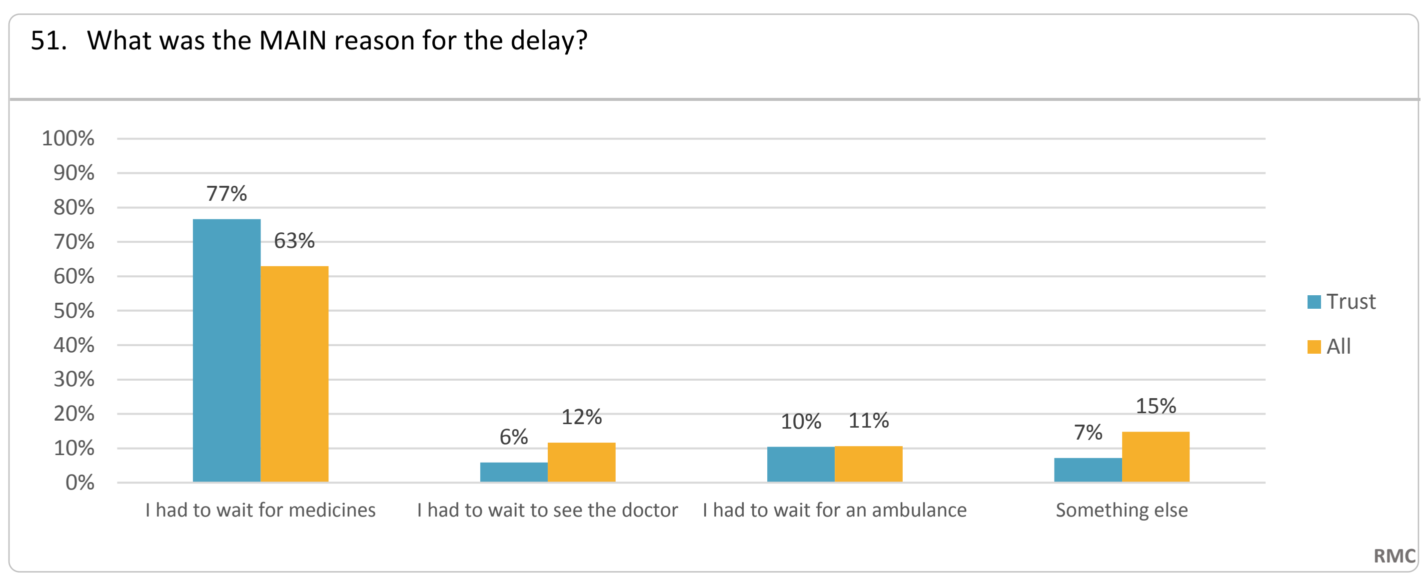
Leaving Hospital - Compositional Charts

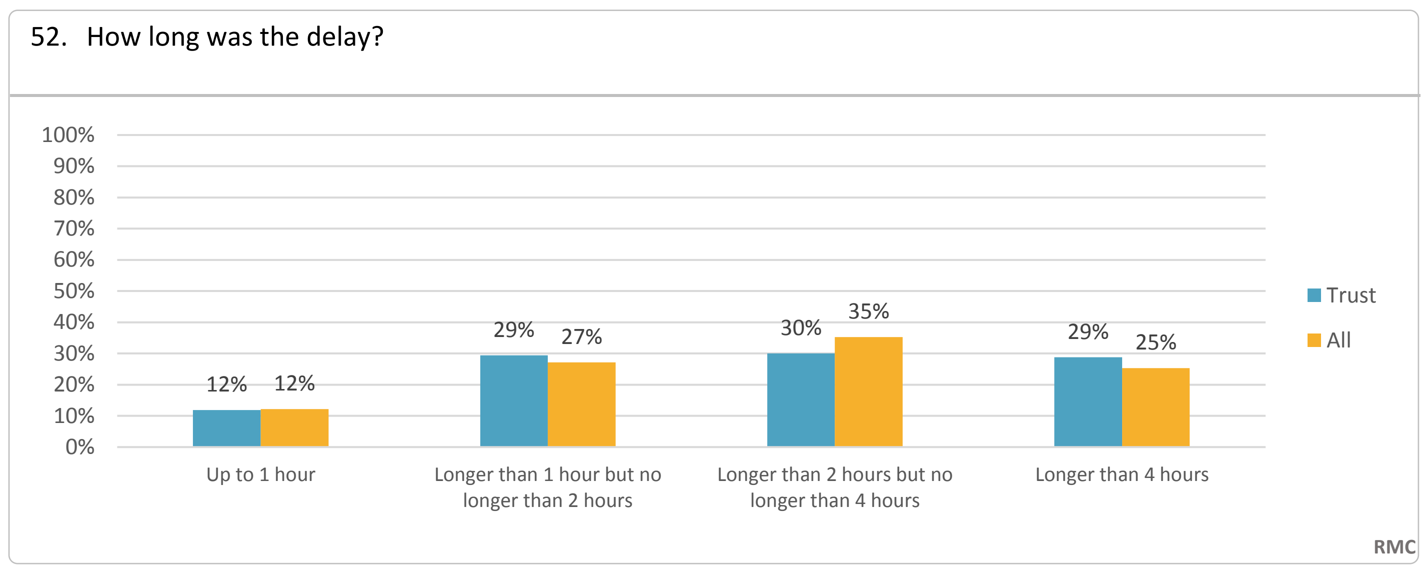


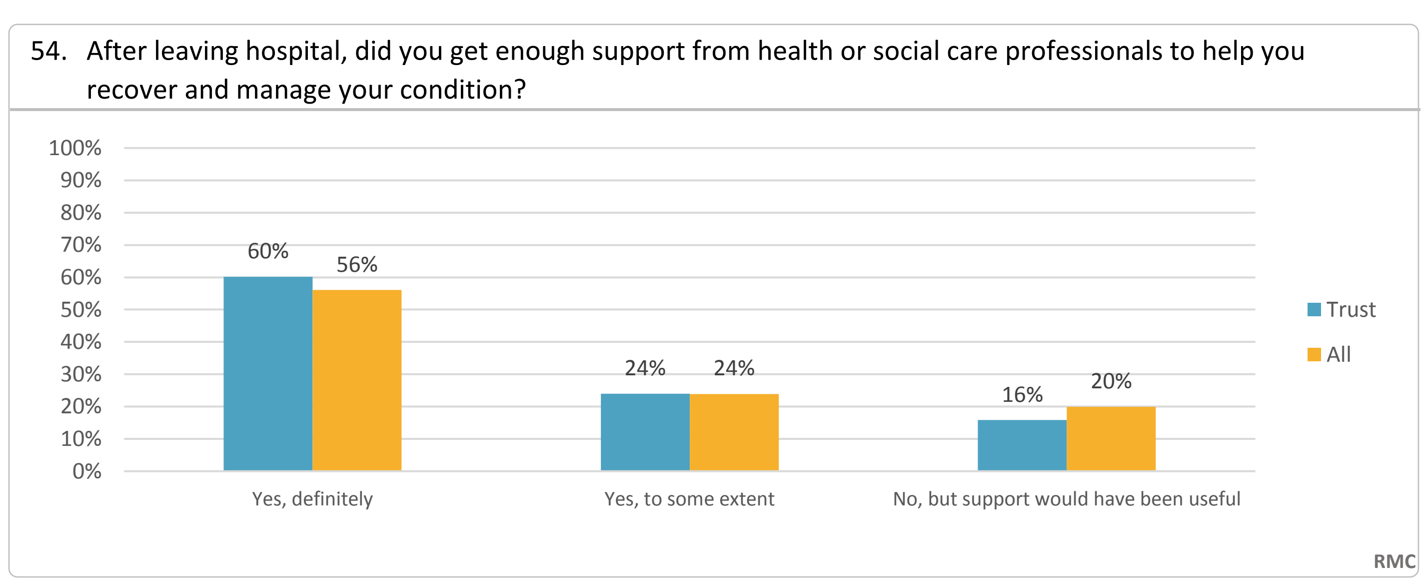




Leaving Hospital - Compositional Charts (continued)

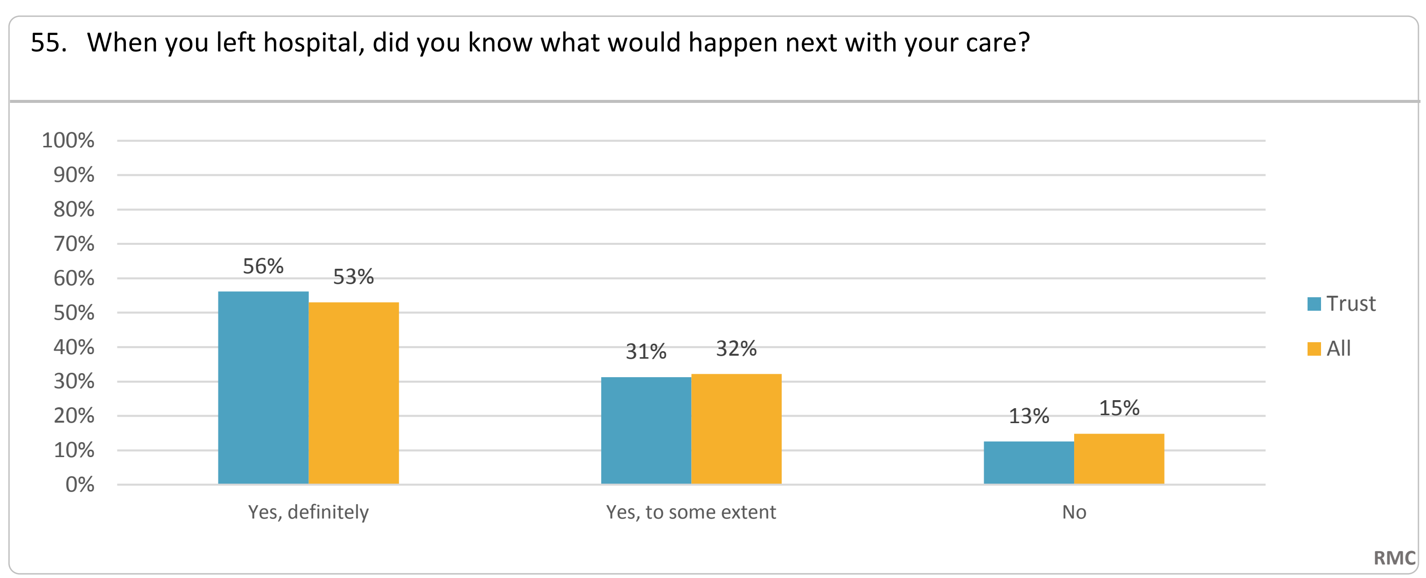




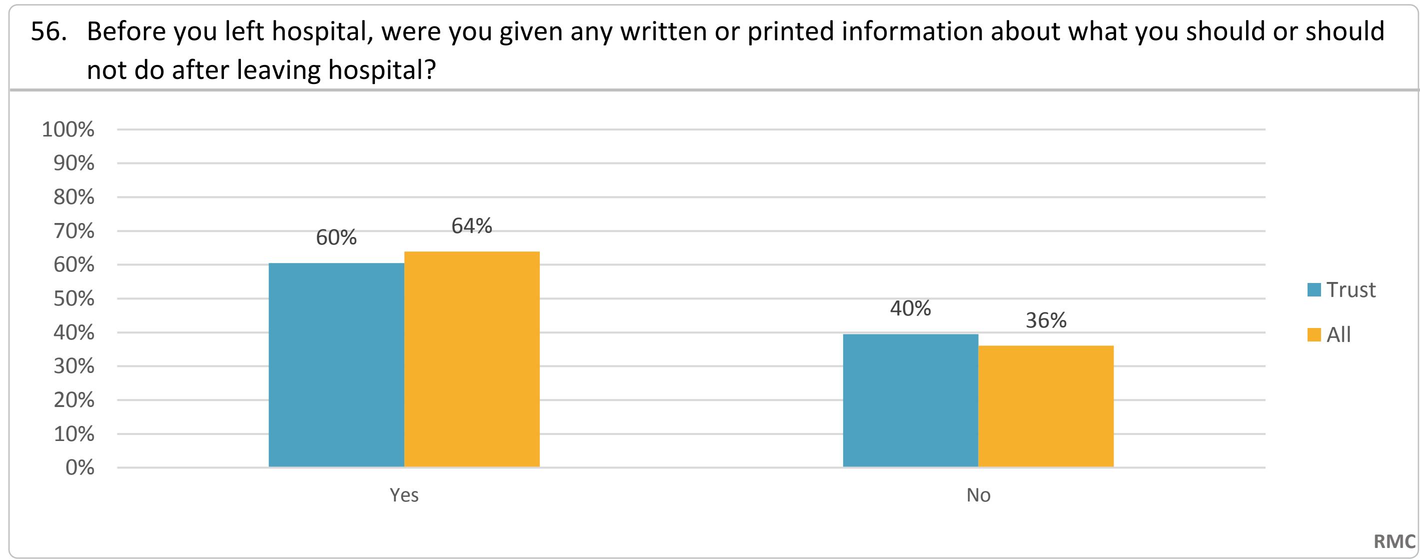


Leaving Hospital - Compositional Charts (continued)

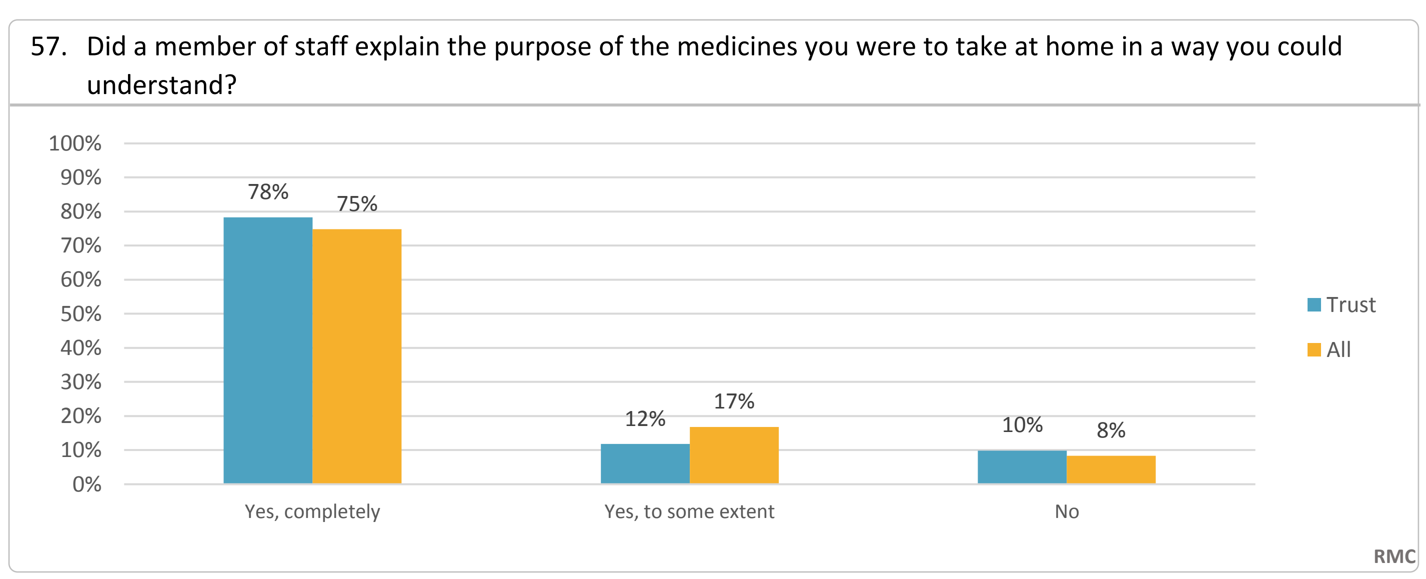
55. When you left hospital, did you know what would happen next with your care?



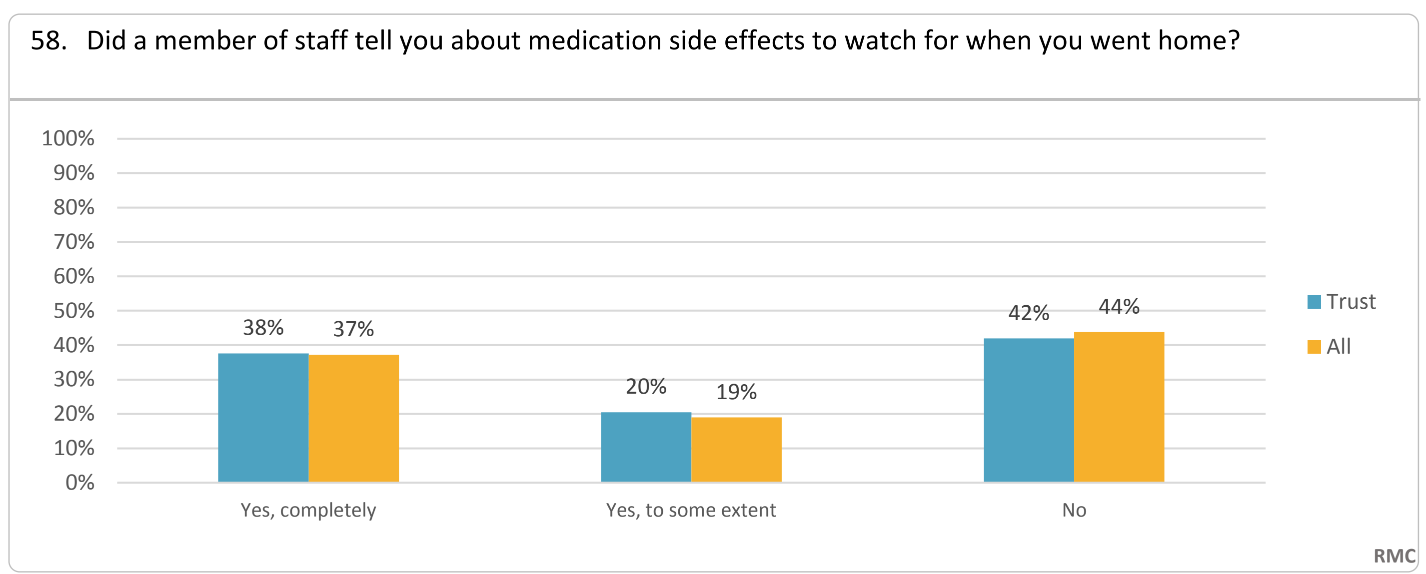
56. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

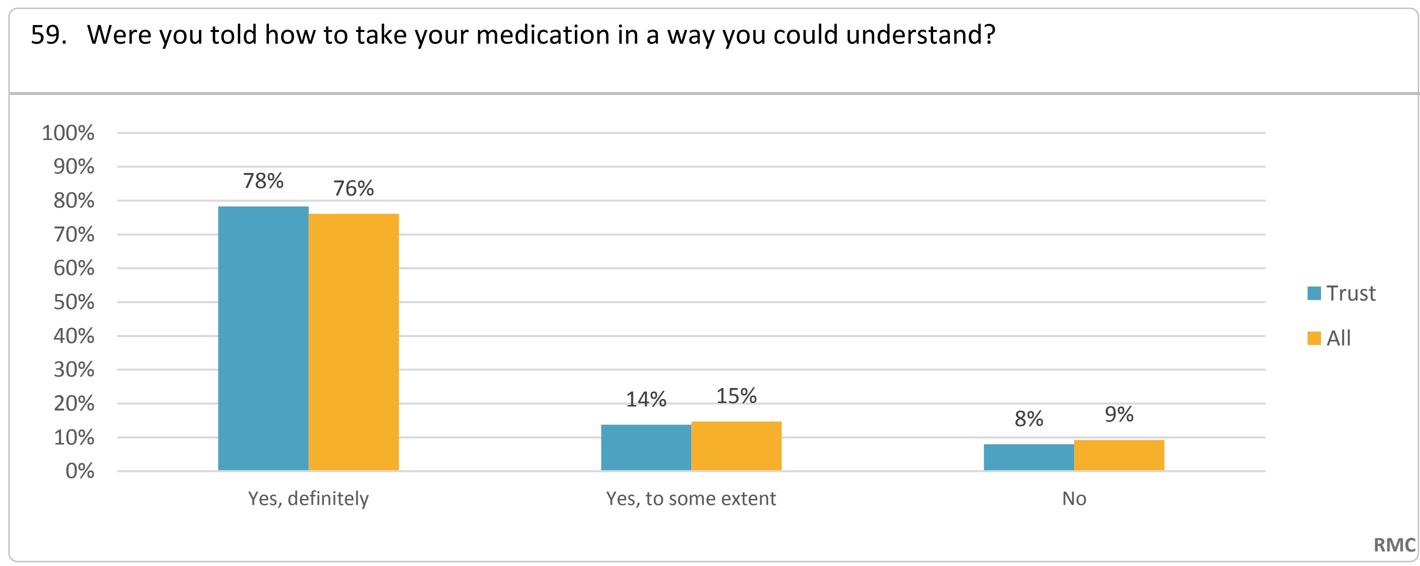


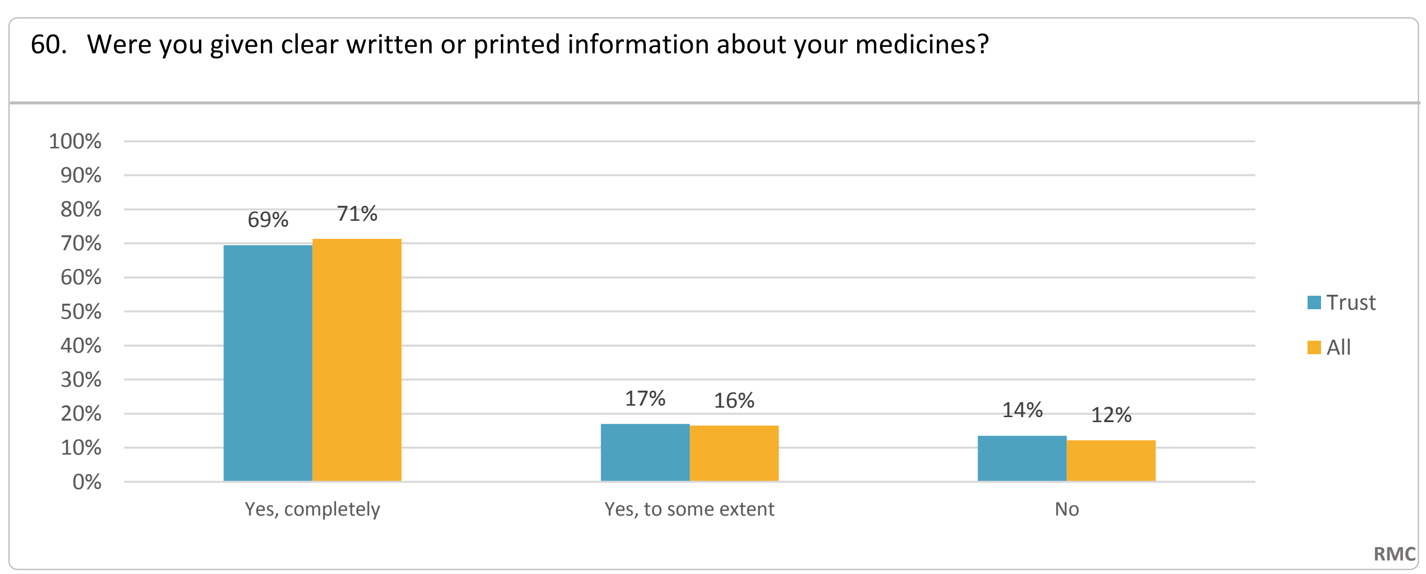
57. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?



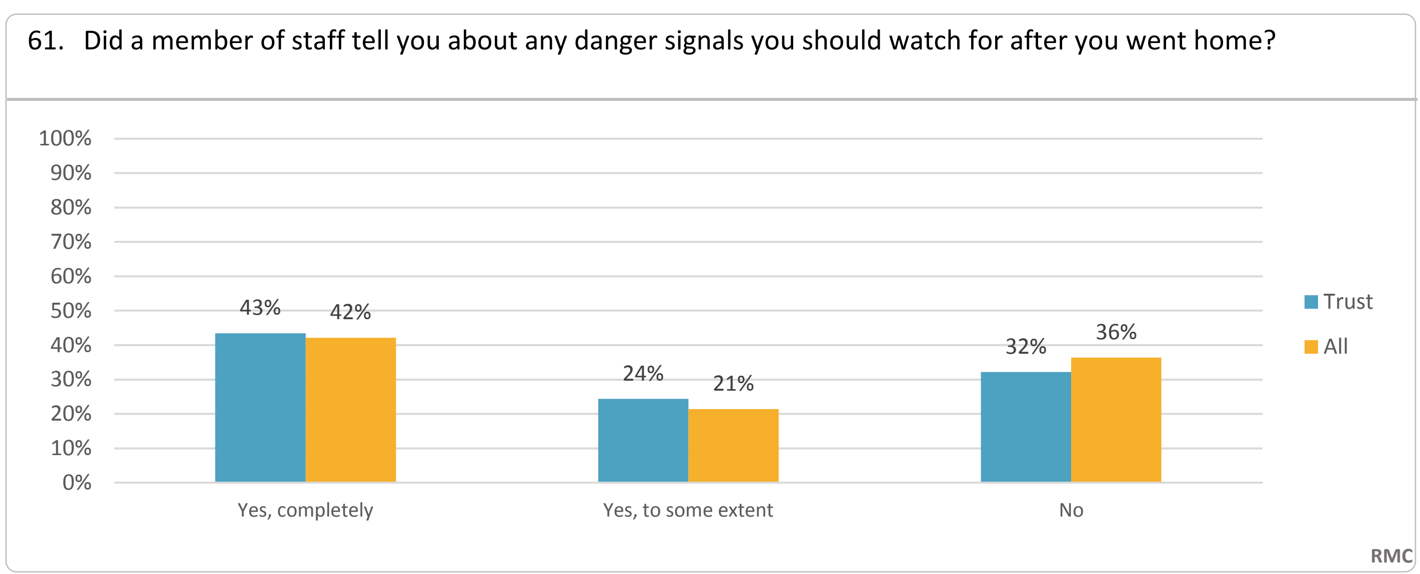
Leaving Hospital - Compositional Charts (continued)

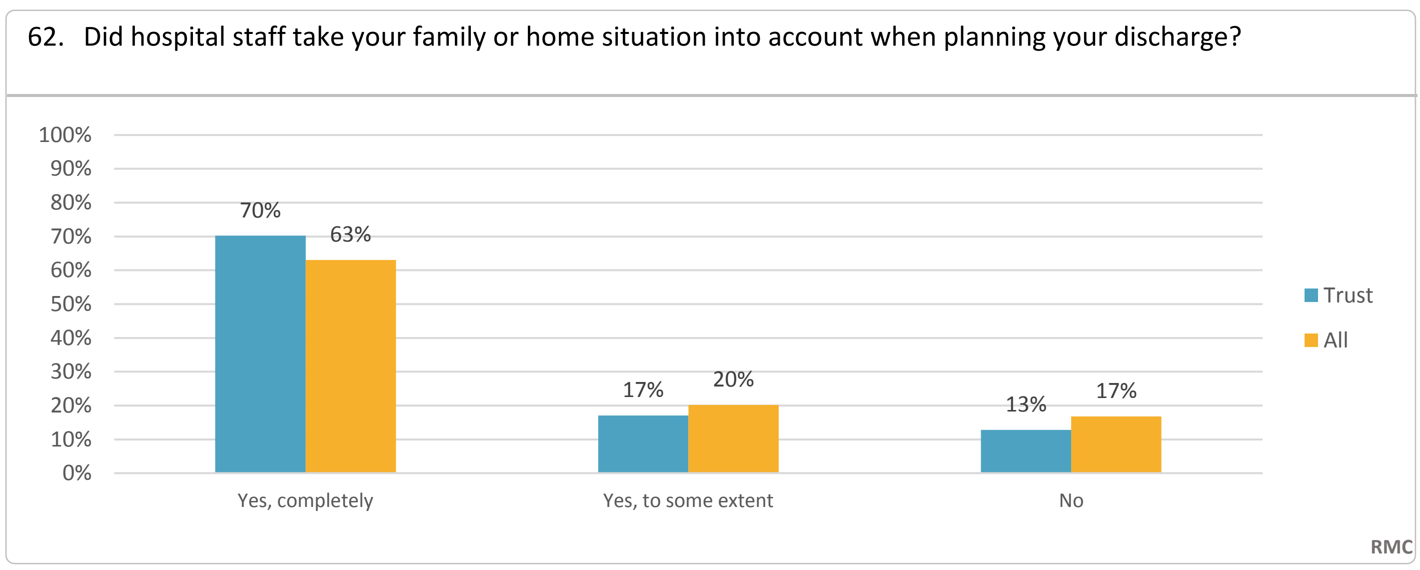


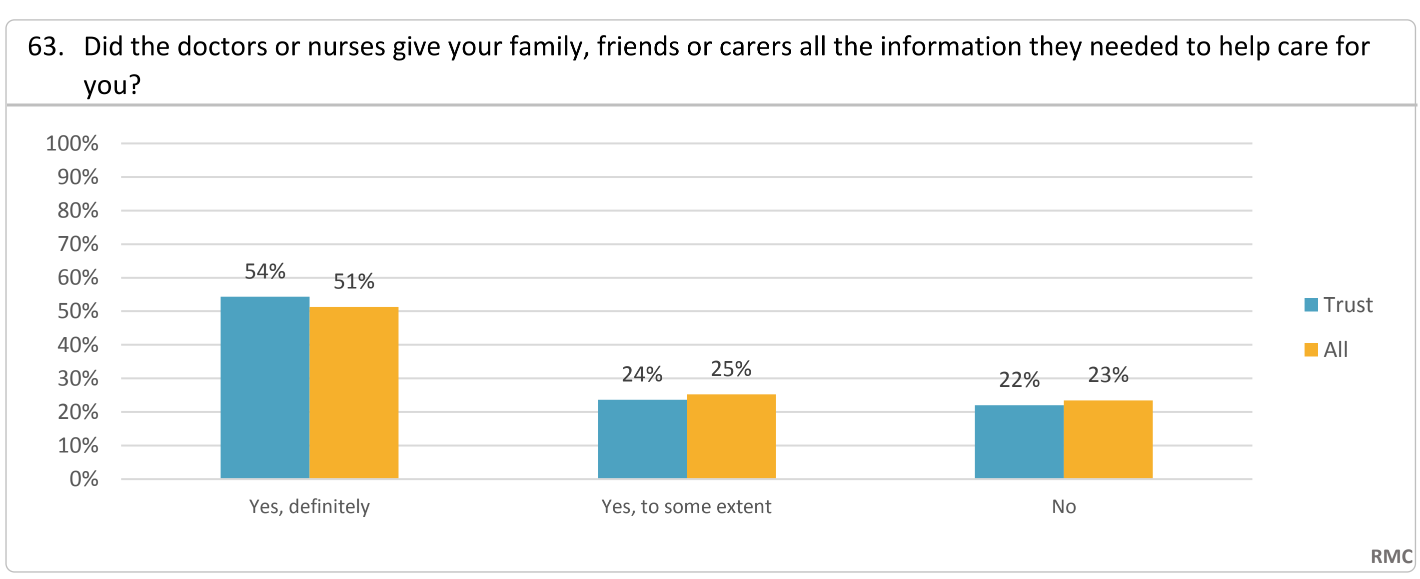




Leaving Hospital - Compositional Charts (continued)

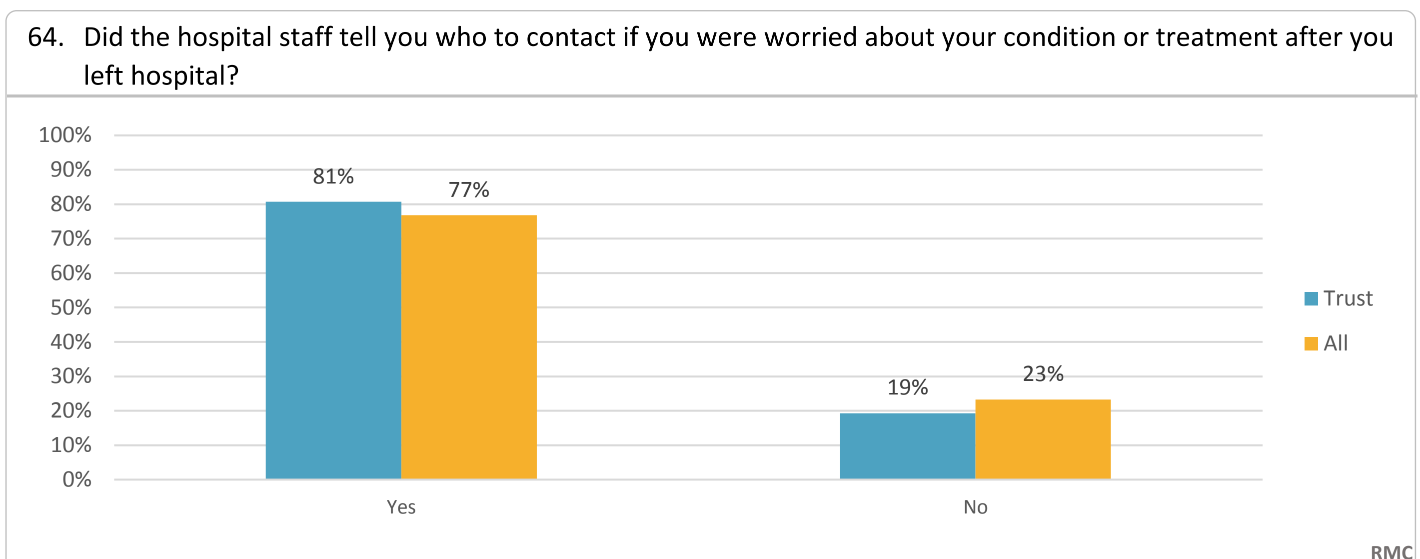




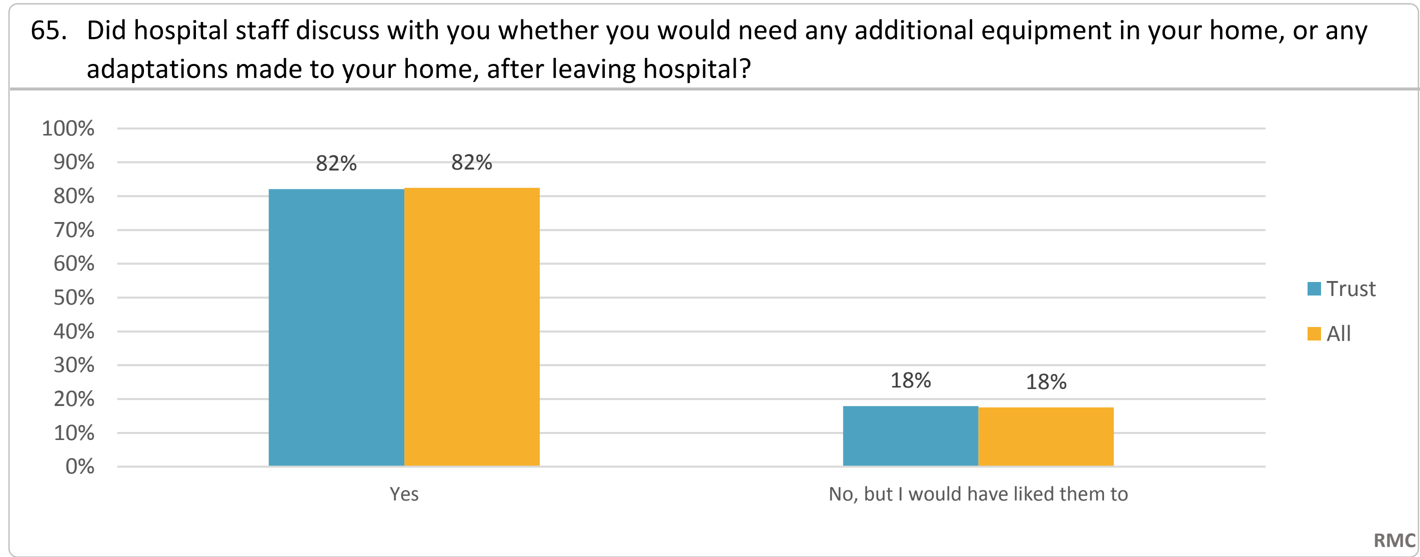


Leaving Hospital - Compositional Charts (continued)

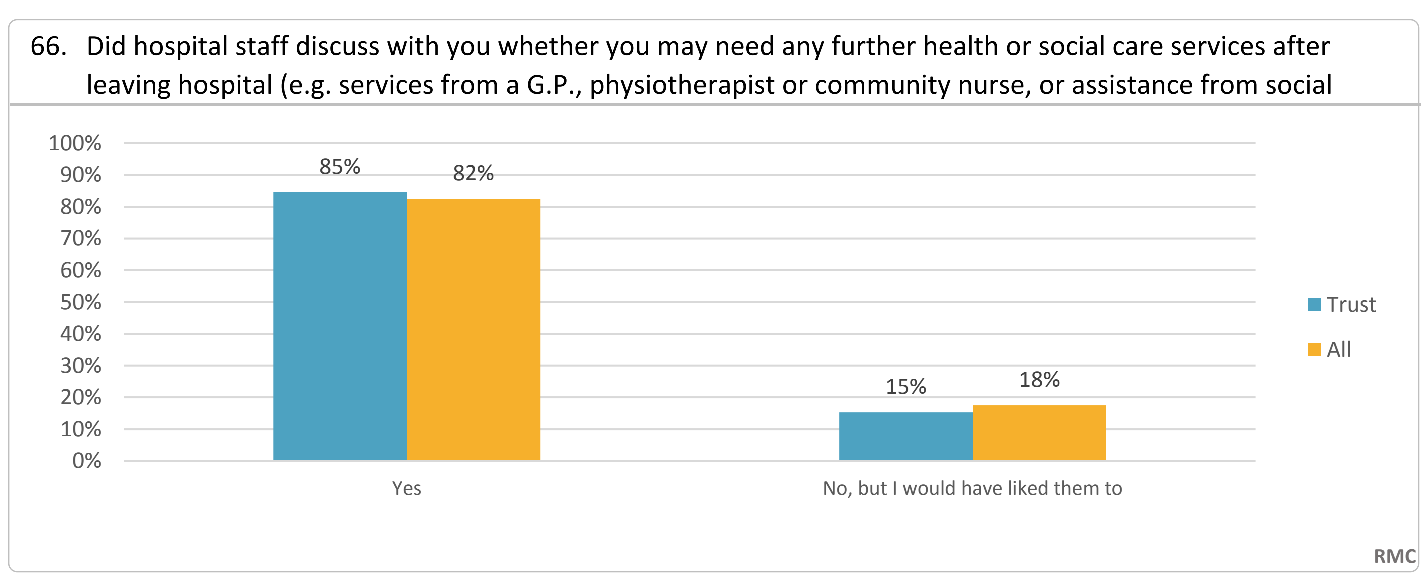
64. Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?



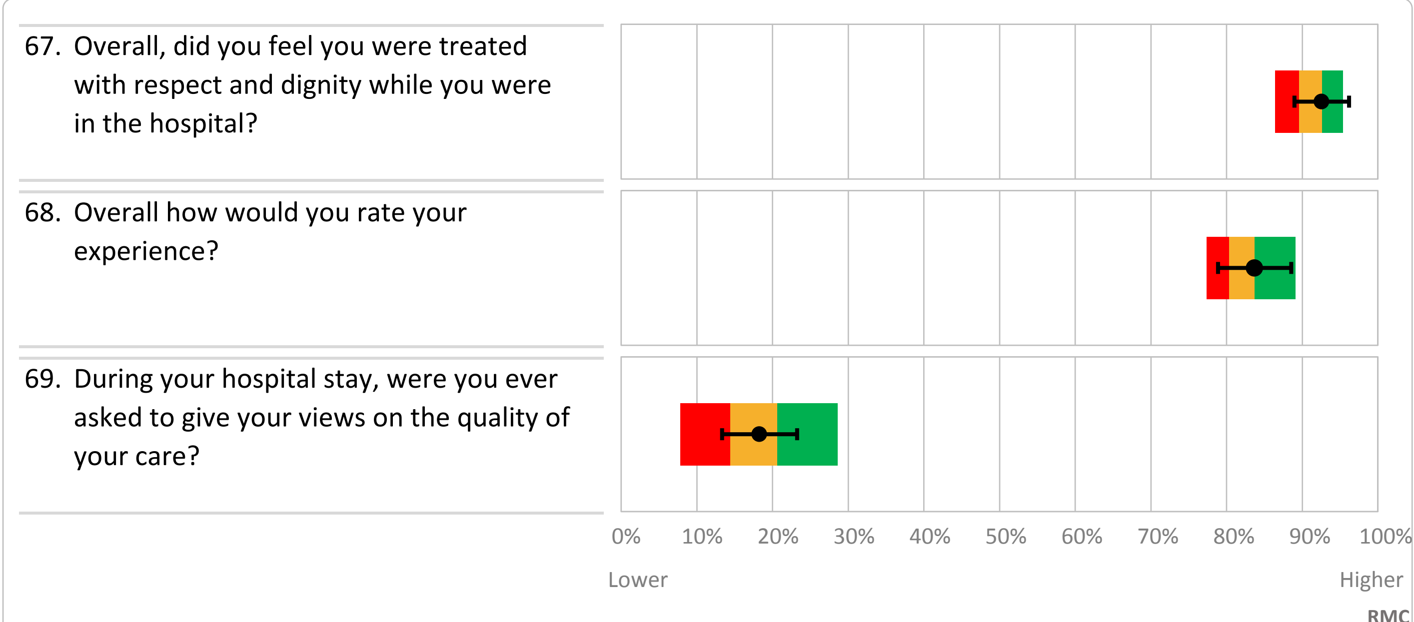
65. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?



66. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a G.P., physiotherapist or community nurse, or assistance from social



Overall - Benchmark Charts and Tables

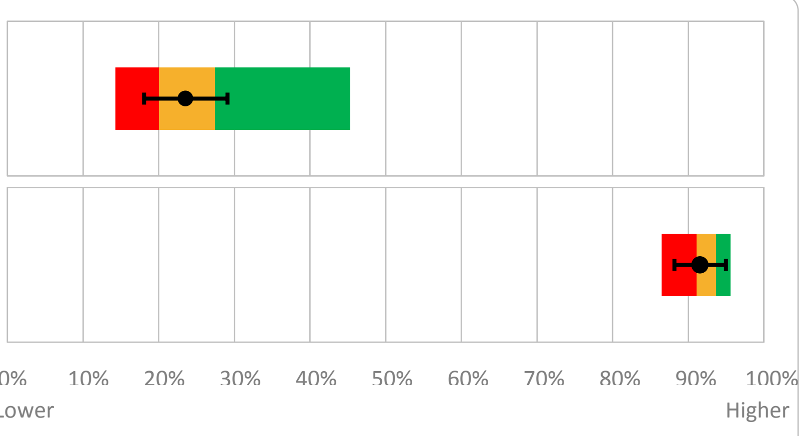


	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 20167		
					Number of Respondents	Score	RAG Rating
67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	86.4%	89.5%	92.7%	95.4%	379	92.6%	●
68. Overall how would you rate your experience?	77.4%	80.4%	83.7%	89.1%	369	83.7%	●
69. During your hospital stay, were you ever asked to give your views on the quality of your care?	7.8%	14.5%	20.7%	28.6%	316	18.3%	●

Overall - Benchmark Charts and Tables (continued)

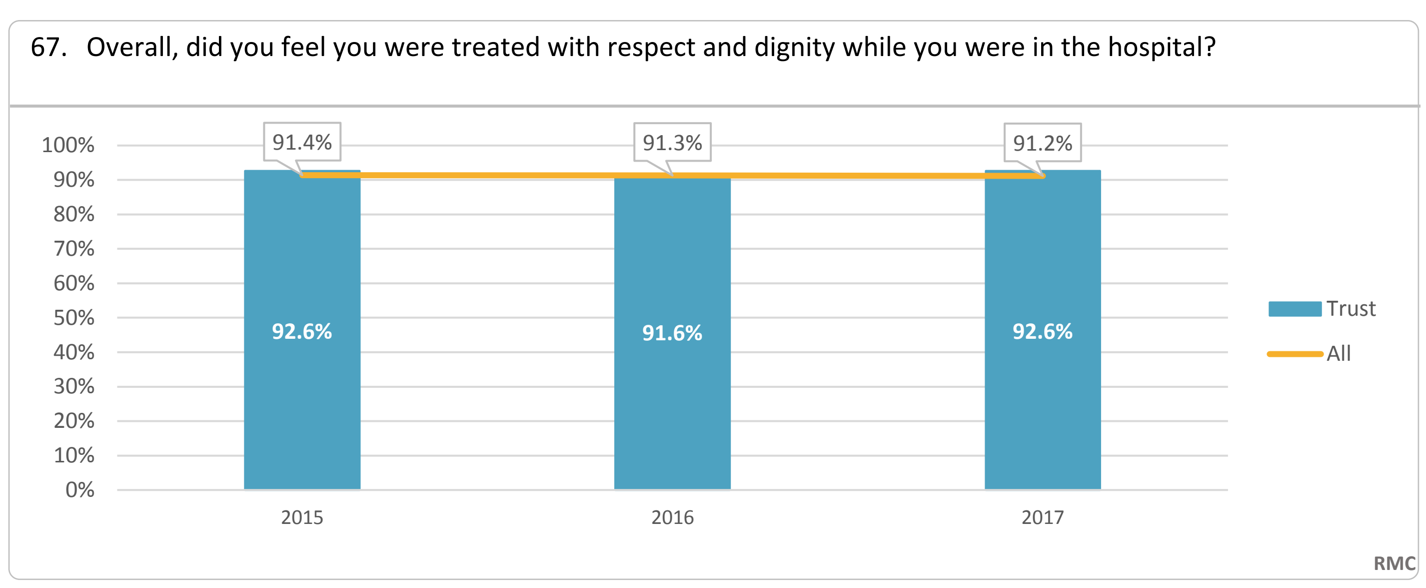
70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

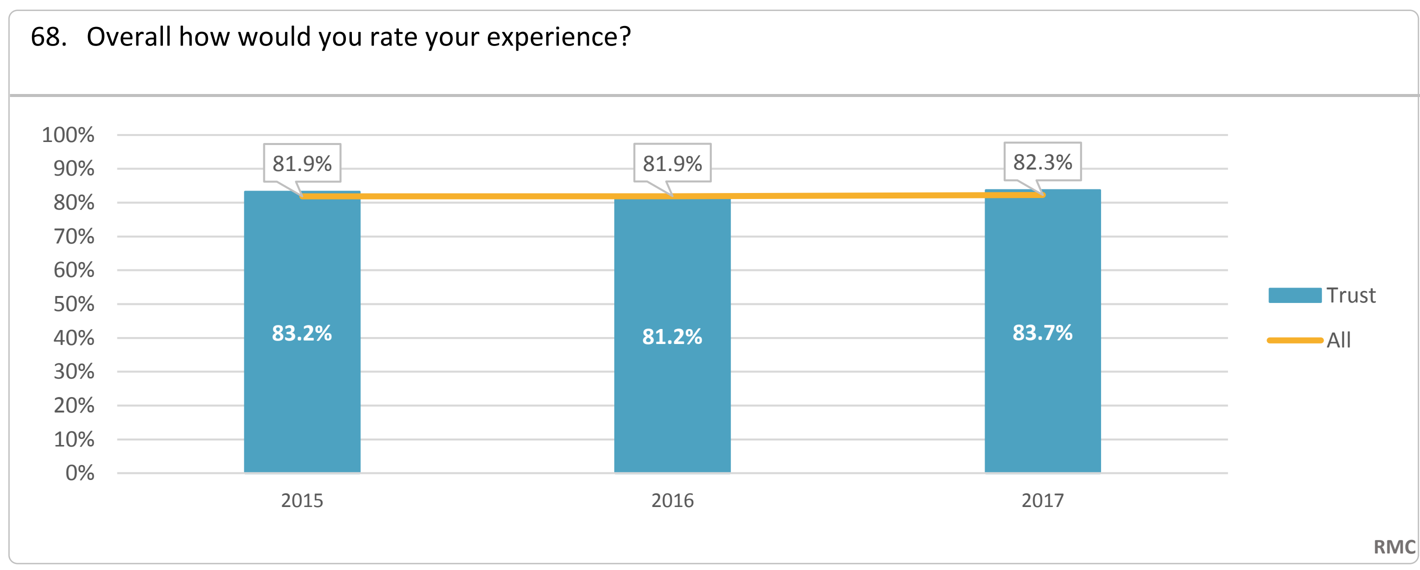
71. Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?

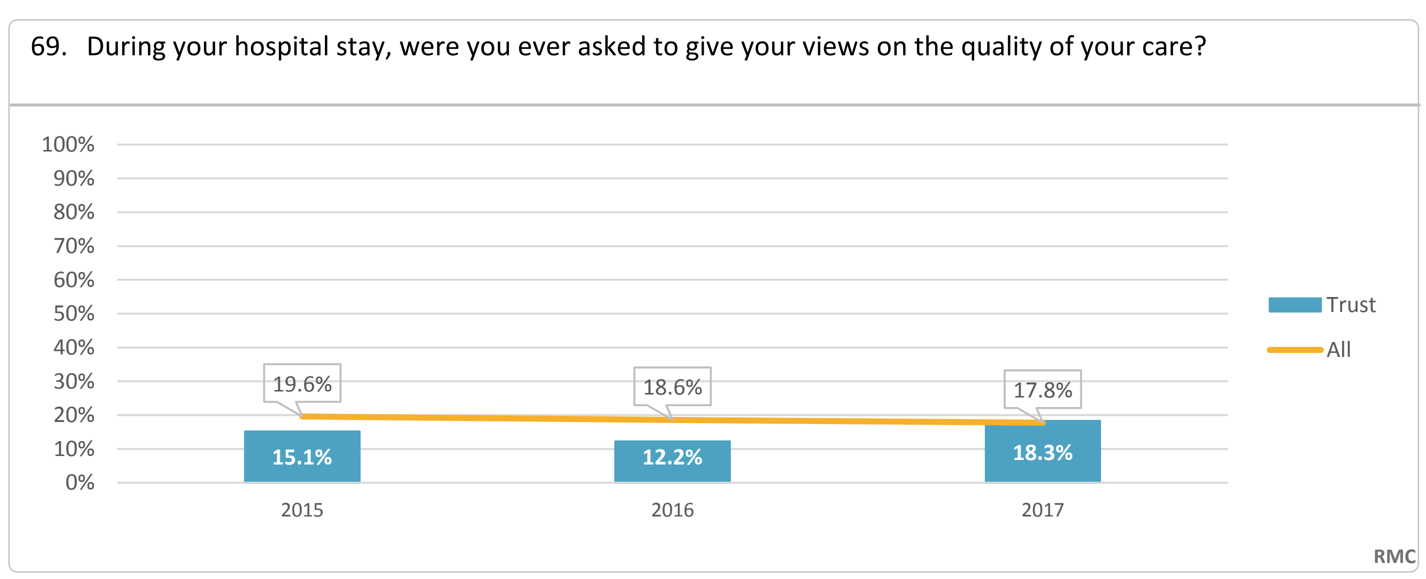


	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2016		
					Number of Respondents	Score	RAG Rating
70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	14.3%	20.0%	27.4%	45.3%	285	23.6%	
71. Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	86.5%	91.1%	93.7%	95.6%	351	91.6%	

Overall - Longitudinal Charts

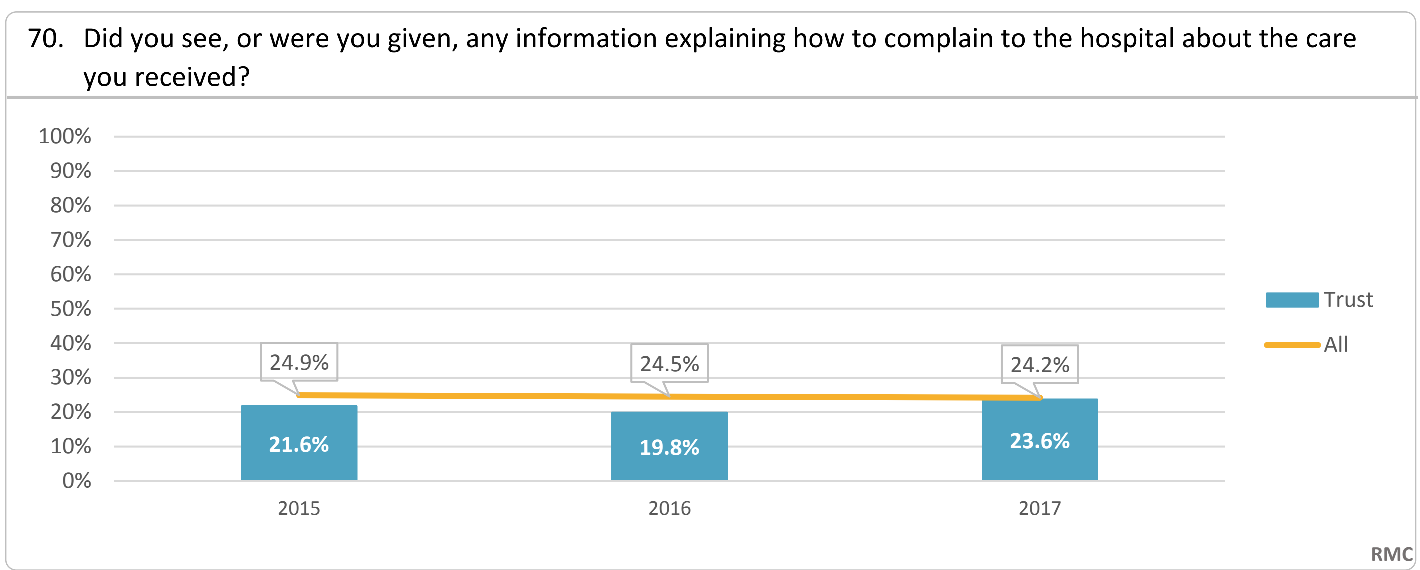




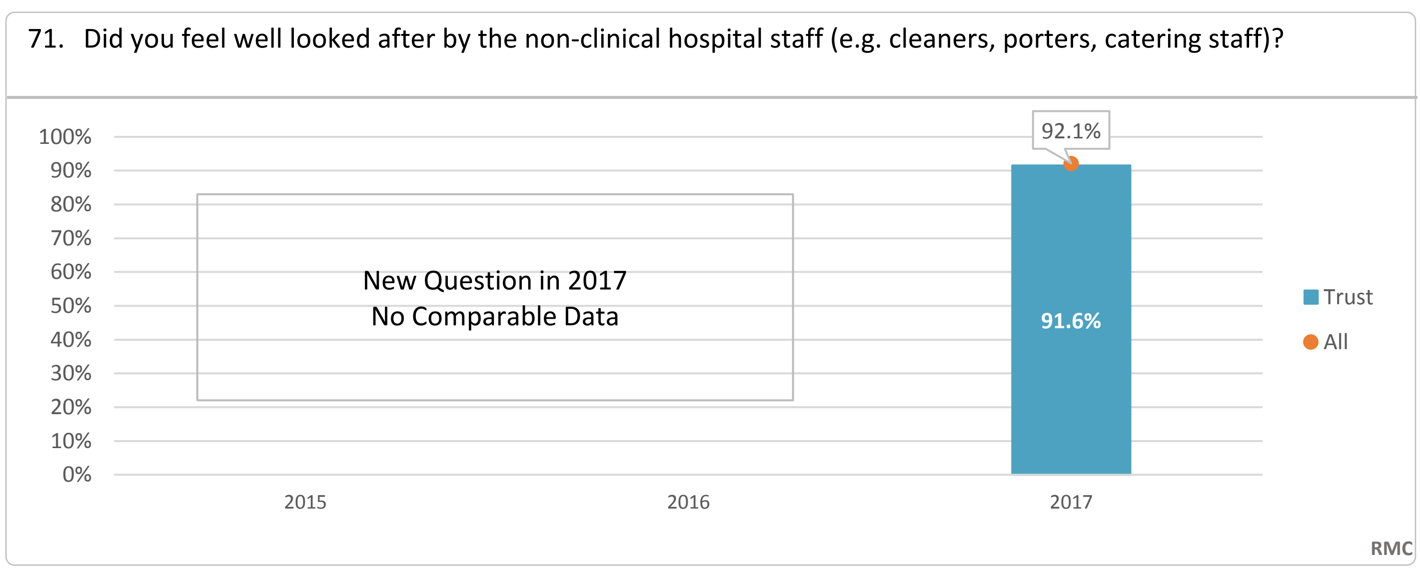


Overall - Longitudinal Charts (continued)

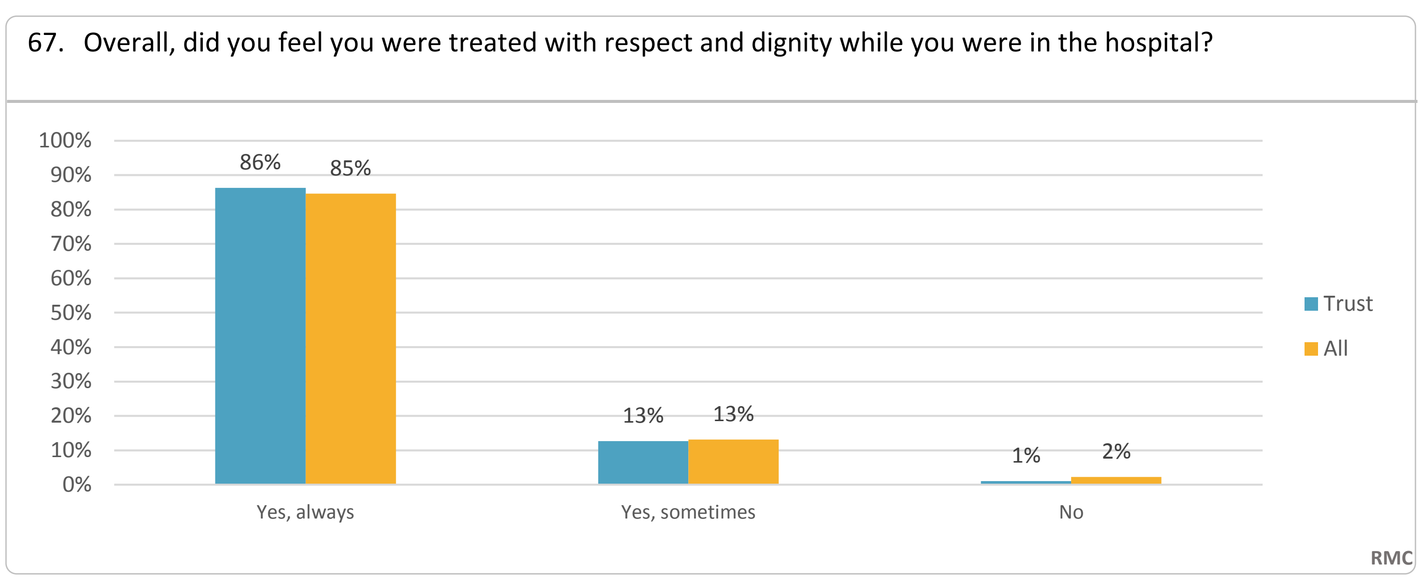
70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

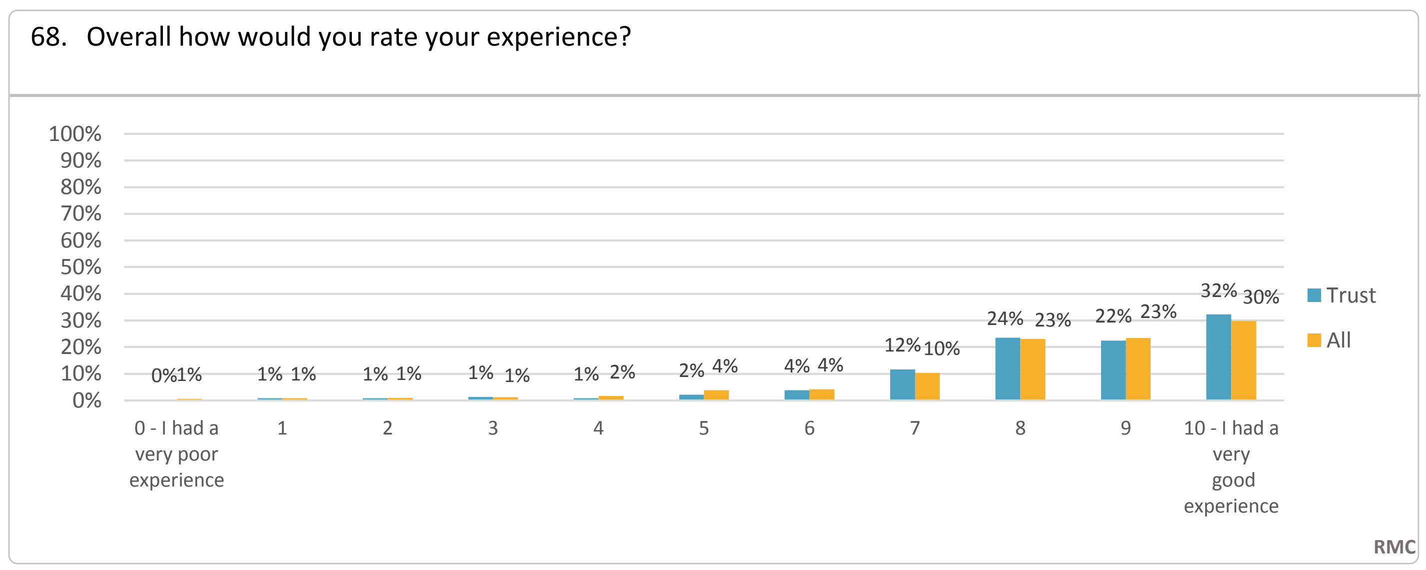


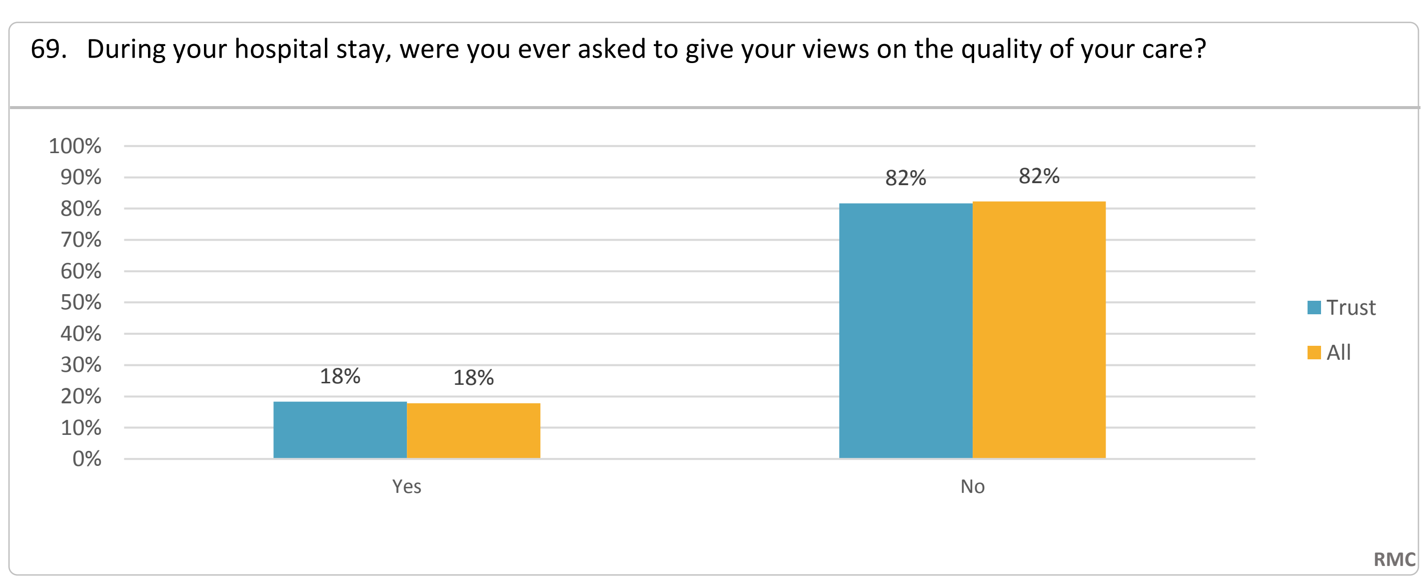
71. Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?



Overall - Compositional Charts

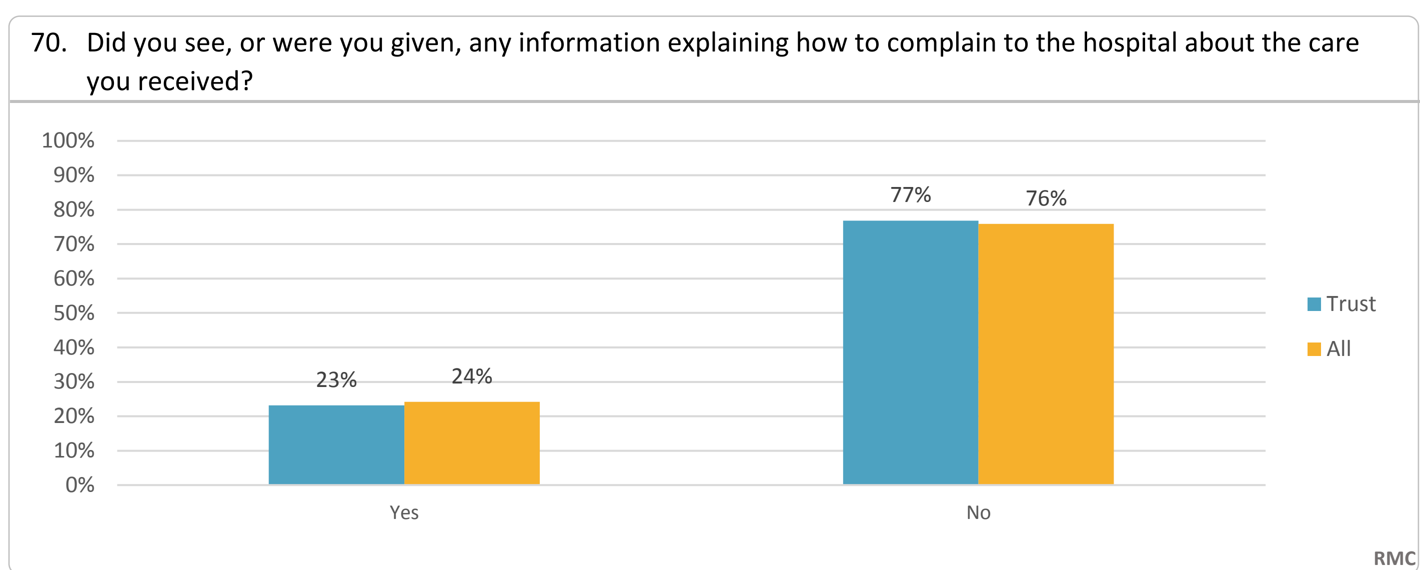




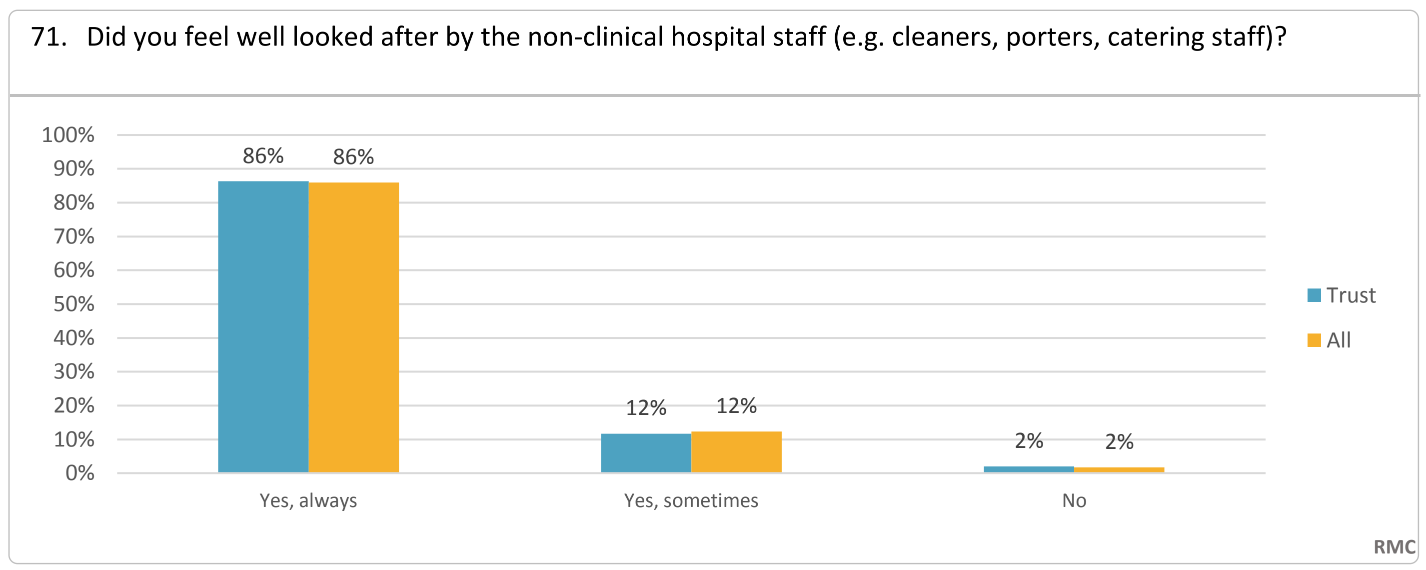


Overall - Compositional Charts (continued)

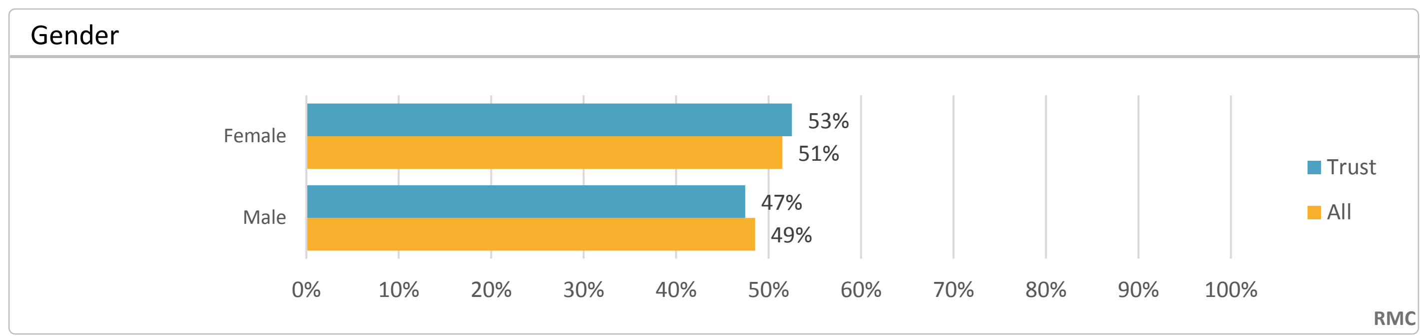
70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

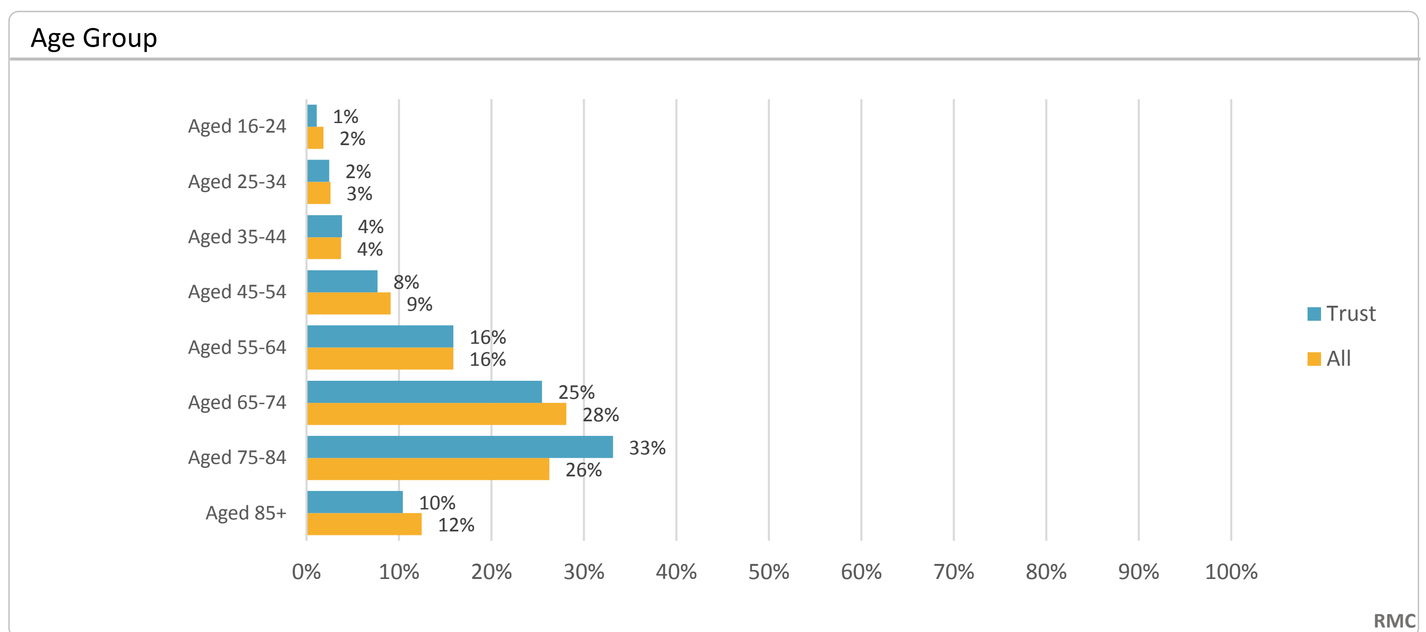


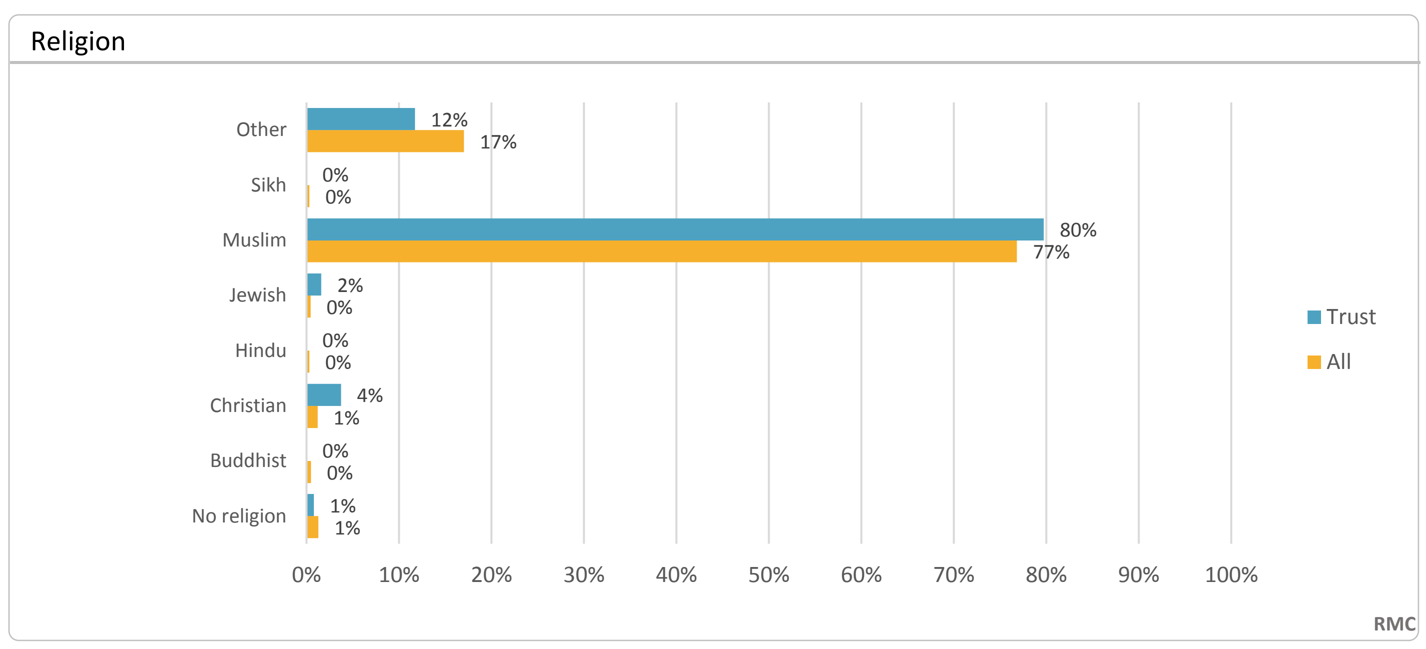
71. Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?



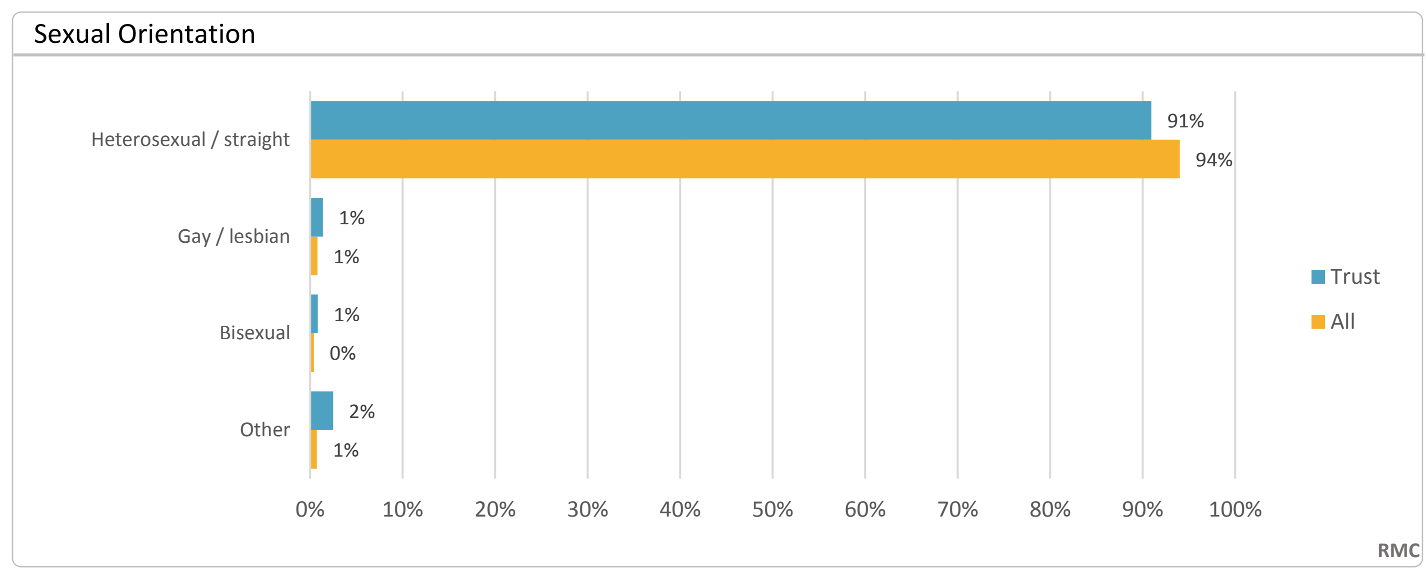
Demographic Characteristics

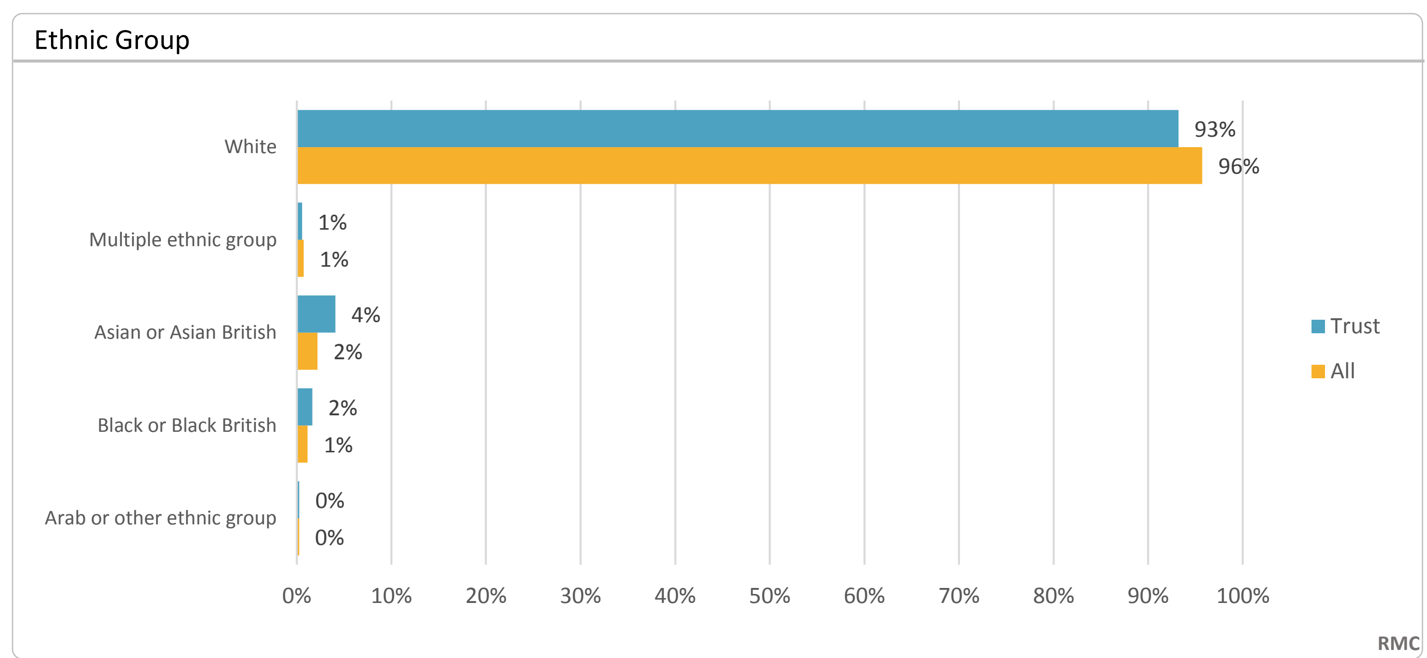






Demographic Characteristics (continued)





Survey results

This report sets out the results from the 2017 National Inpatient Survey for Bolton NHS Foundation Trust, ordered in exactly the same way as the survey questionnaire sent to service users. All the figures shown are derived from the raw, unstandardised, data.

Reading the columns of figures

The results are shown firstly in absolute numbers, then as percentage responses. The first two columns show the results from the previous year. The second two columns show the results for the current year. Please note that where there is no equivalent question from the previous year dashes are displayed in the first two columns.

The purpose of presenting the figures in this way is to give a direct, at-a-glance, comparison between the 2016 results and 2017 results.

Conventions

The percentages are calculated after excluding those respondents that did not answer that particular question. All percentages are rounded to the nearest whole number. When added together, the percentages for all answers to a particular question may not total 100% because of this rounding.

The 'Missing' figures show the number of respondents who did not reply to that particular question. In some cases, the 'Missing' figure is quite high because it includes respondents who did not answer that question or group of questions because it was not applicable to their circumstances (e.g. Q13).

On some questions there are also some figures/responses which are italicised and marked with an asterisk. These figures have been recalculated to exclude responses where the question was not applicable to the respondent's circumstances, or they felt unable to give a definite answer. For example, questions such as Q3 about how much information about the patient's condition of treatment was given to them, where those not answering (Missing), and those saying that they don't know or can't remember are excluded.

Changes made to the data

There are a number of questions which are 'routed' (i.e. where respondents are directed to a subsequent question depending on their answer to the lead question). Sometimes there are conflicts in the answers that respondents give to these questions and the data is corrected to account for this. For example, if response 2 in question 1 is ticked the respondent should move on to question 5. Any data entered for questions 2-4 will be deleted as the respondent should not have answered these questions.

ADMISSION TO HOSPITAL

1. Was your most recent hospital stay planned in advance or an emergency?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
Emergency or urgent	299	74%	270	73%	9,544	62%
Waiting list or planned in advance	94	23%	91	25%	5,460	35%
Something else	9	2%	9	2%	510	3%
Missing	17		22		757	

THE ACCIDENT AND EMERGENCY DEPARTMENT

2.	When you arrived at the hospital, did you go to the A&E Department (also known as the Emergency Department, Casualty, Medical or Surgical Admissions unit)?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes	281	90%	264	92%	9,048	88%
	No	30	10%	22	8%	1,242	12%
	Missing	108		106		5,981	

3.	While you were in the A&E Department, how much information about your condition or treatment was given to you?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Not enough*	*34*	*14%*	*25*	*11%*	*1,207*	*15%*
*	*Right amount*	*191*	*78%*	*189*	*80%*	*5,974*	*75%*
*	*Too much*	*1*	*0%*	*1*	*0%*	*27*	*0%*
*	*I was not given any information about my treatment or condition*	*19*	*8%*	*20*	*9%*	*717*	*9%*
	Don't know / can't remember	38	13%	28	11%	1,074	12%
	Missing	136		129		7,272	

4.	Were you given enough privacy when being examined or treated in the A&E Department?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*198*	*72%*	*213*	*83%*	*6,904*	*80%*
*	*Yes, to some extent*	*67*	*24%*	*44*	*17%*	*1,590*	*18%*
*	*No*	*9*	*3%*	*1*	*0%*	*165*	*2%*
	Don't know / can't remember	14	5%	5	2%	447	5%
	Missing	131		129		7,165	

WAITING LIST OR PLANNED ADMISSION

5.	When you were referred to see a specialist, were you offered a choice of hospital for your first hospital appointment?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*30*	*26%*	*29*	*30%*	*1,562*	*28%*
*	*No, but I would have liked a choice*	*7*	*6%*	*12*	*13%*	*524*	*9%*
*	*No, but I did not mind*	*77*	*68%*	*55*	*57%*	*3,499*	*63%*
	Don’t know / can’t remember	7	6%	2	2%	199	3%
	Missing	298		294		10,487	

6.	How do you feel about the length of time you were on the waiting list before your admission to hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	I was admitted as soon as I thought was necessary	86	76%	69	71%	4,189	73%
	I should have been admitted a bit sooner	17	15%	17	18%	966	17%
	I should have been admitted a lot sooner	10	9%	11	11%	612	11%
	Missing	306		295		10,504	

7.	Was your admission date changed by the hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	No	84	71%	70	72%	4,544	78%
	Yes, once	24	20%	17	18%	996	17%
	Yes, 2 or 3 times	8	7%	9	9%	241	4%
	Yes, 4 times or more	3	3%	1	1%	27	0%
	Missing	300		295		10,463	

8.	In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*93*	*83%*	*83*	*87%*	*4,906*	*86%*
*	*Yes, to some extent*	*18*	*16%*	*10*	*11%*	*686*	*12%*
*	*No*	*1*	*1%*	*2*	*2%*	*122*	*2%*
	Don't know / can't remember	13	10%	3	3%	156	3%
	Missing	294		294		10,401	

ALL TYPES OF ADMISSION

9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
Yes, definitely	71	17%	47	12%	2,055	13%
Yes, to some extent	104	25%	107	28%	3,220	20%
No	234	57%	228	60%	10,650	67%
Missing	10		10		346	

10.	While in hospital, did you ever stay in a critical care area (e.g. Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*100*	*25%*	*71*	*19%*	*3,456*	*23%*
*	*No*	*297*	*75%*	*294*	*81%*	*11,602*	*77%*
	Don't know / can't remember	14	3%	18	5%	891	6%
	Missing	8		9		322	

11.	While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes	-	-	41	11%	1,297	8%
	No	-	-	346	89%	14,760	92%
	Missing	-		5		214	

12.	Did you change wards at night?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, but I would have preferred not to	-	-	20	5%	1,006	6%
	Yes, but I did not mind	-	-	55	15%	2,352	15%
	No	-	-	304	80%	12,558	79%
	Missing	-		13		355	

13.	Did the hospital staff explain the reasons for being moved in a way you could understand?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, completely	-	-	44	56%	1,903	56%
	Yes, to some extent	-	-	18	23%	901	26%
	No	-	-	16	21%	617	18%
	Missing	-		314		12,850	

14. Were you ever bothered by noise at night from other patients?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
Yes	182	44%	164	43%	6,020	38%
No	229	56%	218	57%	9,922	62%
Missing	8		10		329	

15. Were you ever bothered by noise at night from hospital staff?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
Yes	95	23%	71	19%	3,083	19%
No	316	77%	311	81%	12,868	81%
Missing	8		10		320	

16. In your opinion, how clean was the hospital room or ward that you were in?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
Very clean	291	71%	300	78%	11,862	74%
Fairly clean	105	26%	83	22%	3,844	24%
Not very clean	13	3%	1	0%	311	2%
Not at all clean	2	0%	1	0%	71	0%
Missing	8		7		183	

17. Did you get enough help from staff to wash or keep yourself clean?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
* *Yes, always*	*184*	*75%*	*172*	*75%*	*6,846*	*72%*
* *Yes, sometimes*	*46*	*19%*	*39*	*17%*	*1,898*	*20%*
* *No*	*15*	*6%*	*18*	*8%*	*772*	*8%*
I did not need help to wash or keep myself clean	160	40%	156	41%	6,315	40%
Missing	14		7		440	

18.	If you brought your own medication with you to hospital, were you able to take it when you needed to?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	*149*	*61%*	*151*	*69%*	*6,099*	*66%*
*	*Yes, sometimes*	*42*	*17%*	*30*	*14%*	*1,254*	*14%*
*	*No*	*53*	*22%*	*37*	*17%*	*1,873*	*20%*
	I had to stop taking my own medication as part of my treatment	37	9%	41	11%	1,564	10%
	I did not bring my own medication with me to hospital	121	30%	117	31%	4,764	31%
	Missing	17		16		717	

19.	How would you rate the hospital food?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Very good*	*121*	*30%*	*95*	*26%*	*3,903*	*25%*
*	*Good*	*161*	*40%*	*145*	*39%*	*5,767*	*37%*
*	*Fair*	*83*	*21%*	*97*	*26%*	*3,956*	*26%*
*	*Poor*	*33*	*8%*	*32*	*9%*	*1,757*	*11%*
	I did not have any hospital food	12	3%	16	4%	546	3%
	Missing	9		7		342	

20.	Were you offered a choice of food?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	346	86%	329	87%	13,122	83%
	Yes, sometimes	40	10%	34	9%	1,942	12%
	No	16	4%	17	4%	688	4%
	Missing	17		12		519	

THE HOSPITAL & WARD (continued)

21.	Did you get enough help from staff to eat your meals?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	*59*	*57%*	*52*	*65%*	*2,072*	*63%*
*	*Yes, sometimes*	*26*	*25%*	*17*	*21%*	*678*	*21%*
*	*No*	*18*	*17%*	*11*	*14%*	*550*	*17%*
	I did not need help to eat meals	297	74%	301	79%	12,437	79%
	Missing	19		11		534	

22.	During your time in hospital, did you get enough to drink?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes	-	-	353	91%	14,699	92%
	No, because I did not get enough help to drink	-	-	2	1%	171	1%
	No, because I was not offered enough drinks	-	-	17	4%	677	4%
	No, for another reason	-	-	14	4%	380	2%
	Missing	-		6		344	

DOCTORS

23.	When you had important questions to ask a doctor, did you get answers that you could understand?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	*249*	*70%*	*236*	*69%*	*9,999*	*71%*
*	*Yes, sometimes*	*88*	*25%*	*97*	*28%*	*3,472*	*24%*
*	*No*	*17*	*5%*	*9*	*3%*	*708*	*5%*
	I had no need to ask	53	13%	42	11%	1,740	11%
	Missing	12		8		352	

24.	Did you have confidence and trust in the doctors treating you?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	325	79%	327	85%	13,313	83%
	Yes, sometimes	73	18%	50	13%	2,210	14%
	No	12	3%	9	2%	434	3%
	Missing	9		6		314	

25.	Did doctors talk in front of you as if you weren’t there?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, often	27	7%	16	4%	701	4%
	Yes, sometimes	76	19%	56	15%	2,678	17%
	No	305	75%	310	81%	12,511	79%
	Missing	11		10		381	

NURSES

26.	When you had important questions to ask a nurse, did you get answers that you could understand?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	*250*	*69%*	*236*	*73%*	*9,966*	*72%*
*	*Yes, sometimes*	*102*	*28%*	*81*	*25%*	*3,358*	*24%*
*	*No*	*11*	*3%*	*8*	*2%*	*509*	*4%*
	I had no need to ask	46	11%	60	16%	2,131	13%
	Missing	10		7		307	

27.	Did you have confidence and trust in the nurses treating you?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	319	77%	330	85%	13,013	81%
	Yes, sometimes	82	20%	51	13%	2,577	16%
	No	11	3%	5	1%	381	2%
	Missing	7		6		300	

28.	Did nurses talk in front of you as if you weren’t there?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, often	17	4%	16	4%	519	3%
	Yes, sometimes	59	14%	38	10%	1,950	12%
	No	335	82%	331	86%	13,475	85%
	Missing	8		7		327	

29.	In your opinion, were there enough nurses on duty to care for you in hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	There were always or nearly always enough nurses	247	60%	228	59%	9,619	60%
	There were sometimes enough nurses	117	29%	122	32%	4,669	29%
	There were rarely or never enough nurses	46	11%	35	9%	1,638	10%
	Missing	9		7		345	

30.	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	216	53%	238	62%	8,042	51%
	Yes, sometimes	139	34%	94	25%	4,851	30%
	No	55	13%	51	13%	3,013	19%
	Missing	9		9		365	

31.	Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	-	-	*193*	*80%*	*7,785*	*78%*
*	*Yes, sometimes*	-	-	*38*	*16%*	*1,713*	*17%*
*	*No*	-	-	*11*	*5%*	*421*	*4%*
	I was not seen by any other clinical staff	-	-	139	36%	5,860	37%
	Missing	-		11		492	

32.	In your opinion, did the members of staff caring for you work well together?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	*288*	*74%*	*291*	*81%*	*12,053*	*80%*
*	*Yes, sometimes*	*88*	*23%*	*63*	*18%*	*2,607*	*17%*
*	*No*	*15*	*4%*	*6*	*2%*	*494*	*3%*
	Don’t know / can’t remember	17	4%	23	6%	755	5%
	Missing	11		9		362	

33.	Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, often	29	7%	16	4%	1,053	7%
	Yes, sometimes	94	23%	86	22%	3,805	24%
	No	287	70%	281	73%	11,051	69%
	Missing	9		9		362	

34.	Were you involved as much as you wanted to be in decisions about your care and treatment?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, definitely	220	54%	220	58%	9,225	58%
	Yes, to some extent	145	36%	126	33%	5,134	32%
	No	41	10%	34	9%	1,533	10%
	Missing	13		12		379	

35.	Did you have confidence in the decisions made about your condition or treatment?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	284	69%	296	77%	11,907	74%
	Yes, sometimes	99	24%	72	19%	3,207	20%
	No	26	6%	14	4%	877	5%
	Missing	10		10		280	

36.	How much information about your condition or treatment was given to you?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Not enough*	-	-	*50*	*13%*	*2,511*	*16%*
*	*Right amount*	-	-	*313*	*83%*	*12,335*	*80%*
*	*Too much*	-	-	*4*	*1%*	*102*	*1%*
*	*I was not given any information about my treatment or condition*	-	-	*9*	*2%*	*476*	*3%*
	Don't know / can't remember	-	-	10	3%	602	4%
	Missing	-		6		245	

37.	Did you find someone on the hospital staff to talk to about your worries and fears?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*106*	*42%*	*87*	*40%*	*3,590*	*39%*
*	*Yes, to some extent*	*91*	*36%*	*88*	*41%*	*3,241*	*35%*
*	*No*	*58*	*23%*	*42*	*19%*	*2,343*	*26%*
	I had no worries or fears	155	38%	168	44%	6,807	43%
	Missing	9		7		290	

38.	Do you feel you got enough emotional support from hospital staff during your stay?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	*150*	*59%*	*165*	*67%*	*5,674*	*60%*
*	*Yes, sometimes*	*73*	*29%*	*59*	*24%*	*2,554*	*27%*
*	*No*	*30*	*12%*	*23*	*9%*	*1,298*	*14%*
	I did not need any emotional support	154	38%	138	36%	6,473	40%
	Missing	12		7		272	

39.	Were you given enough privacy when discussing your condition or treatment?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	293	72%	305	80%	12,385	78%
	Yes, sometimes	83	20%	57	15%	2,644	17%
	No	30	7%	20	5%	845	5%
	Missing	13		10		397	

40.	Were you given enough privacy when being examined or treated?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	372	91%	364	95%	14,685	92%
	Yes, sometimes	28	7%	18	5%	1,117	7%
	No	10	2%	2	1%	174	1%
	Missing	9		8		295	

41.	Were you ever in any pain?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes	270	67%	221	59%	9,918	63%
	No	135	33%	156	41%	5,885	37%
	Missing	14		15		468	

42.	Do you think the hospital staff did everything they could to help control your pain?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, definitely	185	69%	169	76%	7,281	73%
	Yes, to some extent	59	22%	46	21%	2,188	22%
	No	25	9%	8	4%	520	5%
	Missing	150		169		6,282	

43.	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	-	-	*238*	*67%*	*9,302*	*65%*
*	*Yes, sometimes*	-	-	*101*	*29%*	*4,206*	*29%*
*	*No*	-	-	*15*	*4%*	*838*	*6%*
	I did not want / need this	-	-	26	7%	1,503	9%
	Missing	-		12		422	

OPERATIONS AND PROCEDURES

44.	During your stay in hospital, did you have an operation or procedure?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*207*	*51%*	*210*	*56%*	*9,700*	*62%*
*	*No*	*199*	*49%*	*166*	*44%*	*6,045*	*38%*
	Missing	13		16		526	

45.	Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, completely*	*132*	*75%*	*171*	*86%*	*7,540*	*83%*
*	*Yes, to some extent*	*34*	*19%*	*25*	*13%*	*1,341*	*15%*
*	*No*	*9*	*5%*	*3*	*2%*	*232*	*3%*
	I did not have any questions	34	16%	15	7%	628	6%
	Missing	210		178		6,530	

46.	Beforehand, were you told how you could expect to feel after you had the operation or procedure?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, completely	121	58%	138	65%	6,056	63%
	Yes, to some extent	53	26%	54	25%	2,483	26%
	No	33	16%	21	10%	1,142	12%
	Missing	212		179		6,590	

47.	After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, completely	128	62%	154	73%	6,870	71%
	Yes, to some extent	52	25%	42	20%	2,024	21%
	No	27	13%	15	7%	784	8%
	Missing	212		181		6,593	

LEAVING HOSPITAL

48.	Did you feel you were involved in decisions about your discharge from hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*203*	*52%*	*200*	*56%*	*8,383*	*54%*
*	*Yes, to some extent*	*116*	*30%*	*111*	*31%*	*4,694*	*30%*
*	*No*	*74*	*19%*	*43*	*12%*	*2,321*	*15%*
	I did not want to be involved	14	3%	28	7%	557	3%
	Missing	12		10		316	

49.	Were you given enough notice about when you were going to be discharged?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, definitely	227	55%	218	57%	9,144	57%
	Yes, to some extent	133	32%	136	35%	4,914	31%
	No	51	12%	31	8%	1,950	12%
	Missing	8		7		263	

50.	On the day you left hospital, was your discharge delayed for any reason?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes	174	43%	162	43%	6,427	40%
	No	233	57%	218	57%	9,452	60%
	Missing	12		12		392	

51.	What was the MAIN reason for the delay?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	I had to wait for medicines	115	67%	118	77%	3,917	63%
	I had to wait to see the doctor	24	14%	9	6%	723	12%
	I had to wait for an ambulance	18	10%	16	10%	658	11%
	Something else	15	9%	11	7%	922	15%
	Missing	247		238		10,051	

52.	How long was the delay?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Up to 1 hour	28	16%	19	12%	783	12%
	Longer than 1 hour but no longer than 2 hours	47	27%	47	29%	1,744	27%
	Longer than 2 hours but no longer than 4 hours	53	31%	48	30%	2,268	35%
	Longer than 4 hours	44	26%	46	29%	1,629	25%
	Missing	247		232		9,847	

53.	Where did you go after leaving hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	I went home	354	89%	366	96%	14,125	90%
	I went to stay with family or friends	15	4%	11	3%	613	4%
	I was transferred to another hospital	9	2%	1	0%	375	2%
	I went to a residential nursing home	16	4%	2	1%	396	3%
	I went somewhere else	5	1%	1	0%	184	1%
	Missing	20		11		578	

54.	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*134*	*59%*	*133*	*60%*	*4,822*	*56%*
*	*Yes, to some extent*	*56*	*25%*	*53*	*24%*	*2,055*	*24%*
*	*No, but support would have been useful*	*36*	*16%*	*35*	*16%*	*1,714*	*20%*
	No, but I did not need any support	151	40%	157	42%	6,216	42%
	Missing	42		14		1,464	

55.	When you left hospital, did you know what would happen next with your care?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*183*	*53%*	*183*	*56%*	*7,006*	*53%*
*	*Yes, to some extent*	*104*	*30%*	*102*	*31%*	*4,244*	*32%*
*	*No*	*59*	*17%*	*41*	*13%*	*1,955*	*15%*
	It was not necessary	57	14%	51	14%	2,184	14%
	Missing	16		15		882	

56.	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes	227	57%	225	60%	9,967	64%
	No	170	43%	147	40%	5,620	36%
	Missing	22		20		684	

57.	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, completely*	*188*	*68%*	*206*	*78%*	*8,332*	*75%*
*	*Yes, to some extent*	*56*	*20%*	*31*	*12%*	*1,875*	*17%*
*	*No*	*32*	*12%*	*26*	*10%*	*931*	*8%*
	I did not need an explanation	60	15%	59	16%	2,404	15%
	I had no medicines	63	16%	57	15%	2,144	14%
	Missing	20		13		585	

58.	Did a member of staff tell you about medication side effects to watch for when you went home?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, completely*	*70*	*30%*	*79*	*38%*	*3,512*	*37%*
*	*Yes, to some extent*	*44*	*19%*	*43*	*20%*	*1,790*	*19%*
*	*No*	*117*	*51%*	*88*	*42%*	*4,132*	*44%*
	I did not need an explanation	109	32%	107	34%	4,092	30%
	Missing	79		75		2,745	

LEAVING HOSPITAL (continue)

59.	Were you told how to take your medication in a way you could understand?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*154*	*66%*	*177*	*78%*	*7,408*	*76%*
*	*Yes, to some extent*	*48*	*21%*	*31*	*14%*	*1,426*	*15%*
*	*No*	*32*	*14%*	*18*	*8%*	*896*	*9%*
	I did not need to be told how to take my medication	106	31%	92	29%	3,824	28%
	Missing	79		74		2,717	

60.	Were you given clear written or printed information about your medicines?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, completely*	*163*	*65%*	*164*	*69%*	*7,223*	*71%*
*	*Yes, to some extent*	*47*	*19%*	*40*	*17%*	*1,669*	*16%*
*	*No*	*39*	*16%*	*32*	*14%*	*1,235*	*12%*
	I did not need this	85	25%	80	25%	3,082	23%
	Don't know / can't remember	8	2%	8	2%	368	3%
	Missing	77		68		2,694	

61.	Did a member of staff tell you about any danger signals you should watch for after you went home?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, completely*	*104*	*37%*	*100*	*43%*	*4,492*	*42%*
*	*Yes, to some extent*	*66*	*23%*	*56*	*24%*	*2,283*	*21%*
*	*No*	*111*	*40%*	*74*	*32%*	*3,878*	*36%*
	It was not necessary	120	30%	115	33%	3,987	27%
	Missing	18		47		1,631	

62.	Did hospital staff take your family or home situation into account when planning your discharge?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, completely*	*141*	*53%*	*165*	*70%*	*6,428*	*63%*
*	*Yes, to some extent*	*68*	*26%*	*40*	*17%*	*2,055*	*20%*
*	*No*	*55*	*21%*	*30*	*13%*	*1,709*	*17%*
	It was not necessary	121	30%	130	35%	4,997	32%
	Don’t know / can’t remember	16	4%	10	3%	531	3%
	Missing	18		17		551	

63.	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, definitely*	*134*	*46%*	*133*	*54%*	*5,264*	*51%*
*	*Yes, to some extent*	*69*	*24%*	*58*	*24%*	*2,597*	*25%*
*	*No*	*86*	*30%*	*54*	*22%*	*2,404*	*23%*
	No family, friends or carers were involved	33	8%	50	14%	2,168	14%
	My family, friends or carers did not want or need information	82	20%	73	20%	2,952	19%
	Missing	15		18		669	

64.	Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*253*	*71%*	*276*	*81%*	*10,953*	*77%*
*	*No*	*101*	*29%*	*66*	*19%*	*3,313*	*23%*
	Don’t know / can’t remember	48	12%	32	9%	1,410	9%
	Missing	17		18		595	

65.	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*100*	*82%*	*110*	*82%*	*4,101*	*82%*
*	*No, but I would have liked them to*	*22*	*18%*	*24*	*18%*	*871*	*18%*
	No, it was not necessary to discuss it	277	69%	236	64%	10,720	68%
	Missing	20		22		579	

66.	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a G.P., physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*176*	*82%*	*171*	*85%*	*6,917*	*82%*
*	*No, but I would have liked them to*	*39*	*18%*	*31*	*15%*	*1,468*	*18%*
	No, it was not necessary to discuss it	182	46%	166	45%	7,262	46%
	Missing	22		24		624	

OVERALL

67.	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, always	333	82%	327	86%	13,416	85%
	Yes, sometimes	62	15%	48	13%	2,082	13%
	No	10	2%	4	1%	360	2%
	Missing	14		13		413	

68.	Overall how would you rate your experience?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	0 - I had a very poor experience	6	2%	1	0%	98	1%
	1	3	1%	3	1%	131	1%
	2	2	1%	3	1%	152	1%
	3	7	2%	5	1%	192	1%
	4	9	2%	3	1%	253	2%
	5	24	6%	8	2%	594	4%
	6	19	5%	14	4%	648	4%
	7	43	11%	43	12%	1,592	10%
	8	73	19%	87	24%	3,539	23%
	9	88	23%	83	22%	3,593	23%
	10 - I had a very good experience	116	30%	119	32%	4,577	30%
	Missing	28		23		825	

69.	During your hospital stay, were you ever asked to give your views on the quality of your care?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*41*	*12%*	*58*	*18%*	*2,436*	*18%*
*	*No*	*304*	*88%*	*258*	*82%*	*11,287*	*82%*
	Don’t know / can’t remember	56	14%	50	14%	1,822	12%
	Missing	18		26		726	

OVERALL (continued)

70.	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes*	*61*	*19%*	*66*	*23%*	*2,971*	*24%*
*	*No*	*267*	*81%*	*219*	*77%*	*9,327*	*76%*
	Not sure / don't know	72	18%	83	23%	3,062	20%
	Missing	19		24		911	

71.	Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
*	*Yes, always*	-	-	*303*	*86%*	*12,568*	*86%*
*	*Yes, sometimes*	-	-	*41*	*12%*	*1,801*	*12%*
*	*No*	-	-	*7*	*2%*	*248*	*2%*
	I did not have contact with any non-clinical staff	-	-	22	6%	901	6%
	Missing	-		19		753	

72. Who was the main person or people that filled in this questionnaire?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
The patient (named on the front of the envelope)	339	85%	312	84%	13,190	85%
A friend or relative of the patient	25	6%	29	8%	939	6%
Both patient and friend / relative together	32	8%	27	7%	1,315	8%
The patient with the help of a health professional	3	1%	3	1%	78	1%
Missing	20		21		749	

73. Do you have physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more? Include problems related to old age.	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
Yes	-	-	218	67%	8,640	65%
No	-	-	107	33%	4,721	35%
Missing	-		67		2,910	

74.	Do you have any of the following? Select ALL conditions you have that have lasted or are expected to last for 12 months or more.	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Breathing problem, such as asthma	-	-	106	27%	3,236	20%
	Missing	-		286		13,035	
	Blindness or partial sight	-	-	21	5%	772	5%
	Missing	-		371		15,499	
	Cancer in the last 5 years	-	-	40	10%	1,996	12%
	Missing	-		352		14,275	
	Dementia or Alzheimer's disease	-	-	15	4%	458	3%
	Missing	-		377		15,813	
	Deafness or hearing loss	-	-	69	18%	2,451	15%
	Missing	-		323		13,820	
	Diabetes	-	-	64	16%	2,351	14%
	Missing	-		328		13,920	
	Heart problem, such as angina	-	-	93	24%	3,179	20%
	Missing	-		299		13,092	
	Joint problem, such as arthritis	-	-	143	36%	5,324	33%
	Missing	-		249		10,947	
	Kidney or liver disease	-	-	38	10%	1,206	7%
	Missing	-		354		15,065	
	Learning disability	-	-	4	1%	238	1%
	Missing	-		388		16,033	
	Mental health condition	-	-	25	6%	882	5%
	Missing	-		367		15,389	
	Neurological condition	-	-	19	5%	997	6%
	Missing	-		373		15,274	
	Another long-term condition	-	-	82	21%	2,881	18%
	Missing	-		310		13,390	

75.	Do any of these reduce your ability to carry out day-to-day activities?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Yes, a lot	-	-	124	46%	4,482	42%
	Yes, a little	-	-	99	37%	4,337	41%
	No, not at all	-	-	46	17%	1,848	17%
	Missing	-		123		5,604	

76.	Are you male or female?	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	Male	165	42%	178	47%	7,543	49%
	Female	226	58%	197	53%	8,002	51%
	Missing	28		17		726	

77.	Age:	2016 RMC		2017 RMC		2017 All	
		#	%	#	%	#	%
	16-24	6	2%	4	1%	281	2%
	25-34	13	3%	9	2%	396	3%
	35-44	21	5%	14	4%	571	4%
	45-54	44	11%	28	8%	1,389	9%
	55-64	64	16%	58	16%	2,422	16%
	65-74	113	28%	93	25%	4,286	28%
	75-84	80	20%	121	33%	4,004	26%
	85+	57	14%	38	10%	1,902	12%
	Missing	21		27		1,020	

ABOUT YOU (continued)

78. What is your religion?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
No religion	32	8%	44	12%	2,637	17%
Buddhist	0	0%	0	0%	48	0%
Christian	332	84%	299	80%	11,896	77%
Hindu	2	1%	6	2%	70	0%
Jewish	0	0%	0	0%	47	0%
Muslim	18	5%	14	4%	185	1%
Sikh	0	0%	0	0%	75	0%
Other	5	1%	3	1%	200	1%
I would prefer not to say	4	1%	9	2%	327	2%
Missing	26		17		786	

79. Which of the following best describes how you think of yourself?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
Heterosexual / straight	358	93%	331	91%	14,079	94%
Gay / lesbian	1	0%	5	1%	118	1%
Bisexual	2	1%	3	1%	60	0%
Other	2	1%	9	2%	110	1%
I would prefer not to say	24	6%	16	4%	610	4%
Missing	32		28		1,294	

80. What is your ethnic group?	2016 RMC		2017 RMC		2017 All	
	#	%	#	%	#	%
A. White						
English / Welsh / Scottish / Northern Irish / British	367	92%	337	92%	14,343	93%
Irish	5	1%	3	1%	119	1%
Gypsy or Irish Traveller	0	0%	0	0%	5	0%
Any other White background	3	1%	3	1%	265	2%
B. Mixed						
White and Black Caribbean	2	1%	1	0%	35	0%
White and Black African	0	0%	0	0%	17	0%
White and Asian	1	0%	1	0%	37	0%
Any other Mixed / multiple ethnic background	0	0%	0	0%	21	0%
C. Asian or Asian British						
Indian	8	2%	10	3%	158	1%
Pakistani	6	2%	5	1%	83	1%
Bangladeshi	0	0%	0	0%	17	0%
Chinese	0	0%	0	0%	27	0%
Any other Asian background	3	1%	1	0%	51	0%
D. Black or Black British						
African	1	0%	6	2%	80	1%
Caribbean	2	1%	0	0%	76	0%
Any other Black / African / Caribbean background	1	0%	0	0%	21	0%
E. Other Ethnic Group						
Arab	0	0%	1	0%	15	0%
Any other ethnic group	0	0%	0	0%	22	0%
Missing	20		24		879	

2017 Inpatient Survey

Comments Report

Bolton NHS Foundation Trust

Produced by Quality Health

The questionnaire included three sections where patients could make comments in their own words about the care they had personally received. The comments were under the following headings:

1. Is there anything particularly good about your care?
2. Is there anything that could be improved?
3. Any other comments?

The comments received for your Trust are set out overleaf and all comments from each patient have been grouped together. If a patient made a comment under all three headings then all three will appear one after the other; if the patient made only one comment under one heading, then only that one will appear.

Each comment, or grouping of comments is referenced by the participant's unique questionnaire ID, (QID) e.g. Q1234567. Should a participant choose to send us a continuation of their comments, or any additional free text comments outside of the designated questionnaire boxes, we will scan and send these to you separately referenced with the same relevant QID, which will allow you to link any such comments if applicable.

Please be advised that these comments are provided to you in their entirety and have not been sanitised or anonymised in any way. This has been made possible due to a disclaimer added to the survey notifying patients that the comments they provide will be looked at in full by the NHS Trust, CQC and researchers analysing the data. This disclaimer also notifies patients that their comments may be published, but does include a commitment to remove any information that could lead to the patient being identified before doing so. The full disclaimer wording, which appears above the free text comments box, is provided below for your information:

Please note that the comments you provide in the box below will be looked at in full by the NHS Trust, CQC and researchers analysing the data. We will remove any information that could identify you before publishing any of your feedback.

This report contains unabridged comments that could contain sensitive or personal information and we would, therefore, ask you to ensure it is handled in a confidential manner. It is entirely up to the Trust to decide whether to publish any of your patient comments and we would ask that you ensure appropriate steps are taken to fully anonymise any comments before doing so. We have provided the document in an editable format to ensure you have the option to do this, should you require it.

Q15153796	Was there anything particularly good about your hospital care?	After discharge appointment with a cardio professional lady Joanne. Very informative, excellent.
	Was there anything that could be improved?	No.
Q15153798	Any other comments?	I found that all the staff treated myself and the other patients with dignity and informed us all what they were and how they would administer any treatment. I have nothing to complain about, only praise for all the staff, both on the ward and in A&E department.
Q15153800	Was there anything that could be improved?	More nurses.
Q15153801	Was there anything particularly good about your hospital care?	The staff made me feel good about myself. They were very supportive and friendly, I felt safe in their care.
	Was there anything that could be improved?	Nothing.
Q15153806	Was there anything particularly good about your hospital care?	The care I received was excellent, no complaints at all, everyone involved they were just 100%. A good experience, no complaints at all.
	Was there anything that could be improved?	None.
	Any other comments?	I have read about the NHS Trust receiving thousands of complaints a week. All I can say is the hospital, my GP, my dentist to me are excellent, I got 100% satisfaction.
Q15153828	Was there anything that could be improved?	No bed, sat on a chair all day even though they planned the procedure for that day. When I was due to leave, 24 hours later than I should have, they said needed another night. Even though I was fit and well and they're always complaining.
	Any other comments?	They haven't enough beds. I had to self discharge. Also, did not receive any of my medication at all in 36 hours.
Q15153852	Was there anything particularly good about your hospital care?	I found from the receptionist at admissions to the surgeon who operated on me and all the staff in between (Nurses, porters, doctors, catering staff were all excellent).Thank you.

Q15153861	Was there anything particularly good about your hospital care?	The nurses and doctors on the ward were excellent even though they were extremely busy.
	Was there anything that could be improved?	On more than two occasions, a bed had been available from early morning, but I was not contacted by bed managers to go onto ward. Resulting in having to stay in overnight as too late to do procedure. This meant I was taking a bed and nurses/doctors time when not really necessary.
Q15153866	Was there anything particularly good about your hospital care?	Yes the care I received was outstanding by all the staff, no matter how busy they were. Really enjoyed my stay.
Q15153878	Was there anything particularly good about your hospital care?	I was treated by very friendly and efficient nurses and health care assistants, also with a lot of humour which made my stay much less stressful.
Q15153881	Was there anything particularly good about your hospital care?	The A&E department were outstanding in the care given, and attention to detail. Ward staff were attentive and caring.
	Was there anything that could be improved?	More staff on the ward. Better food. On discharge, shorting waiting times for medication.
	Any other comments?	A good hospital.
Q15153883	Was there anything particularly good about your hospital care?	Everyone from ambulance staff, A&E doctors and nurses. All staff on ward were very good with me.
	Was there anything that could be improved?	More senior doctors available at weekends and at night. This view is from previous stays and visits to hospital.
Q15153895	Was there anything particularly good about your hospital care?	I haven't stayed at hospital for long, but the treatment and care I received was next to none. The doctors and the staff were attentive. I'm very happy. Thank you so much, NHS.
Q15153905	Was there anything particularly good about your hospital care?	I was from start to finish well pleased with my stay, the staff were lovely, food was really good and I couldn't have asked for any better treatment, after 2 cancelations I was pleased to get it over with and had a really pleasant experience.
	Was there anything that could be improved?	Perfect - nothing really.
	Any other comments?	Well done, I mean that, I wasn't expecting it to be so pleasant and straightforward.
Q15153914	Any other comments?	I was in for 9 days with breathing problems (COPD), but I think I was sent home too soon.

Q15153916	Was there anything particularly good about your hospital care?	Yes, good continuity of nursing and care staff and good pre-operation preparation with leaflets and information session. There were follow up visits whilst on ward from surgeon.
	Was there anything that could be improved?	Patients had to pay for even 'free to air' TV by independent provider (Hospedia?)
Q15153949	Was there anything particularly good about your hospital care?	Satisfactory.
	Was there anything that could be improved?	Indian vegetarian food could be improved.
Q15153955	Was there anything particularly good about your hospital care?	All the doctors are very nice and good to explain. All the nurses was very good.
Q15153958	Was there anything particularly good about your hospital care?	The medical staff doctors, nurses were wonderful.
	Was there anything that could be improved?	It could be cleaner. When you say two visitors mean it.
	Any other comments?	On the day of my operation I was taken back to the ward to a lot of disruption, I counted 10 visitors round a bed, including children and a baby in a pram.
Q15153963	Was there anything particularly good about your hospital care?	Staff is good but doctors are rubbish.
	Any other comments?	Just advice, think about patients, they are human as well. Doctors are rubbish, I had an operation 17th of September. They discharged me 22nd of September. Then liar doctors said we will call you and give you a medicine, but today is 5th November. I am still waiting, had a call to Dr Smith's secretary, she makes new excuses every time so cheap. Dr Smith not a good person.
Q15153969	Was there anything particularly good about your hospital care?	Everyone was lovely. Nicknamed me Barbara Windsor.
Q15153972	Was there anything particularly good about your hospital care?	Some HCA staff here brilliant, but some needed to be told a few times before I was given a jug of water. It may of been because I was in a side room. I had to ask the cleaners sometimes I was dehydrated. A request for receiving pain medication earlier than usual at the night was not fulfilled.
	Was there anything that could be improved?	As above.

Q15153977	Was there anything particularly good about your hospital care?	All staff including non-clinical were very helpful and caring.
Q15153980	Any other comments?	Whilst in hospital I had a procedure (ERCP) done, but this was stopped in the course of it and I wasn't told why, with the result my throat bled for a few hours afterwards, I mentioned this to a nurse on the ward, and was told this can happen.
Q15153989	Was there anything particularly good about your hospital care?	Not really.
	Was there anything that could be improved?	Yes, more information about medications you are still given such as morphine and the side effects they can cause. I fell and finished up with fracturing my left kneecap and having to stay in hospital and having to have caring when I came home.
Q15156992	Was there anything particularly good about your hospital care?	The friendliness of the nurses and assistants.
	Was there anything that could be improved?	My operation was postponed three times in a week. The constant starving/eating led to the worst constipation ever.
	Any other comments?	Whilst I was held up in a hoist to poo with the curtains closed, a hospital staff admin lady entered my bed space and stared at me for several seconds before leaving. She brought nothing in, nor looked at any papers or took anything away with her. I felt so embarrassed.
Q15157000	Was there anything particularly good about your hospital care?	I have had a problem with my bladder for over 2 years and my consultant would not give up until she found the problem and made plans to fix it. I have nothing but pure respect for my care that I received from the hospital.
Q15157003	Was there anything particularly good about your hospital care?	Did the what help I needed.
	Was there anything that could be improved?	Yes, more staff. They all worked too hard which could lead to mistakes being made!
	Any other comments?	Good, helped me get well, thank you.
Q15157008	Was there anything particularly good about your hospital care?	The care from all involved from the time I arrived to my discharge, fantastic profession from all parties. Love to do it myself.
	Was there anything that could be improved?	Not applicable.

Q15157030	Was there anything particularly good about your hospital care?	The nurses were very good and hard working.
	Was there anything that could be improved?	I woke around 6:00 am and would not get a cup of tea until official breakfast time although I asked several times.
	Any other comments?	The wait for prescriptions has always been a problem and yet no one has the common sense to sort this out. It is not rocket science.
Q15157043	Was there anything particularly good about your hospital care?	All doctors and staff were very helpful, it took time to understand everything, but later, after the operation, things were better to understand, under the circumstances etc. and with all the other issues I had to deal with, my other problems with my health.
Q15157044	Was there anything particularly good about your hospital care?	I was very well looked after, wouldn't mind another stay.
Q15157045	Was there anything particularly good about your hospital care?	Doctors, nurses and staff.
Q15157047	Was there anything that could be improved?	Time taken for pharmacy to deliver medicines before leaving hospital.
Q15157051	Was there anything particularly good about your hospital care?	Physio was very good and the haematology team. I have been in hospital several times for long periods over the last 6 months on various wards which have all been good standards, but unfortunately the short stay on the last ward was not up to all the other wards' standards.
	Was there anything that could be improved?	Cleaning of side rooms on A1. One member of staff on night shift was very rude and aggressive, but was dealt with the following day after complaint.
	Any other comments?	Overall it is a good hospital with great staff doing their best.
Q15157058	Was there anything particularly good about your hospital care?	A student nurse who was very good at seeing when someone needed emotional support.
	Was there anything that could be improved?	More nurses so that they could have more time for each patient. Non urgent requests had to left a long time frequently.
	Any other comments?	Very thankful for the treatment I received, but felt the staff were always battling against a lack of resources. I was admitted on a Monday but not diagnosed until Friday because of waiting times for scans.

Q15157070	Was there anything particularly good about your hospital care?	I was only in overnight, having been operated on day of admission.
	Any other comments?	Hospital appointment information as to delay (registration) 07:15 operating room 17:00 (5pm). No TV or reading matter in waiting room. Bored stiff.
Q15157073	Was there anything particularly good about your hospital care?	The care from nurses was 5 star.
Q15157076	Was there anything particularly good about your hospital care?	All clinical staff were amazing even under clear under staffing issues.
	Was there anything that could be improved?	The food is the most bland, disgusting, unorganised chaos. Not once did I get what I had ordered in 9 days, also it was never hot or nutritious.
	Any other comments?	The NHS is under such strain, but I cannot complain over the care I received.
Q15157082	Was there anything particularly good about your hospital care?	The staff couldn't do enough for me - they were excellent.
Q15157086	Was there anything particularly good about your hospital care?	Everything was just fine about my hospital care.
	Was there anything that could be improved?	Not as far as I am concerned.
	Any other comments?	Yes the doctor was great and all the nurses on the ward were too.
Q15157095	Any other comments?	Patients could be asked to turn their mobile phones/tablets off early evening as some people would prefer to rest and sleep, but can't as too noisy.
Q15157110	Was there anything particularly good about your hospital care?	The nurses and staff were very caring and very helpful.
Q15157127	Was there anything particularly good about your hospital care?	Treated with kindness and care at all times by all staff at hospital.
Q15157138	Was there anything particularly good about your hospital care?	I was very well looked after all the time I was there. Thanks.
	Was there anything that could be improved?	Not really.

Q15157165	Was there anything particularly good about your hospital care?	The surgery gave a good result.
	Was there anything that could be improved?	The food.
	Any other comments?	Noise levels as it's too noisy to sleep at night. Not sure how this could be achieved though. I appreciate silence would be impossible.
Q15157171	Was there anything particularly good about your hospital care?	I only stayed in hospital for a short time, while I was there the staff treated me with respect and dignity at all times.
Q15158591	Was there anything particularly good about your hospital care?	Staff was helpful. Bed uncomfortable.
	Was there anything that could be improved?	Menus could have been improved, wasn't enough nice dinner i.e. steak, hot pot, rice, roast, Yorkshire puddings, rice pudding.
Q15158592	Was there anything that could be improved?	Shortage of nurses.
Q15158593	Was there anything particularly good about your hospital care?	Everything was really good. The theatre staff made me feel at ease.
	Was there anything that could be improved?	The wait for take home drugs.
Q15158595	Was there anything particularly good about your hospital care?	The nurses do an excellent job, but not enough staff on. They were never still. Buzzers going all night, job well done.
Q15158604	Any other comments?	Thank you.
Q15158621	Was there anything particularly good about your hospital care?	The care given by all staff, friendly, efficient, responsive and concerned.
	Was there anything that could be improved?	Unfortunately, my first night was in a small ward with four seriously ill patients who were in great pain. Their constant calling for help was very distressing. The nursing staff gave them every support but their suffering has remained with me.

Q15158622	Was there anything particularly good about your hospital care?	The doctors and nurses were exceptional. Cleaning was very good. Food was also very good. My stay was very comfortable and professional.
	Was there anything that could be improved?	No, not to my knowledge.
	Any other comments?	I treat people and staff like I treat myself.
Q15158631	Was there anything particularly good about your hospital care?	I was placed in a private room after the procedure.
	Was there anything that could be improved?	I was not told until 21:00 hours that I was being kept, so missed evening meal, I had 2 slices of toast.
	Any other comments?	I was only in hospital 1 night. This was unexpected as I assumed day patients went home after treatment.
Q15158632	Was there anything particularly good about your hospital care?	The staff.
	Was there anything that could be improved?	No.
	Any other comments?	Very good here.
Q15158636	Was there anything particularly good about your hospital care?	My stay was short, all care was good I was given.
Q15158660	Was there anything particularly good about your hospital care?	The doctor (specialist) and staff whole very professional and helpful. They made me feel confident and relaxed during the operation as the whole team worked well together with the specialist doctor to fix my problem.
Q15158663	Any other comments?	I was transferred to Wythenshawe for an angiogram. The care and procedure was excellent. However, after the treatment, I waited 11 hours to be taken back to Bolton, during which time I was given a bed on a ward and more or less forgotten about. This was the only negative aspect of my care.

Q15158671	Was there anything particularly good about your hospital care?	As I was in hospital for nearly eight weeks, I felt down at times. The staff were very understanding and helped me where they could.
	Was there anything that could be improved?	Whilst I was in hospital, I was catheterised twice, eventually after waiting two weeks for urology to see me, I was fitted with a flip on/flip off valve, approximately 10 days before discharge. Approximately one week after discharge, I had problems with my bladder, I suspected an infection. After phoning the ward and my own doctor, we contacted the urology department at Bolton Hospital. They told me I should have had spare valves and the district nurse informed about me. This had not been done, they told me to come in straight away, they then sorted me out and informed the district nurse.
Q15158672	Was there anything that could be improved?	The letter that I was given day before discharge stated that the diagnosis as bradycardia infused syncope to a non medical trained person such as myself. This is meaningless and needs to be translated to common usage, at no time was I given any advice as to what I could do, e.g. alter diet to prevent this happening again.
Q15158675	Was there anything particularly good about your hospital care?	I have been admitted, electively, on to the same ward for the last 5 years. On this occasion conditions were improved, i.e. cleanliness and more commitment from clinical staff. (Been on 3 times this year).
	Was there anything that could be improved?	I hope the above standard continues, I have felt on past stays vulnerable, not safe and not cared for. On this stay an agency nurse woke me 4 times during the night for 'paperwork'. The ward manager requested, I believe, he would not work on the ward again.
	Any other comments?	First your students were wonderful despite their inexperience. Newly qualified less so. I found some arrogant and unable to communicate in order to satisfy patients needs to feel safe.
Q15158688	Was there anything particularly good about your hospital care?	I was well cared for and I thank everyone there who looked after me.
	Any other comments?	Give them more money, they deserve every penny.
Q15158690	Was there anything particularly good about your hospital care?	The doctors and nurses were excellent, time spent waiting for other doctors to see me on the accident emergency department lengthened my stay taking up emergency bed.
	Was there anything that could be improved?	I have dementia, It would have been nice to have been moved to a side room to relieve my stress and agitation and allow another emergency to use the cubicle I was in.

Q15158699	Was there anything particularly good about your hospital care?	Yes the nurse who cared for Maureen on B1, her manner, patience and nothing was ever too much trouble. Very reassuring. A good role model for other nurses.
	Was there anything that could be improved?	Communication between family and agencies. One group saying one thing, then others saying different.
Q15158706	Was there anything particularly good about your hospital care?	No.
Q15158718	Was there anything particularly good about your hospital care?	Dedicated staff.
	Was there anything that could be improved?	Waiting for medication before discharge.
	Any other comments?	Good consultants.
Q15158727	Was there anything particularly good about your hospital care?	Yes physiotherapy.
	Was there anything that could be improved?	More staff needed!
Q15158729	Was there anything particularly good about your hospital care?	Generally okay.
Q15158736	Was there anything particularly good about your hospital care?	Friendly staff who always travel to help.
	Was there anything that could be improved?	Not really every thing seemed ok.
	Any other comments?	Would not be afraid to have to go to hospital if health warranted it.
Q15158738	Any other comments?	I felt I was treated very well but I felt that my emergency treatment was something to do with an original operation for gall bladder removal on the 10/7/17. I was readmitted on the 16th with an infection which took 5 days before discharge and weeks of clinic visits for diagnosis to change.
Q15158743	Was there anything particularly good about your hospital care?	All staff and doctors were very attentive to my needs and very comforting to be around. Excellent.
	Was there anything that could be improved?	No.

Q15158755	Was there anything particularly good about your hospital care?	The ward I was on I found the staff from the doctors and nurse to the cleaners and tea lady all very kind a helpful, cheerful and very helpful.
Q15158756	Was there anything that could be improved?	The waiting time to be admitted, but I know this is very difficult.
Q15158771	Was there anything that could be improved?	Patients and family need to know about the different members of staff and their role. There are so many different types of uniform that it is difficult to tell who does what. Information given should be the same, no matter who gives it. Often given different information.
	Any other comments?	Patient needs to be taken into consideration more, especially if they are elderly when giving information. Also, family should be able to get information much easier and more willingly. Some staff seem not to want to give you any information. Relatives need to know what is happening.
Q15158782	Was there anything particularly good about your hospital care?	All tests and examinations and treatment were carried out in an efficient and thorough manner to resolve the problem of acute pain, which necessitated morphine several times.
	Was there anything that could be improved?	No.
	Any other comments?	No.
Q15158784	Was there anything that could be improved?	Waiting times for discharge medication. I was on chemotherapy at the time of attendance to A&E and had to wait in the main waiting room. Not good for someone who is immunosuppressed. A separate waiting area or cubicle should be available.
Q15164193	Was there anything particularly good about your hospital care?	The experiences I had in hospital were very good. The staff were very obliging, and helpful. Friendly in all ways.
	Was there anything that could be improved?	Possibly correspondence between various departments, regarding after care, but not services in general.
	Any other comments?	Free car parking for visiting/patients. But overall not much to moan about.
Q15164217	Was there anything that could be improved?	Food was lacking in size. I was constantly hungry.
Q15164221	Was there anything particularly good about your hospital care?	Care and attention by doctors and nurses very good. A friendly atmosphere was at all times relaxing.
Q15164222	Was there anything particularly good about your hospital care?	I was treated with respect throughout.

Q15164229	Was there anything particularly good about your hospital care?	My care prior to my operation (which was an emergency one, not planned/scheduled) was fantastic. The doctors and nurses couldn't have been more helpful or informative. They told me about my operation and also what should have happened with my aftercare.
	Was there anything that could be improved?	My aftercare was non-existent. I didn't get spoken to about how my operation had gone. I was given painkillers at 6 am, but nothing afterward (discharged approximately 5pm). I wasn't given any pain relief to take home. A nurse didn't contact me regarding stitches as I was told would happen by pre-op doctor. When I woke up in the morning after being given tablets at 6am, a doctor was at the foot of my bed. He said "Do you want to go home?", I replied "Yes" and he said "OK then you can do". This is all the 'aftercare' I was given. I would like information about how to complain please.
Q15164232	Was there anything particularly good about your hospital care?	My care from going to A&E to going to the ward was extremely good. I cannot fault the care I received one bit everybody was brilliant.
Q15164235	Was there anything particularly good about your hospital care?	The treatment which I received was second to none from doctors, nurses, physiotherapists and all the ancillary staff, they treated us with great patience, care and a happy smile and word.
	Was there anything that could be improved?	Waiting time communication at clinics.
	Any other comments?	After care. After about the last 12 clinic appointments. On 7 occasions I have waited, once 55 minutes, once 40 minutes and times over an hour. Whilst I fully understand why there are times when the doctor is very busy, but it would be helpful if we as patients were informed about how long the clinic is behind.
Q15164243	Was there anything particularly good about your hospital care?	The student nurses and nurses in general. Incredible people.
	Was there anything that could be improved?	More staff.
Q15164244	Was there anything particularly good about your hospital care?	I was not long in the ward.
	Was there anything that could be improved?	Yes. My nephrostomy tube got blocked, I think it would be quicker to have been sent to the ambulatory and instead of casualty. It took only five to ten minutes for the nurse to unblock it in the ward. I was in casualty from 4.50pm and was taken to ward at around 8.30pm. It took only five minutes to unblock it. I came home at 11.00pm at night, I was there for six and a half hours - didn't need to be admitted in ward.

Q15164247	Was there anything particularly good about your hospital care?	I was totally satisfied with my stay in hospital. I was treated well during my stay.
	Was there anything that could be improved?	I found everything fine.
Q15164256	Was there anything particularly good about your hospital care?	Smooth co-ordination of various monitoring and tests. No hanging around. Always know what was going on and what was coming next.
	Was there anything that could be improved?	In 6 bedded assessment ward, only one shower and toilet. Extra toilet would of been better.
	Any other comments?	Felt I`d had a thorough and professional service.
Q15164257	Was there anything particularly good about your hospital care?	I am an 83 year old elderly lady. Because I do not look or act like 83, I was not treated like 83. Wonderful staff who enjoyed my sense of humour.
	Was there anything that could be improved?	Probably extra staff at times. They work so hard, that goes for all the staff.
	Any other comments?	In hospital often during 2011/12 and early 2013. I was in a nice side room due to getting bugs in my lungs which come from 2 years in and out after picking up (to name one) MRSA. It shows up in lung when I get infection.
Q15164264	Was there anything particularly good about your hospital care?	The ladies in grey on C3 Ward.
	Was there anything that could be improved?	Yes, communication. Realistic goals i.e. distance able to walk. Dignity due to not being incontinent but being doubly so in hospital.
	Any other comments?	Moved during night when told wouldn't be due to age and possible stay. Discharge lounge failed to advise family of on way home - no one in. Left at a neighbours and not a close one at that. Then ambulance calling at daughters home to inform her of me being at a neighbours. Within our family we have a consultant, doctor, 2 nurses, ward clerk, head of business, intelligence, technical instructor for OT/PT. Many years given to NHS - no special preferences should be given but we completely (particularly family) feel let down by the experience on C3 Ward.
Q15164267	Was there anything particularly good about your hospital care?	I was cared for very well and nurses very friendly.
	Was there anything that could be improved?	Only negative I have was the bathrooms not being cleared of other peoples bedpans as soon as they left them there. One day I walked into bathroom with 3 full bedpans, not a nice sight and smell.

Q15164269	Was there anything particularly good about your hospital care?	All the doctors, nurses and staff were very kind, helpful and took great effort in avoiding patients getting bedsores.
	Was there anything that could be improved?	I was very satisfied with the treatment during my stay in hospital.
Q15164280	Was there anything particularly good about your hospital care?	I got nice and perfect sight care.
	Was there anything that could be improved?	No.
	Any other comments?	I am glad and peaceful for hospital's care about me. Thanks.
Q15164282	Was there anything particularly good about your hospital care?	No coordination between staff and no uniform for doctors.
Q15164283	Was there anything particularly good about your hospital care?	Nurses and doctors were good, treating very well.
	Was there anything that could be improved?	Waiting time. Hours and hours waiting for bed in wards.
Q15164284	Was there anything particularly good about your hospital care?	Individual nurses went over and above to assist.
Q15164288	Was there anything particularly good about your hospital care?	Good nursing team.
	Was there anything that could be improved?	Food menu.
	Any other comments?	Considering I fractured my skull, with blood clots on the Thursday I was discharged on the Saturday, although I wasn`t feeling well at all - much to soon!
Q15164290	Was there anything that could be improved?	The best.
Q15164295	Was there anything particularly good about your hospital care?	Very satisfied. Thank goodness for the NHS.

Q15164300	Was there anything particularly good about your hospital care?	My mother was recently admitted to Bolton hospital after a stroke with breathing problems, 95 years old, blind deaf etc. I, her daughter and full-time carer. What I found that these wards with over 20 patients are very limited with the number of staff required to care for these type of patients. Feeding, washing properly, fluids, oral hygiene, no real contact between patients and staff as they are too busy and patients like my mother requires reassurance and attention. My mother was very fearful and anxious as she was not sure where she was. They need attention in their care and encouragement, especially to feed and take drinks. To be reassured and told where they are especially at night. We, the family, do all we are allowed to do, but patients that are blind and deaf are quite different as fear and anxiety plays a part in their surroundings as they cannot see or hear. Thank you.
Q15164302	Was there anything that could be improved?	Attended on 27.07.2017 for the removal of bladder stones. My admission time was 12:00. At 3pm waiting for my operation I was moved to a ward. At 5:15pm, still waiting for my operation, the ward sister phoned urology to be told that I would not get the operation that day. I went home and re-admitted myself at 6:30am as instructed on the next day. I had the operation mid-afternoon. On discharge from hospital I was told that I would be called back in 4 weeks for a review. It is now 10 weeks since my operation and I still await the call for a review. In my opinion, all of this amounts to appalling service.
Q15164303	Any other comments?	I was told I would need and have a MRI scan, but this was not mentioned in my discharge letter to my GP and in consequence I have not had one. My daughter can confirm I was told I would need a scan.
Q15164307	Was there anything particularly good about your hospital care?	All staff from doctors, nurses, catering and cleaner was very caring and professional.
	Was there anything that could be improved?	Although this was 'not at all times'. The doctors was 10/10 for everything as was the cleaners, but then not all nurses could be very accommodating with a 'I know better' attitude. One particular senior nurse was very rude and took her position far to serious (not in a professional manor) shouting at patients when it was very unnecessary (In front of staff and other patients). The power had definitely gone to her head. Likewise more patience is needed when talking to and treating elder patients.
Q15164317	Was there anything particularly good about your hospital care?	Being kept informed all the way along the line about what was going to happen and what medication I was going to be given. Being in the care of Doctor Webster and his team was a very positive experience, they could not have helped anymore than they did. I wish to thank them most sincerely.
	Any other comments?	The physiotherapists that came to my home after I left hospital also gave me every help, they could and offered many ideas for helping myself.

Q15164318	Was there anything particularly good about your hospital care?	Quickly attended to. Clear instructions about my condition. Had confidence in doctor and support staff, consider this a much better level of service and treatment than Preston Royal.
	Was there anything that could be improved?	Food.
Q15164321	Was there anything particularly good about your hospital care?	Overall I could find no fault with any aspect of my care whilst in hospital.
	Was there anything that could be improved?	No.
Q15164324	Was there anything that could be improved?	Generally there are not enough members of nursing staff to carry out efficient, quicker caring of patients. Doctors are slow to arrive and cause delays in treatment of patients because of the time issues.
	Any other comments?	Because of the time pressure doctors/consultants are rather brief. As a patient I felt I had to ask more questions to get a full picture of my illness/required treatment. Had I not been persistent I may have felt I could have been poorly informed.
Q15164346	Was there anything particularly good about your hospital care?	All members of staff that I came into contact with during my stay were exceptional. I could not have asked for better care.
	Was there anything that could be improved?	No.
	Any other comments?	I have recovered well.
Q15164347	Was there anything particularly good about your hospital care?	The nurses were very caring and pleasant, as were other members of staff.
	Was there anything that could be improved?	The food at main meal times were not as good as it could have been. Noise at night on the main wards could have been better. Sleep was difficult to achieve.

Q15164351	Was there anything particularly good about your hospital care?	The nurses were very good at taking regular observations and were very patient with elderly patients.
	Was there anything that could be improved?	The nurses did not always tell you if your observations were normal. The non white nurses were in some cases very difficult to understand and also they were a lot friendlier with the non white patients often speaking in a very dismissive way to the white ones. This is not a racist comment but a fact.
	Any other comments?	One nurse, when adjusting my catheter said in a loud voice (on a mixed ward), "He's very small", referring to my penis. I found this very embarrassing and totally unnecessary and it still bothers me now.
Q15164353	Was there anything particularly good about your hospital care?	It was wonderful.
	Was there anything that could be improved?	No.
	Any other comments?	The staff on the ward I was on, G3 women's, were wonderful I could not ask for better.
Q15164355	Was there anything particularly good about your hospital care?	The care I got in hospital was very good. I was healed very well indeed and I am grateful for everything, they have saved my life. Thank you.
Q15168797	Was there anything particularly good about your hospital care?	Was seen every day by team 3 groups. Could not fault doctors/nurses and other staff, all helpful.
	Was there anything that could be improved?	More bathrooms and toilets.
Q15168808	Was there anything particularly good about your hospital care?	The nursing staff/consultants.
	Was there anything that could be improved?	More nurses.
Q15168810	Was there anything particularly good about your hospital care?	Yes it was excellent in everything they did for me.
	Was there anything that could be improved?	More money for hospitals, for nurses and doctors.
Q15168827	Was there anything that could be improved?	More nursing staff at night.

Q15168831	Was there anything particularly good about your hospital care?	All the ward staff on G5 were very good.
Q15168833	Was there anything particularly good about your hospital care?	They were very good.
	Was there anything that could be improved?	No.
	Any other comments?	All staff were excellent.
Q15168835	Was there anything particularly good about your hospital care?	Doctors, nurses and all the staff were brilliant. They all treated me and all the other patients very, very good. I was critical, I was rushed in hospital the staff fought to save my life and they did. I don't remember the first 2 when I started to come round I was treated brilliant so were all the other patients. I was in intensive care.
	Was there anything that could be improved?	The Royal Bolton hospital is the best hospital, the very, very best it doesn't need improving.
Q15168836	Was there anything particularly good about your hospital care?	No.
	Was there anything that could be improved?	No
	Any other comments?	No
Q15168840	Was there anything particularly good about your hospital care?	My whole care in hospital was excellent. I have no grumbles at all about my treatment, it was first class.
	Was there anything that could be improved?	My only grumble was transport home. I was told that an ambulance had been booked on Tuesday evening to take me home on Wednesday morning, it had not been booked and I was left waiting from 8:30am Wednesday morning until an ambulance picked me up at 4:25pm. I arrived home at 4:45pm (this was over 8 hours, which is ridiculous).
Q15168850	Was there anything particularly good about your hospital care?	The ward was very clean. All staff were brilliant, including cleaners. It was a pleasant stay in hospital.
	Was there anything that could be improved?	Not on that ward. It was well managed all staff were brilliant.
	Any other comments?	To have such lovely staff like this makes you feel safe and well looked after. Can't give them enough praise. They were brilliant.

Q15168853	Was there anything particularly good about your hospital care?	Very good.
	Was there anything that could be improved?	No.
Q15168854	Was there anything particularly good about your hospital care?	First of all not enough privacy when the doctors telling the patients bad news, you can hear everything and everybody can hear about your health problems.
	Was there anything that could be improved?	Could take patients in a private room.
Q15168872	Was there anything particularly good about your hospital care?	Yes. The tea lady and they always spoke to you with your first name not Mr, it made you feel special on a one to one basis.
	Was there anything that could be improved?	No.
	Any other comments?	No.
Q15168880	Was there anything particularly good about your hospital care?	Nurses were brilliant. Doctors too saved my life, had pneumonia and sepsis.
	Was there anything that could be improved?	No.
	Any other comments?	My stay in hospital 10 days, it was wonderful. Everyone went above and beyond their duty.
Q15168881	Was there anything particularly good about your hospital care?	On arrival I went straight to an assessment ward and dealt with quickly.
	Was there anything that could be improved?	Food - but not a major issue.
	Any other comments?	At one point I had suspected sepsis, the care was immediate.
Q15168883	Was there anything that could be improved?	Yes, food left to be served so very cold. Get rid of outside catering (they hadn`t got a clue). Good meals ruined, good change of food ruined. I did speak to a manager in catering, who was very helpful.
	Any other comments?	No other problems, I was well taken care off.

Q15168884	Was there anything particularly good about your hospital care?	Not really. Hated it.
	Was there anything that could be improved?	Nurses need to stop standing about chatting and do their job, and stop being so noisy at night. Not many patients get any sleep, I didn't for three days. I was glad to be discharged, as do many patients.
	Any other comments?	Have a separate building for what they call 'bed blockers'. That's all the nurses (not their fault) seem to bother with.
Q15168885	Was there anything particularly good about your hospital care?	Some of the nurses came across as very caring.
	Was there anything that could be improved?	Seemed to be a shortage of nurses. Some patients were very ill and noisy, disturbing the quieter patients. Feel these could have been moved around more.
Q15168886	Was there anything that could be improved?	In elderly patient ward, I noticed that nurses just likes to put incontinence pads instead of encouraging the patient to use the toilet.
	Any other comments?	Hospital stay made me incontinent which is very bad.
Q15168889	Was there anything particularly good about your hospital care?	Excellent service, caring nurses.
	Any other comments?	Many thanks.
Q15168904	Any other comments?	I was looked after very well but on discharge only knew I hadn't to lift anything heavy for three weeks. Would have liked to have been given a list of what to do and not to do. E.g. when I could drive again, exercise again. I only thought about this when I got home.
Q15168909	Was there anything particularly good about your hospital care?	Generally good attention from virtually all nursing staff and doctors.
	Was there anything that could be improved?	Help with eating when it was obvious that difficulties were being experienced. Control of noisy patients during night time hours.
Q15168916	Was there anything particularly good about your hospital care?	The care and attention of the nurses and doctors on the ward.
	Was there anything that could be improved?	Staff didn't seem to know she had learning difficulties.
	Any other comments?	I was well cared for and all the staff were very kind.

Q15171791	Was there anything particularly good about your hospital care?	Staff was always very helpful when needed, can only say a very big thank you for the care and attention I received from all doctors and nurses.
Q15171792	Was there anything particularly good about your hospital care?	Staff were very good.
	Was there anything that could be improved?	Not really for my treatment, I was only in 1 night.
	Any other comments?	Very polite and helpful, thank you.
Q15171796	Was there anything particularly good about your hospital care?	Yes, everyone was very helpful. I cannot thank them enough.
Q15171798	Was there anything particularly good about your hospital care?	No hospital is good, as you are ill to be there. The HIU was excellent, Mark was in constant care and his attention to washing, shaving, etc., was very caring, even though Paul was in a coma.
	Was there anything that could be improved?	Yes. A junior heart doctor in A&E wanted to send him home because there was nothing wrong there. The male nurse on, said no, not going home until found out what is wrong. Paul had his gall bladder out, found it was gangrenous, plus he has septicaemia. I dread to think what would have happened had I listened to the junior heart doctor. Wrote by Mrs S Lancashire.
Q15171804	Was there anything particularly good about your hospital care?	Very kind nurses and great consultant.
	Was there anything that could be improved?	When I got home nurses at doctors was not very helpful.
Q15171806	Was there anything particularly good about your hospital care?	The staff that I met were exemplary. The operation outcome and recover time exceeded my expectations.
	Was there anything that could be improved?	Those cancellations and the waiting list. The hospital was superb once I got there, but I would have been saved a lot of pain had it happened when first scheduled.
Q15171807	Was there anything that could be improved?	My only complaint about hospital stay, I spent 7 hours in surgical admissions and was finally taken up to ward where I sat for another hour, only to be told by a doctor to go home because there was 3 people ahead of me. I was told to come back next day, I came back next day to have to wait another 3 hours. At which point I complained and a nurse got me attended to. Two days without food or drink.

Q15171812	Was there anything that could be improved?	The discharge procedure I was told I could go home the next days, but I had to wait until nearly evening time to receive my medication from the pharmacy down at the front of the hospital main entrance.
Q15171821	Was there anything particularly good about your hospital care?	Not particularly impressed by the hospital.
	Was there anything that could be improved?	Not impressed by nursing staff.
Q15171828	Was there anything particularly good about your hospital care?	I have been to Bolton Hospital a few times in the last five years. I have always been treated with much respect/concern and enthusiasm by all members of staff from consultants to cleaners. I have also noticed the improvements being made inside which gives it a nice, clean feeling and a sense of purpose to staff and patient receiving quality care and support at its best.
Q15171831	Was there anything that could be improved?	Cancellations and waiting time for admission.
Q15171833	Was there anything particularly good about your hospital care?	Fantastic nurses, as was the treatment. Can't thank the hospital enough.
	Was there anything that could be improved?	Not really.
	Any other comments?	Only downside, had to wait two hours for ambulance to go to hospital.
Q15171835	Was there anything particularly good about your hospital care?	The night staff (staff nurse) was lovely. I was feeling quite sick due to the pain relief I was given, resolved this for me.
	Was there anything that could be improved?	Postoperative care, would like to have seen nurse led service check up or even consultant post operative check. Not given referral to GP who did not appear to have understanding of post operative care of my operation. Q and A for relatives as my husband read my leaflet. Hysterectomy/salpingo oophorectomy.
Q15171838	Was there anything particularly good about your hospital care?	The whole experience was punctuated by consistent, professional care from the moment I arrived at A&E until I was discharged.
	Was there anything that could be improved?	No.
	Any other comments?	Thank you.
Q15171843	Was there anything particularly good about your hospital care?	Professional, caring people.

Q15171844	Was there anything that could be improved?	Better food.
Q15171852	Was there anything particularly good about your hospital care?	I found the staff very helpful, treated me with dignity and respect, at all times. The nurses had a wonderful sense of humour.
	Was there anything that could be improved?	I felt I need a little more care for washing and dressing when I got home, this was never discussed and I didn`t like to ask.
	Any other comments?	In general my stay was very comfortable, I can`t say a bad word. Thank god for NHS and all staff.
Q15171853	Was there anything particularly good about your hospital care?	Consultant on my ward, Dr Ahmed. Felt like if it wasn't for him I would never have got better.
	Was there anything that could be improved?	Privacy on A&E.
	Any other comments?	No.
Q15171855	Was there anything particularly good about your hospital care?	Regular checks while in hospital.
	Was there anything that could be improved?	The food wasn't as good as previous visits. Not enough qualified staff to many students.
	Any other comments?	As above. Too many students, had to wait for qualified nurse. Was moved from side ward to a bed on ward to keep eye on me, this didn't happen.
Q15171861	Was there anything particularly good about your hospital care?	I was operated on by Mr Varghese and the result was excellent. The care that I received from all the medical and nursing staff was excellent.
Q15171868	Was there anything particularly good about your hospital care?	General high standard of care and support.
Q15171877	Was there anything particularly good about your hospital care?	The nurses were brilliant.
	Was there anything that could be improved?	Bigger food portions.
	Any other comments?	All round good service.
Q15171884	Was there anything particularly good about your hospital care?	I had a bad fall on July 2nd 2017. I had several injuries (face and legs). I have a 'care line', someone pressed it and from the arrival of ambulance until discharge I had excellent care.

Q15171888	Was there anything particularly good about your hospital care?	All members of staff were caring, friendly, helpful and professional people.
Q15171889	Any other comments?	Very upset about aftercare.
Q15171892	Was there anything particularly good about your hospital care?	All the staff was amazing!
	Was there anything that could be improved?	Just need more staff in case of emergencies.
	Any other comments?	Just want to say the hospital has saved my life over 10 times. A big thank you!
Q15171902	Was there anything particularly good about your hospital care?	The variety of information given from the first visit through to follow up. The support offered and the clear options on follow up treatment which is on-going at moment.
Q15171915	Was there anything particularly good about your hospital care?	My short stay in hospital was a caring experience with wonderful staff on all levels, who worked hard in every aspect of hospital life.
Q15171919	Was there anything that could be improved?	Having been in hospital on numerous occasions there has always been a shortage or nurses resulting in mistakes being made and medication been missed altogether!
	Any other comments?	You don't get any sleep.
Q15171941	Was there anything particularly good about your hospital care?	The doctors and nurses were really supportive and helpful. I cannot thank them enough. Unfortunately, my family and myself have needed help from the hospital over a few years. In all our visits we received excellent care.
	Was there anything that could be improved?	Not that I could think about.
	Any other comments?	Thanks to all at RBH.
Q15173593	Was there anything particularly good about your hospital care?	The whole staff on the ward were excellent, a perfect team who work together, pleasant, friendly and couldn't be more helpful.
Q15173596	Any other comments?	I saw one doctor who said they would do a polypectomy and coil fitted, only to find out that they was only doing a polypectomy by the second doctor so they will come back. Not happy at all put a complaint in with PALS.
Q15173599	Was there anything that could be improved?	No discharge letter, no medication given, told to see the GP, that took four days to get medication from them.

Q15173606	Was there anything particularly good about your hospital care?	All the staff on the ward I was on were very approachable, I was never once made to feel that I couldn't ask them anything. Nothing was too much trouble for them and when the pain was bad, the nurses acted promptly with the pain relief.
Q15173617	Was there anything particularly good about your hospital care?	My nursing was very good, but the wards were very noisy. Some visitors were rowdy.
	Was there anything that could be improved?	The food supplied this visit was inedible. I understand the provider had changed and it was obvious. The food was a poor standard.
	Any other comments?	Always on previous visits the food was very good.
Q15173619	Any other comments?	I have never had any problem with my hospital stay and have always been treated well.
Q15173622	Was there anything particularly good about your hospital care?	The quality of care from staff was very good, always willing to help you.
	Was there anything that could be improved?	Food. Better quality more choice needed.
Q15173628	Was there anything that could be improved?	A&E could be improved with the creation of a dedicated over 75 A&E as the one in Dorchester hospital I went to before coming home to Bolton. It was so much quicker for the elderly like myself (92) than the normal, 4 hour wait and much less stressful.
	Any other comments?	At Royal Bolton staff stayed very pleasant, even though they were under too much pressure.
Q15173642	Was there anything particularly good about your hospital care?	Not in particular.
	Was there anything that could be improved?	For more NHS staff and less agency staff (who do not inspire confidence). With regard to food, the standard has reduced to the point where most meals are inedible.
	Any other comments?	Sorry for the delay in returning this form, but since receiving it I have once again been in hospital. I didn't expect things to have changed in 3 weeks so the comments above still stand).
Q15173644	Was there anything particularly good about your hospital care?	Everything was really quite good.
Q15173646	Was there anything that could be improved?	Bathroom facilities could be improved.

Q15173649	Was there anything particularly good about your hospital care?	Generally very good.
	Was there anything that could be improved?	For me not really.
	Any other comments?	I can't complain about Bolton hospitals, they have always been there for me when needed.
Q15173652	Was there anything particularly good about your hospital care?	I was looked after by the 'nurses' 90% brilliant. Made me cups of tea at night when wanted and I used to enjoy sitting with 'nursing' staff having a laugh and joke.
	Was there anything that could be improved?	Could have given me treatment (antibiotics) of my 'cystitis' (very painful).
	Any other comments?	I felt really at home on the ward (C2), the night staff especially. P.S. sorry about my writing (hope you can read it?).
Q15173662	Was there anything particularly good about your hospital care?	Friendly staff. Being made to feel that your health was important to nurses and doctors regardless of if your condition was minor or severe. Due to my good treatment I have requested that if I require any further treatment that I may need, be referred to Bolton.
Q15173670	Was there anything particularly good about your hospital care?	Everything were good and very well handled, I was just surprised the last day how the nurses team interviewed me, too much.
	Was there anything that could be improved?	I want them to make a good report everywhere from hospital to inland review so I can start receiving my carer money cause I am doing a lots of jobs.
	Any other comments?	Just this because I think my carer's money is affected.
Q15173672	Was there anything particularly good about your hospital care?	Nursing staff very helpful and caring.
	Was there anything that could be improved?	No.
Q15173674	Was there anything particularly good about your hospital care?	The friendly attitude of the general staff.
	Was there anything that could be improved?	The time waiting in A&E department because of a bleeding cut on my head before I had an x-ray.
	Any other comments?	The time spent for an ambulance until we took a chance on making our way in our own car.

Q15173679	Was there anything particularly good about your hospital care?	I was attended to quite soon.
	Was there anything that could be improved?	Nothing I can think of.
	Any other comments?	I am glad we have such a good hospital and staff.
Q15173706	Was there anything particularly good about your hospital care?	Helpful staff with an understanding of my needs.
	Was there anything that could be improved?	Quality of food. Food often overcooked (kept in heated trolleys too long).
Q15173712	Was there anything particularly good about your hospital care?	The consultant and lady doctor in ACU acted very well and were excellent after I had collapsed in a side room and was unconscious.
	Was there anything that could be improved?	In ACU I complained to a nurse monitoring me 3 times that I was seriously unwell. I told her I didn't know what was wrong but I was getting blurred vision, dizziness and couldn't breathe properly. She said my blood sugars and blood pressure was okay. She then closed the window because she was cold. I insisted that she opened the window and that she do something. She then reluctantly did my blood pressure, at this point she said it was very low and was going to fetch the doctor. At this point I fell to the floor unconscious. I feel that if she had acted when I told her, I would not have fallen on the floor unconscious on my own.
Q15173713	Was there anything that could be improved?	Very good hospital. God bless you all for looking after me.
Q15173719	Any other comments?	Over the past 4 years I have been admitted to hospital several times, usually for the same condition. I have been treated very well on every occasion.
Q15173720	Was there anything particularly good about your hospital care?	The doctor who looked after me was brilliant.
Q15173725	Was there anything that could be improved?	More nursing staff.
Q15173728	Was there anything particularly good about your hospital care?	All staff good, kind and professional.
	Was there anything that could be improved?	No.

Q15173731	Was there anything particularly good about your hospital care?	Felt well looked after from A&E through to the ward. 2 operations in 3 days. Quality of care very good throughout, considering it was an emergency.
	Any other comments?	Excellent follow up in orthopaedic department.
Q15173743	Was there anything particularly good about your hospital care?	Level of care was, in my opinion, exceptionally good throughout. I felt proud of my local hospital and the clear dedication of the staff who looked after me. Thank you.
	Was there anything that could be improved?	The nursing staff on my ward worked incredibly hard, even staying after the end of their shift to finish off. I know the NHS is short of money but in an ideal world I would like to see more staff to relieve that pressure a bit.
Q15173763	Was there anything that could be improved?	Yes, definitely need to improve the care provided in Bolton. I stayed in Salford Royal for two weeks and staying in Bolton was very disappointing, felt you get treated unfairly and no care shown.
Q15173777	Was there anything particularly good about your hospital care?	Treatment was well coordinated between specialist surgeon, physiotherapists and district nurse.
Q15173778	Was there anything particularly good about your hospital care?	Ten out of ten.
	Was there anything that could be improved?	Nope.
	Any other comments?	Ten out of ten.
Q15173786	Was there anything particularly good about your hospital care?	Well looked after.
	Was there anything that could be improved?	Communication between staff and family.
Q15180048	Was there anything particularly good about your hospital care?	All members of staff were very kind and helpful to me. They work very hard and I can't praise them enough.
	Was there anything that could be improved?	Two patients were very noisy. Shouting all night so that everyone else were unable to sleep.
Q15727166	Any other comments?	This questionnaire is not wholly appropriate to my situation. I was in CCU 'bed blocking' until I was transferred to Royal for an angiogram and subsequent bypass surgery.
Q15727177	Any other comments?	Not sure what ward it was on, but think it was the main nurse but she was stuck up and thinks my other half was my dad and the nurses from the other ward new it was and they told the ward who was picking me up.

Q15727201	Was there anything particularly good about your hospital care?	The staff that were working were very friendly, tried their best to keep me comfortable in the A&E.
	Was there anything that could be improved?	I think more staff are needed at the A&E and at the hospital (short staffed). I thought it was a very long waiting period to get me admitted to a ward and getting a bed. I was allocated a bed in the middle of the night, which was very frustrating for me.
Q15727214	Was there anything that could be improved?	I was informed that I would have to wait for up to 3 hours for medication to be distributed when I was being discharged or I could leave and buy my own painkillers which I did.
Q15729198	Was there anything that could be improved?	Yes, having a stoma nurse.
Q15730704	Was there anything particularly good about your hospital care?	It was as good as expected, under the circumstances. Not enough funding from the government, over-worked, under-paid as well. No respect for the good work you do or thanks.
	Was there anything that could be improved?	Not without proper funding from government. Funding treating people from abroad who leave without paying for treatment.
Q15730705	Was there anything particularly good about your hospital care?	Yes, a side room with it's own toilet and compassionate care.
Q15730714	Was there anything particularly good about your hospital care?	The way patients are received and looked after in A&E department on admission first class.
	Was there anything that could be improved?	More one to one care, not possible with staff workload!
	Any other comments?	Sorry about the late return for this survey.
Q15730736	Was there anything particularly good about your hospital care?	Most staff very good.
	Was there anything that could be improved?	Sack the cook! Would not feed the dog food given. Poor gent in next bed was unable to eat it.

Q15730739	Was there anything particularly good about your hospital care?	Everything was good!
	Was there anything that could be improved?	Not on my treatment. An Asian family of a patient thought the rules didn't apply to them (i.e. too many visitors including children bouncing on their relatives bed). Staff too frightened to say anything (racial fear). When I am on holiday abroad I've had to provide my own translation.
	Any other comments?	The only thing that could be improved is the attitude of some of the patients but that is not the fault of the NHS.
Q15734810	Was there anything particularly good about your hospital care?	ICU was very good, nurses very caring.
	Was there anything that could be improved?	Noise at night in HDU was very bad, particularly because I was next to nurses desk. No sleep allowed.
	Any other comments?	The hospital lost my glasses, they were reactalight and varifocal. I had to pay £200 for a replacement.
Q15734824	Was there anything particularly good about your hospital care?	Very understanding and non judgemental about mental health and self harm.
	Any other comments?	Better pay for nurses.
Q15738086	Was there anything particularly good about your hospital care?	I think everybody appeared to be doing there best.
	Was there anything that could be improved?	Yes, I thought you could do with a few more doctors.
	Any other comments?	I think the hospital staff as a whole are doing a great job under difficult circumstances.
Q16414091	Was there anything that could be improved?	Maybe told when I could get out of bed to wash myself.
Q16414124	Was there anything particularly good about your hospital care?	The staff were really helpful and polite, checking to see if I was ok. Offered me ear plugs at night due to a patient very loud/vocal on the ward next to me.
	Was there anything that could be improved?	One patient very distressed and vocal enough on the night. Should have been on a different ward (mental health issues). The nurses had to give her most of the care and were unable to calm her down. I didn't sleep all night due to this patient in distress.

Q16414128	Was there anything particularly good about your hospital care?	Yes. My GP referred me to a GP unit at the hospital where my bloods for suspected heart attack was taken and ECG and then I saw a consultant directly the results came back. The investigations were done by the same person and in the same room. I was given a cup of tea and everyone smiled and I was reassured.
	Was there anything that could be improved?	The nurses at the reception desk talked very loudly, but as everything else was so good, I didn't want to complain.
	Any other comments?	It was a really good service I received and less stressful than waiting in A&E.
Q16414161	Any other comments?	Being told I had cancer without my wife being there to support me.
Q16414163	Was there anything particularly good about your hospital care?	The hospital care was excellent. Physio was each day for the 3 months he was there.
	Any other comments?	However Ian's physio stopped after 4 weeks of coming home because there wasn't anymore they could do for him. So we haven't any treatment for him. He is in bed. Our friend visits every week with reflexology. We are devastated.
Q16414170	Was there anything particularly good about your hospital care?	All hospital staff brilliant, caring and helpful.
	Was there anything that could be improved?	Too long held in theatre waiting room. Needs to be better system so you go straight from ward to theatre. The waiting increased your nervousness.
Q16414208	Was there anything particularly good about your hospital care?	The staff, doctors and consultants could not have done more, the care was exceptional, their fastidiousness and dedication second to none. I felt lucky to have such a wonderful, professional and diligent team looking after me.
	Was there anything that could be improved?	The only thing to be improved was the food, it was pretty dreadful. I was in for stomach problems and the lack of something good to eat didn't help my condition.
	Any other comments?	I felt happy and confident in Ms Faulkner, she is diligent and quite exceptional in her field of work.
Q16414436	Was there anything particularly good about your hospital care?	Staff were brilliant and looked after me well i.e. doctors and nurses. Cleanliness of the hospital was good. Food was belting.
	Was there anything that could be improved?	Visiting times need to be longer.

Q16414456	Was there anything particularly good about your hospital care?	I was well looked after and treated like a human being.
	Was there anything that could be improved?	No.
	Any other comments?	Hope my next visit is just as pleasant. Thank you.
Q16414458	Was there anything particularly good about your hospital care?	I was only in 2 days after an accident and was looked after very well.
Q16414478	Was there anything particularly good about your hospital care?	The care I received was fantastic all round.
	Was there anything that could be improved?	I wasn't given the correct medication when discharged, therefore I suffered terribly with sickness until this was resolved.
	Any other comments?	Thank you Royal Bolton Hospital and my GP surgery for acting so quickly when I needed treatment for meningitis.
Q16414507	Was there anything that could be improved?	Communication!
Q16414518	Was there anything particularly good about your hospital care?	Very friendly staff on the wards.
	Was there anything that could be improved?	No.
Q16414520	Was there anything particularly good about your hospital care?	The first ward I was in was brilliant, C2?
	Was there anything that could be improved?	The next was a surgical ward, I think C3? The toilets were not very good. One broken. Loose seats and soiled seats at night, not a good ward to stay.
Q16414523	Was there anything particularly good about your hospital care?	The whole process was quite efficient.
Q16414563	Was there anything particularly good about your hospital care?	Because of my pain the nurses offered assistance at all times. They were excellent.
	Was there anything that could be improved?	Not to my knowledge, I was well cared for.
	Any other comments?	Yes I'd like to thank everyone from cleaner to specialist for my care. Including ambulance crew who were amazing. Thank you all.

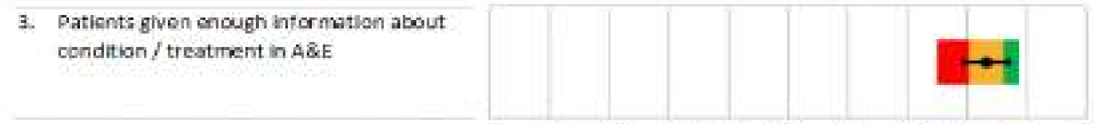
Q16414596	Was there anything particularly good about your hospital care?	Everybody does their best in somewhat difficult circumstances.
	Was there anything that could be improved?	I have had many visits to hospital, both planned, A&E, surgical medical and day case. Some areas definitely could be managed. Emergency units such as ITU, HDU, CCU are excellent, but it would seem the more well you get, the less staff there are to look after you. Which is difficult when you first come from high care to the wards. Makes you feel unheard and unsafe.
Q16414646	Was there anything that could be improved?	My operation was cancelled twice, I found this very distressing as I have never had an operation before and did not know what to expect.
Q16414666	Any other comments?	I was only in hospital 2 - 3 days each week over a month. I was grateful for what they did.
Q16414673	Was there anything that could be improved?	11 hours on an A&E unit is not acceptable. This causes more patient distress than most other things.
	Any other comments?	Doctors/nurses/all support staff work in a dedicated and supportive way, but are equally frustrated I am sure.
Q16414704	Was there anything that could be improved?	A lot - see answers to questionnaire.
	Any other comments?	I was admitted with respiratory condition to D1 via A&E and moved to B1 not respiratory ward, no explanation given. The ward was totally unsuitable for my condition. During my stay I did not get a respiratory doctor at all, was seen by a duty doctor who spoke to me as if I was five years old! Rude.
Q16414731	Was there anything particularly good about your hospital care?	Excellent in all areas.
Q16414738	Was there anything particularly good about your hospital care?	Everything was brilliant.
	Was there anything that could be improved?	No.
	Any other comments?	Thank you very much.
Q16414739	Was there anything particularly good about your hospital care?	Yes, the care and treatment, feeding (meal times) were always first rate which has always been the case in all of my admittances each and every occasion.
	Was there anything that could be improved?	Perhaps waiting time to be seen on admittance and on being discharged.
	Any other comments?	I thank all hospital staff who saw to me on every occasion.

Q16414740	Was there anything particularly good about your hospital care?	Everything was very good about my hospital care, I cannot find anything bad about it and I would like to thank everybody who looked after me.
	Was there anything that could be improved?	No.
Q16414742	Was there anything particularly good about your hospital care?	The staff on CCU were caring and helpful. You could not ask them anything, or they would tell you or your family when they came to visit.
	Was there anything that could be improved?	The food was very poor some days. Dad lost a lot of weight. Some of the choice he could not eat. Had to bring some meals into him.
	Any other comments?	On the other wards dad was on, sometimes not enough staff.
Q16414744	Any other comments?	I have been back to hospital three times and have no complaints what so ever.
Q16414754	Was there anything particularly good about your hospital care?	All I can say, if you have a hospital weekend stay I would willingly say, the way I was looked after was wonderful.
	Was there anything that could be improved?	If you don't mind me saying, but I think you should charge £2 + £5 a day for meals, if you where at home you would still eat.
	Any other comments?	Thank you so much.
Q16414759	Was there anything particularly good about your hospital care?	I was admitted to Royal Bolton Hospital with severe breathing problems and to D4 ward. All the staff were good though very overworked.
	Was there anything that could be improved?	More nurses would help. Less paperwork or clerical assistance. Since there seemed to be a lot of white collars just carrying papers and not doing much else.
	Any other comments?	I noticed some day staff stayed 2 hours over duty time to complete paperwork.
Q16414762	Was there anything particularly good about your hospital care?	Very good.
Q16414783	Was there anything particularly good about your hospital care?	I received well timed and considerate treatment. My hospital experience was dealt with in a very professional and caring manner throughout.
	Any other comments?	Apologies this is second form, I completely misplaced the last one in house alterations.

Q16414797	Was there anything particularly good about your hospital care?	The care on high dependency unit was excellent, staff were very attentive on both wards I was on.
	Was there anything that could be improved?	The speed of release prescriptions so people can go home quicker.
Q16414805	Was there anything particularly good about your hospital care?	It was alright until coming home and waiting for medication and an ambulance.
	Was there anything that could be improved?	Yes, it was a six hour wait in departure place in a chair after a hip operation - not good! Also when he got home he couldn't get upstairs to bed. He only had a Zimmer frame, we had to ask through our doctor for social services to send higher toilet seat and stick and a physiotherapist for home visits.
	Any other comments?	When they brought me home they did not put my medication in, and they asked if my wife could pick them up, which she couldn't, so they had to send it in a taxi.
Q16415050	Was there anything particularly good about your hospital care?	Some of the staff are very good, but when they are on from 7:30am until 7:30pm, you can tell they are overworked. Also you have a nurse one day, then different nurse the next day and they don't know about you.
	Was there anything that could be improved?	Yes, the food, it's awful and they didn't change the bed for 3 days, then I had to ask. You are only allowed 2 visitors, but if you are coloured they are allowed 4 or 5, it's too much when you're ill, the staff should tell them. The toilet was not clean, I got CD 2 years ago.

Initial analysis of 2017 Adult In-Patient Survey results

Example



*** Surveyed by Quality Health**

Section	No. of questions	Better than 2016	Worse than 2016	Better than other Trusts *	Worse than other Trusts*	Recommendations from 2016 survey	Recommendations From 2017 survey
The Accident & Emergency Department	2	2	0	2	0	Ensure more patients are given as much privacy as possible when being examined or treated in A&E	Continue to review the provision of regular and updated information given to patients about their condition and/or treatment in A&E
Waiting List or Planned Admission	3	2	1	1	2	Review the number of reasons for the no. of times there have been changes of admission dates by the hospital particularly where these occur twice or more	Review the reasons for the number of times there have been changes of admission dates by the hospital particularly where these occur twice or more. Continue action to reduce waiting times as far as possible.
All Types of Admission	1	1	0	0	1	Whilst shortage of beds is a national issue, the Trust should continue to monitor wait times and prioritise patients who are most at risk	Whilst shortage of beds is a national issue, the Trust should continue to monitor wait times and prioritise patients who are most at risk.

Section	No. of questions	Better than 2016	Worse than 2016	Better than other Trusts *	Worse than other Trusts*	Recommendations from 2016 survey	Recommendations From 2017 survey
The Hospital and Ward	11 (3 new)	4	4	8	3	Ensure patients are given help from staff when needed at meal times. Look at staff availability ad ensure suitable star are available when needed. Look at why so many patients are saying there are high levels of noise from other patients at night.	Further ensure that patients are given help from staff when needed at meal times. Look at staff availability and ensure that suitable staff are available when needed. Undertake spot checks to ensure this is happening. Take steps to ensure that patients moved at night are clear about why this change is necessary. Look at why some patients are saying there are high levels of noise from other patients at night. If necessary, measure noise levels to ensure that staff are aware of actual levels and can take action where needed. Look at why some patients still rate food as only fair or poor. Look at food quality, temperature, timing of food arriving and the operation of the catering contract.
Doctors	3	2	1	3	0	Ensure that patients are acknowledged and included in all conversations which are around them and their care.	Further address communication issues between doctors, nurses and patients through the training and induction of junior staff.
Nurses	5	4	1	4	1	Ensure that patients are acknowledged and included in all conversations which are around them and their care.	Review staffing levels and skill mix in the light of patient perceptions of nurse staffing levels.

Section	No. of questions	Better than 2016	Worse than 2016	Better than other Trusts *	Worse than other Trusts*	Recommendations from 2016 survey	Recommendations From 2017 survey
Your Care and Treatment	12 (3 new)	9	0	12	0	Investigate why some patients perceive that staff are not working well together and if this links to being given conflicting information. Some patients would like to be move involved in decisions made about their care. There was some criticism of privacy particularly when discussing conditions or treatment. Examine reasons for poor pain control on wards.	One in four patients would like to be more involved in decisions made about their care. Continue to review methods by which staff can involve patients in decisions about their care and treatment. Further ensure that patients know there is a member of staff to talk to if they have any worries or fears, or need emotional support.
Operations and Procedures	3	3	0	3	0	Prioritise the provision of information and explanations given to patients to ensure they are told as much as they want to be about what the operation will entail, before, during and after, including anaesthesia and its effects. Look at the best method for giving this information and if possible tailor to patient's needs.	Share and celebrate the success in this section of the survey. Look what more can be done to further ensure that patients are given information and explanations about how they would feel after the operation/procedure, including anaesthesia and its effects. Look at the best method for giving this information and if possible tailor to the patient's needs.

Section	No. of questions	Better than 2016	Worse than 2016	Better than other Trusts *	Worse than other Trusts*	Recommendations from 2016 survey	Recommendations From 2017 survey
Leaving Hospital	18	16	2	12	6	Review the extent to which patients feel involved in decisions about their discharge from hospital. Consider how the information which patients are provided with then they leave hospital can be improved including on important issues such as purpose pf medication, side-effects, how to take medicines and danger signs to look out for. Ensure staff ask about patients' home situation and take this into account when planning their discharge. Ensure all patients are given verbal and written information about who to contact if they are worried about their condition or treatment after returning home.	Review the extent to which clinical staff provide the patient's family with adequate information about caring for the patient The main reason for delays in discharge was patients having to wait for medication to take home. Review the way in which discharge medication is ordered and delivered to the patient with a view to reducing delays or improving efficiency of the process. Review process for giving patients clear and understandable information, both verbal and written, about what to do and what not to do after leaving hospital. Look at the provision and clarity of information that is given to patients about the medication side-effects to watch for and what to do if they are worried. Review how patients are given information about danger signals to watch for after discharge, and review the clarity of that information including what to do if they are concerned or worried.

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Section	No. of questions	Better than 2016	Worse than 2016	Better than other Trusts *	Worse than other Trusts*	Recommendations from 2016 survey	Recommendations From 2017 survey

Overall	5 (1 new)	4	0	4	1	Look for ways to improve patient feedback. Ensure information about how to complain is available to patients in hospital; staff are up to date on complaints procedures and bale to explain and easily communicate this to patients.	Look for ways to improve patient feedback, as many patients would like to be asked about their views on the quality of their care. Ensure that information about how to complain is available for patients in hospital; staff are up to date on complaints procedures and able to explain and easily communicate this to patients.
Total	63 (7 new)	47	9	48	15		

The staff made me feel good about myself. They were very supportive and friendly, I felt safe in their care.

The care I received was excellent, no complaints at all, everyone involved they were just 100%.

The A&E department were outstanding in the care given, and attention to detail. Ward staff were attentive and caring.

The staff couldn't do enough for me they were excellent.

The care I received was outstanding by all the staff, no matter how busy they were. Really enjoyed my stay.

I was treated by very friendly and efficient nurses and health care assistants, also with a lot of humour which made my stay much less stressful.

Overall it is a good hospital with great staff doing their best

The care from nurses was five star

Treated with kindness and care at all time by all staff.

Very satisfied. Thank goodness for the NHS.

The care given by all staff, friendly, efficient, responsive and concerned.

The doctors and nurses were exceptional

All staff and doctors were very attentive to my needs and very comforting to be around. Excellent.

The staff I met were exemplary.

To have such lovely staff like this makes you feel safe and well looked after. Can't give them enough

The Royal Bolton Hospital is the best hospital, the very, very best it doesn't need improving

My whole care in hospital was excellent. I have no grumbles at all about my treatment, it was first class.

I found the staff very helpful, treated me with dignity and respect at all times.

Very good hospital. God bless you all for looking after me.

Compliments from 2017 Adult In-Patient Survey

Agenda Item No : 15

Meeting	Board of Directors

Date	28th June 2018

Title	62 Day Cancer Performance and Guidance Change

Executive Summary	To provide a summary of the Trust's performance against the national waiting times standards, and to advise on guidance changes that will impact the way in which performance is calculated from July 2018.

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

62 Day Cancer Performance

Purpose of paper

This paper has been written to provide the Board with a summary of the Trust's performance in 17/18 against the current National Cancer standards and to inform the Board of changes to the way performance will be measured in 18/19 following the introduction of the National Allocation Policy (addendum publication to Cancer Waiting Times version 9). This has been broken down in to three elements:

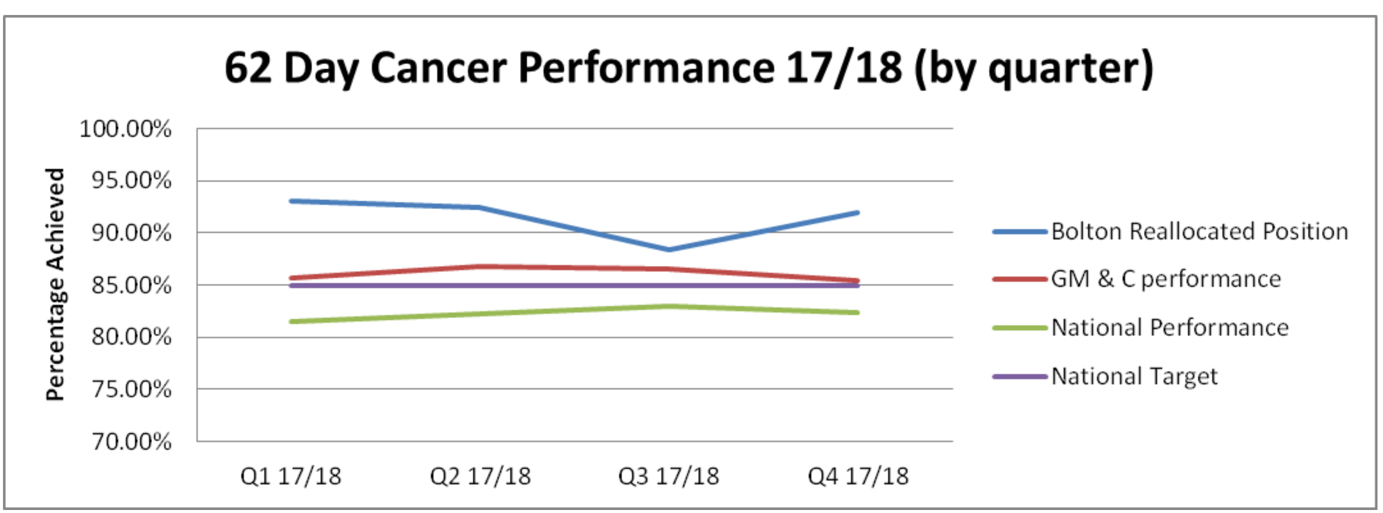
- Performance against the national Cancer Waiting Times (CWT) standards in the financial year 17/18
- Summary of the changes relating to the introduction of National Allocation Policy and the implications for the Trust
- Actions and future planning considerations

1. Performance against the national Cancer Waiting Times (CWT)standards in 2017/18

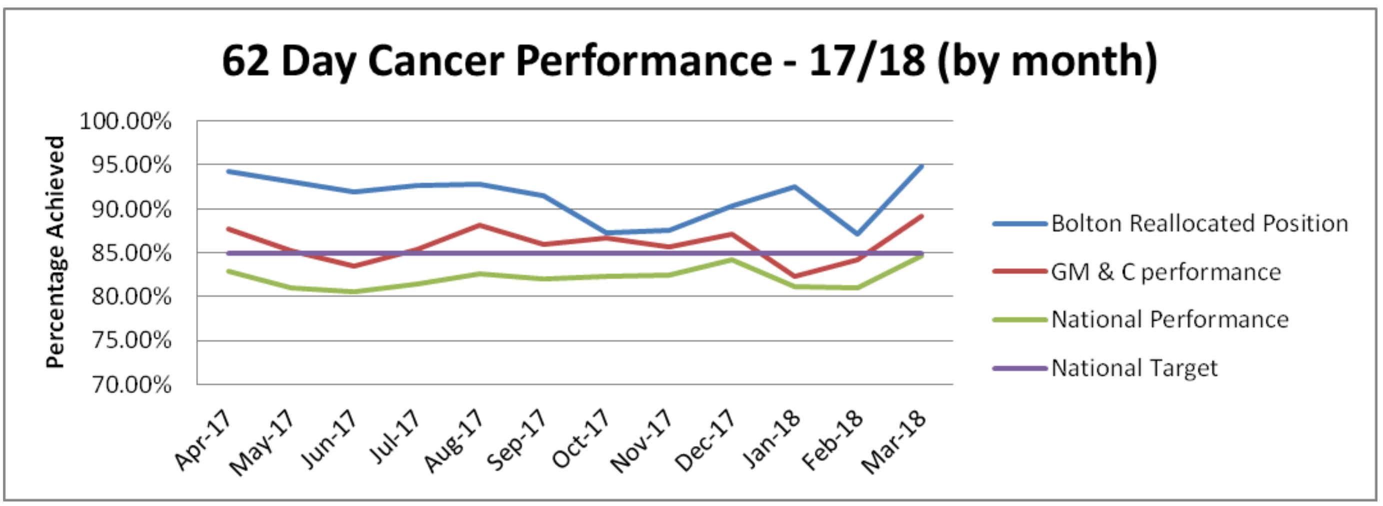
The Trust is managed against a range of national quarterly cancer standards. However, when discussing Cancer performance, the 62 day referral to treatment target is the key standard for all Trusts. This standard is defined as '**Maximum 62 days from urgent GP (GMP or GDP) referral for suspected cancer to first definitive treatment'.** The target is 85% of patients.

Bolton NHS Foundation Trust has successfully delivered the quarterly national 62 day standard consistently since Q3 2013/14.

The graph below highlights the Trust's excellent performance against this key standard compared with the Greater Manchester & Cheshire regional (GM&C) position, and the national position. This performance is a 're-allocated' position. This is based on a GM&C reallocation policy which has operated since 2011 across all 12 Trusts in the region. This is a patient centred policy with rules around the timely transfer of patients across the region for diagnostics and treatment and holds to account the Trust most responsible for the pathway breach.



Although individual monthly performance is not mandated, the Trust has achieved the target of 85% each consecutive month since September 2014.



2. **<u>Summary of the changes with the introduction of the Addendum to version 9 of CWT (national guidance) and the implications for the Trust</u>**

National Allocation Guidance was initially issued in April 2016. The rationale for this was to bring equity and reduce the overall number of patients waiting beyond 62 days for treatment. At this time GM&C already had a fully functional, patient focussed breach reallocation policy. GM&C Director of Operations responded to NHSE to state that we would not be adopting this guidance, in favour of retaining the existing policy. However, in March 2018, GM&C Trusts were informed that they would be required to adopt the national guidance, which is applicable from July 2018.

A number of regional teams and CCGs have expressed concern with the content of the Addendum. A further revision is now expected, but a timescale has not yet been confirmed. The changes are expected to be to the multi centre elements of the Addendum. The Trust is working to the implementation date set of 01 July 18.

Based on the expected revision to the new guidance the changes are described below.

<u>Two Centre Pathways</u>

At present, the majority of patient pathways span one or two Trusts. A two centre pathway is described as a first seen Trust who undertakes the diagnostic elements of the pathway and a treating Trust who delivers the patient's first definitive cancer treatment.

The following items describe the key changes in pathways involving two Trusts.

- The maximum transfer for treatment timeframe between Trusts will change from Day 42 and will now be Day 38. First seen Trusts (including Bolton) will lose 4 pathway days from these 2 centre pathways.

- Currently, compliance (patients treated in time) would be shared between the first seen and treating Trust, even if the patient is transferred after Day 42. From July, the first seen Trust will no longer receive any of the treatment compliance if the transfer is after Day 38 and the patient is treated in time. For Bolton, this will be a loss of treatment numbers.

- Patients transferred after Day 42 currently, who breach the 62 day standard, would be reallocated in full to the first seen Trust. Reallocation for late transfer (now Day 38) will only be applicable if the treating Trust delivers the first definitive treatment within 24 Days – otherwise both Trusts share the breach.

The above changes will result in GM&C organisations gaining breaches, and losing compliances (treatment in time); this is considerably different to the way organisations across GM&C currently calculate performance.

Three Centre Pathways (or pathways involving more Trusts)

Presently in GM&C there are a number of established 'traditional' three centre pathways. These pathways are defined as three centre when responsibility for the patient and their care is transferred to a 'middle Trust' who does not deliver the patient's treatment. Three centre rules also apply in situations when treatment plans change. I.e. patient for surgery at one Trust and now needs Oncology at another. Therefore making a three centre pathway with the surgical site the 'middle' Trust.

The allocation of breaches and compliances in the existing GM&C breach reallocation policy has defined transfer times in multi-centre pathways as Days 19 for the first two Trust, with patients needing to be at the Treating Trust by Day 38. This ensures breaches and compliances can be determined easily.

Currently compliance would be allocated 0.5 to the first seen Trust and 0.5 to the treating if the patient is treated in time, regardless of when they were transferred to the final Trust. In the expected update, the compliance would be allocated differently, in a more complex manner.

If the patient is transferred to the Treating Trust by Day 38, and treated in time the compliance will be split 0.5 to either the first or middle Trust – whichever has had the patient for the shortest time, and 0.5 to the Treating Trust. If the patient reaches the Treating Trust after Day 38 and is treated in time, the full compliance is allocated to the Treating Trust, regardless of who was responsible for the delay in the diagnostic phase.

Breaches are allocated on the same principals as compliances, but where the length of time spent in a Trust is the determining factor; the breach is allocated to the Trust who has had the patient the longest.

The way in which compliance and breaches will be allocated to Trusts will be an impact for Bolton; although the impact is less significant than in the Addendum issued in April. Predicting performance will not be as accurate due to the counting of days and agreements needed between Trusts, rather than a pre-determined date.

Implications for Bolton NHS Foundation Trust.

Two centre pathways

The implications are that the Trust would need to transfer patients out 4 days earlier than the present policy indicates.

Where collaborative work is currently undertaken between the first and treating Trusts to prevent a patient breaching when the patient has been sent over after the agreed pathway transfer date (such as waiting for formal sign off by the once weekly SMDT) Bolton would no longer get a share of the patient compliance (denominator).

Three (or more) centre pathways

The Trust is likely to gain some breaches and lose some treatments based on the new rules. However, the way in which multi- centre pathways is determined is unchanged, so this will only impact a small number of current pathways (approximately 15 patient pathways per quarter). See appendix A for example.

Resources

There will be resource implications for the cancer teams, in particular for the tracking teams as there are 12 additional data fields which require data to be collected, validated and reported on. There will also be resource implicaions for the Data Quality team as additional validation and checking will need to be carried out. A business case has been submitted, and is pending further discussion with the CCG over funding.

Performance

Based on a review of the 17/18 Q4 performance and applying the expected rule changes it is anticipated that the Trust would have gained 3 additional breaches and lost 15 compliances which equates to a 3.4% reduction in the overall performance. Although this would still have resulted in a pass for Q4, if the same principals had been applied to Q3, this quarter would have failed the standard.

Predicting performance for a month or quarter will be difficult, given that multi centre pathways will only be determined after the patient has been treated. This only represents a small amount of pathways but this will still have an impact on performance calculations, and the Trust may only know its true performance after upload (6 weeks after month end).

It should be noted that the Trust will be reporting against the current GM&C reallocation policy in Q1 and the new national allocation policy from Q2 onwards.

3. Actions and future planning considerations

With regard to the new guidance, Divisions are focussing on pathway changes which will help improve the speed in which patients can be transferred for treatment and to achieve the Day 38 standard (as opposed to Day 42). A significant element of this work is reducing the time to first attendance.

In addition to the Addendum to CWT V9.0 additional guidance is expected on the new 'Faster Diagnosis' standard. The standards and criteria have not yet been issued, but draft guidance suggested the target will be to diagnose or exclude cancer for 50% of patients by day 14 and 90% by day 28. Results from the national test sites are not yet available. It is anticipated that the introduction of this guidance will be heavily resource dependent. A full analysis will be conducted in due course. Recording is expected from April 2019 with compliance by April 2020.

Appendix A

Existing 3 centre Pathway example – compliance   (example Upper GI pathway)

Date	Pathway Date	Pathway element	Accountable Trust
Fri 30.03.18	Day 0	Patient referred	Bolton (28 days in total)
Tue 03.04.18	Day 4	Outpatient appointment	
Sat 07.04.18	Day 8	OGD (camera test)	
Tues 10.04.18	Day 11	CT	
Fri 13.04.18	Day 14	Patient seen in clinic for results Refer for PET and EUS (specialist tests undertaken at other Trusts)	Specialist tests at Salford and at Christie
Mon 16.04.18	Day 17	Formalise plan at Multi-disciplinary meeting (MDT)	
Thur 19.04.18	Day 20	PET scan performed	
Mon 24.04.18	Day 24	EUS performed	
Fri 27.04.18	Day 28	Sector MDT discussion. Outcome to be seen at Salford and plan for surgical intervention. Patient transferred to Salford	Salford (10 days in total)
Tues 08.05.18	Day 38	Patient no longer considered for surgery. Salford transfer patient to Christie for chemotherapy	Christie (22 days in total)
Fri 01.06.18	Day 60	Chemotherapy treatment given (first definitive treatment	

0.5 compliance Bolton (diagnostic phase), 0.5 compliance Christie (treatment phase)

3 centre Pathway example using new guidance – compliance (example Upper GI pathway)

Date	Pathway Date	Pathway element	Accountable Trust
Fri 30.03.18	Day 0	Patient referred	Bolton (28 days in total)
Tue 03.04.18	Day 4	Outpatient appointment	
Sat 07.04.18	Day 8	OGD (camera test)	
Tues 10.04.18	Day 11	CT	
Fri 13.04.18	Day 14	Patient seen in clinic for results Refer for PET and EUS (specialist tests undertaken at other Trusts)	Specialist tests at Salford and at Christie
Mon 16.04.18	Day 17	Formalise plan at Multi-disciplinary meeting (MDT)	
Thur 19.04.18	Day 20	PET performed	
Mon 24.04.18	Day 24	EUS performed	
Fri 27.04.18	Day 28	Sector MDT discussion. Outcome to be seen at Salford and plan for surgical intervention. Patient transferred to Salford	Salford (10 days in total)
Tues 08.05.18	Day 38	Patient no longer considered for surgery. Salford transfer patient to Christie for chemotherapy	Christie (22 days in total)
Fri 01.06.18	Day 60	Chemotherapy treatment given (first definitive treatment	

0.5 compliance Salford Foundation Trust (diagnostic phase) 0.5 compliance Christie (treatment phase)

Despite an identical pathway, Bolton do not receive any part of the compliance in the new rules as they had the patient longer in the diagnostic phase than the middle Trust.

As Bolton undertakes more of the pathway work than Salford, it would also be expected that Bolton will take the breaches for patients on these three centre pathways who are not treated in time. Bolton undertake a greater proportion of the pathway, this usually means the Trust has the patient for longer than the middle Trust. In the new guidance the breach is allocated to the Trust who had the patient the longest.

Agenda Item No : 16

Meeting	Board of Directors

Date	28 June 2018

Title	Updated Paper on 18 week RTT (Referral to treatment) – current position and backlog clearance

Executive Summary	To provide a summary of the Trust's performance against the National 18 week RTT incomplete standard and plans to deliver backlog clearance. Paper has been updated to include potential impact of cancellations on delivery of backlog clearance.

Previously considered by	Board of Directors May 2018

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

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

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

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

Referral to treatment recovery plan

May 2018

Background

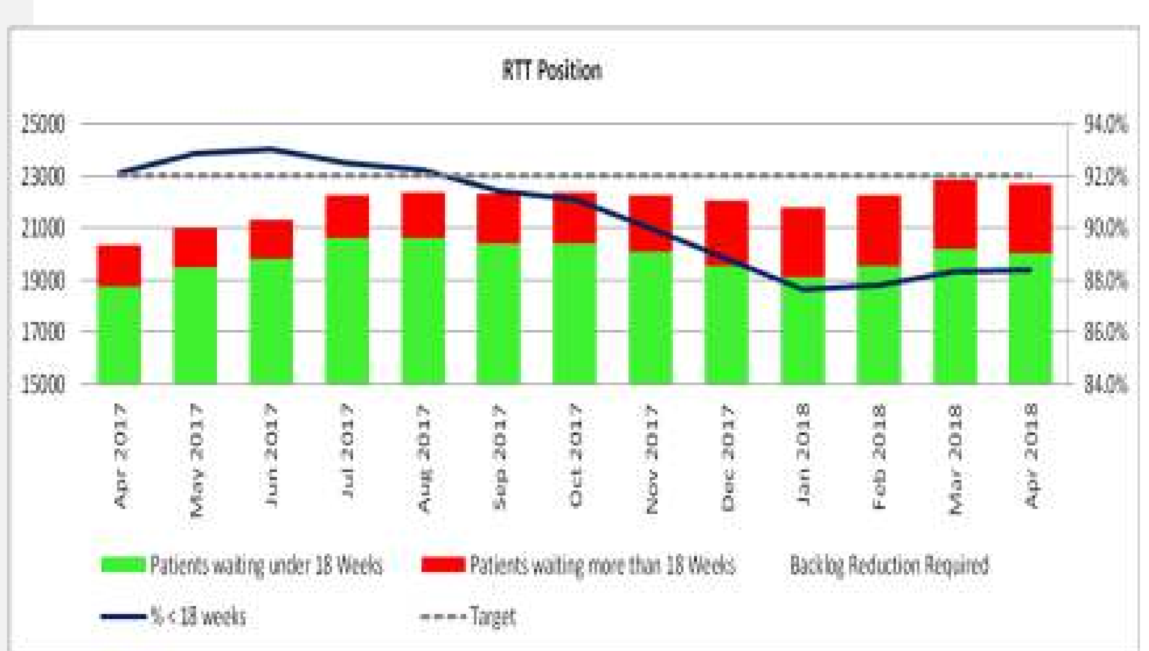
Nationally, meeting demand for elective services is becoming increasingly challenging in a context of finite resource (both finance and workforce) and the need to manage non-elective demand.

Increase in demand at specialty level combined with key capacity constraints has resulted in deterioration of the elective position, with the 92% incomplete standard (which requires 92% of patients awaiting treatment to have been waiting less than 18 weeks) having been failed from Sept 2017.

Winter pressures and cancellations as a result of national emergency planning guidance contributed to the further deterioration of performance. As such there has been significant growth in the backlog of patients from January 2018.

In addition, the cancellation of this level of elective activity has had an onward impact on the capacity available to treat those patients under 18 weeks as patients who were cancelled then needed to be treated in upcoming lists.

The figure opposite shows the current backlog as a proportion of the total waiting list and performance against the 92% incomplete standard.



Background continued

In recognition of the challenges faced the recent joint NHS England and NHS Improvement planning guidance does not stipulate adherence to the 92% incomplete standard. Instead it states simply that RTT waiting list should be no higher in March 2019 than it was in March 2018.

Both Bolton NHS Foundation Trust and NHS Bolton CCG are committed to returning to 92% in the current year and beyond. The purpose of this paper is to set out how this will be achieved. There are three broad steps that we will take to recover the referral to treatment position and sustain the improved performance and a detailed section on each:

1. **Validation of waiting lists (page 2)**
   Technical and clinical validation of the huge number of patients on the waiting list.
2. **Backlog clearance (pages 3-6)**
   There is a need to invest non-recurrent monies to clear the backlog. The CCG has committed additional resources of almost £1m to facilitate this. Discussions between the CCG and FT have identified a number of key priorities for this work:
   - Reducing clinical risk
   - Preventing 52 week pressure
   - Achieving 92% on compliance overall (but not by speciality)
   - Creating capacity for repatriation of NHS work done elsewhere in Bolton.
3. **Proposals for sustained improvement (page 7)**
   There are underlying capacity shortages in a number of specialties. This includes the specialties with the highest backlog numbers such as T&O, General Surgery and Ophthalmology. Work will be needed to reduce demand, increase capacity, and increase productivity in these areas.

1. Waiting list validation

Technical validation
As of 10 June there were 23140 patients on the waiting list. Of these 2435 are over 18 weeks. On average there are 2,000 patients added to the waiting list each week.

Currently, we are only able to validate part of the waiting list. If we wish to validate the PTL as a whole there are options to consider, both for the method of validation and the priority order.

Option 1 – use existing FT staff, both existing validators and those that have had prior experience of validation, to work additional hours to clear the list. Working on an average of 50 patients per day this would take 10 people 47 working days to achieve.

Option 2 – an external company is engaged to provide validation services. This option is currently being explored.

Option 3 – combination of internal staff, and shortfall made up from the use of an external company.

Next stages
- Option 3 being progressed with Bolton FT staff being offered additional hours at the weekend (no pay variation)
- Procurement supporting the engagement of an external organisation. References in place; currently undertaking system compatibility checks.
- Mini validation planned to target 150 patients from the PTL not normally validated to understand potential impact.

Clinical validation
In additional to the trust-wide technical validation work, specialties are exploring the validation of clinical notes by consultants through 'virtual' clinics.

2. Backlog clearance – page 1 of 3

Initial work on backlog clearance focused on six specialties based on the key areas identified overleaf. These are: cardiology, ENT, general surgery, gynaecology, ophthalmology, and trauma and orthopaedics (including the orthopaedic interface service).

Specialty	Backlog	Clearance plan	Cost	Trajectory	Status
Cardiology	▪ Now: 76, all non-admitted	▪ Scheduled additional 10 new patient clinics to create 100 additional outpatient slots to allow for growth. 8 follow up sessions have also been provisionally created to ensure patients can be brought back after diagnostics. Plan in place for Echo support	£22,755	97.1% by 30.09.18	GREEN – Viable solution, planning underway
ENT	▪ Now: 120 – 58 non-admitted – 42 admitted	▪ Locum in place delivering additional outpatient sessions to remove the non-admitted backlog, and bring waiting times down to enable patients going on to admitted pathways to be treated in time. Plan to reduce admitted backlog thorough session conversion	£72,881	95.7% by 30.09.18	GREEN – Viable solution, planning underway
General surgery	▪ Now: 434 – 146 non-admitted – 288 admitted	▪ Challenges with staffing weekend lists at RBH ▪ Focus on admitted pathways via Leigh ▪ Focus on addressing non admitted pathway as part of phase 1. ▪ Plan altered to reduce expected clearance numbers	£317,775	85.6% by 30.09.18	RED – Viable solution, off plan

2. Backlog clearance – page 2 of 3

Specialty	Backlog	Clearance plan	Cost	Trajectory	Status
Gynaecology	▪ Now: 85 – 46 non-admitted – 39 admitted	▪ Additional clinics: – 78 additional outpatient slots needed. Specialty arranging dates – Additional theatre lists commenced. 5 additional sessions still to be identified	£100,039	99.2% at 30.09.18	GREEN – Viable solution, planning underway
Ophthalmology	▪ Now: 646 – Plan to remove non admitted backlog of 740 (569 plus expected growth)	▪ Additional clinics commenced June 18 and are scheduled through to September	▪ Dependent on internal £109,075 vs outsourcing £128,130 ▪ Costs of outsourcing not yet clear	97.7% at 30.09.18	AMBER – Viable solution, requires additional information for approval
Trauma and orthopaedics Including orthopaedic interface service (OIS)	▪ Now: ▪ OIS: – 245 non-admitted ▪ Orthopaedics: – 165 non-admitted – 204 admitted	▪ Aim: no wait over 40 weeks by end of June ▪ OIS/non-admitted – 141 additional slots: – 4 additional slots per month for 4 months – 50 slots in June & 60 July 'Super Saturdays' ▪ Elective orthopaedics/admitted – 78 additional cases: – 3 upper limb cases in June – 71 lower limb cases from May to Sept – 4 F&A cases in May	▪ Arrangements through North West Surgical Services (NWSS). Work commenced June 18 ▪ OIS £47,723 ▪ Orthopaedics £361,704 ▪ Total £409,427		GREEN – Viable solution, planning underway

2. Backlog clearance – page 3 of 3

Specialty	Backlog	Clearance plan	Cost	Trajectory	Status
Plastic Surgery	▪ Now: 42 – 2 non-admitted – 42 admitted	▪ Additional theatre lists identified through July and August to remove the RTT backlog	£23,253	97.4% by 30.09.18	GREEN – Viable solution, planning underway
Haematology	▪ Now: 12 - 12 non-admitted	▪ Additional clinics: ▪ For 28 patients to include growth	▪ £20,210		AMBER – Viable solution, requires approval
Validation			▪ Internal £81,550 ▪ External 116,500		AMBER – Viable solution, requires approval
Oral Surgery	▪ Now: - 48 non-admitted - 76 admitted	▪ Additional theatre sessions. To deliver 48 additional admitted treatments			GREEN – Viable solution, planning underway

Impact of proposed backlog clearance

Specialty	Over 18 Weeks Non	Over 18 Weeks Adm	To clear by September (current Backlog + Backlog Growth)	Capacity Identified	% Assumption Clock Stopped	Reduction	Backlog as at 30/09/18	% Incomplete Performance as at 30/09/18	Backlog as at 30/09/18 (assuming 100% Clock Stops)	% Incomplete Performance as at 30/09/18 (assuming 100% Clock Stops)	Tolerance for 92%
General Surgery	146	288	217	100	100%	100	399	85.6%	399	85.6%	0
Urology	66	74	73			0	156	85.0%	156	85.0%	0
Trauma & Orthopaedics	165	204	352	78	100%	78	347	64.2%	347	64.2%	0
ENT	58	42	11	79	50%	40	71	95.7%	31	98.1%	61
Ophthalmology	569	77	470	760	75%	570	163	95.1%	0	100.0%	103
Oral Surgery	48	76	73	48	100%	48	98	88.9%	98	88.9%	0
Plastic Surgery	7	37	31	44	100%	44	5	97.4%	5	97.4%	10
Paediatric Surgery	4	13	4			0	17	88.9%	17	88.9%	0
Anaesthetics	4	2	0			0	5	98.2%	5	98.2%	17
General Medicine	69	3	8			0	78	95.1%	78	95.1%	50
Clinical Haematology	12	0	0	12	75%	9	1	99.4%	0	100.0%	12
Audiology	13	0	0			0	13	97.1%	13	97.1%	23
Palliative Medicine	0	0	0			0	0	100.0%	0	100.0%	0
Cardiology	72	4	2	100	52%	52	24	98.1%	0	100.0%	76
Dermatology	10	0	0			0	9	99.1%	9	99.1%	68
Neurology	2	0	1			0	2	93.8%	2	93.8%	1
Rheumatology	18	0	4			0	21	94.7%	21	94.7%	11
Paediatrics	7	0	6			0	12	98.7%	12	98.7%	60
Elderly Medicine	2	0	2			0	5	96.5%	5	96.5%	6
Gynaecology	46	39	15	85	100%	85	12	99.2%	12	99.2%	106
Oncology	2	0	2			0	2	97.6%	2	97.6%	5
OIS	245	0	76	141	100%	141	140	94.2%	140	94.2%	54
Respiratory Medicine	7	0	6			0	6	99.0%	6	99.0%	40
Endocrinology	4	0	1			0	5	94.8%	5	94.8%	3
Diabetic Medicine	0	0	0			0	0	100.0%	0	100.0%	13
Cardiothoracic Surgery	0	0	0			0	0	100.0%	0	100.0%	2
A&E	0	0	0			0	0	100.0%	0	100.0%	0
Total	**1576**	**859**	**1003**	**1447**		**1167**	**1597**	**92.7%**	**1316**	**93.9%**	**161**

Headline

If we implement everything in the 18-week backlog clearance plan outlined previously performance will increase to between 92.5% and 93.8% depending on the proportion of clock stops at first appointment.

Notes

- The cost of implementing everything in the backlog clearance plan is not yet known, assumptions added.
- Figures are based on current waiting list size, prior to any validation.
- Other specialities are continuing to explore options for the deliver of additional capacity
- Performance is estimated based on average clock stops. 100% clock stops at first appointment is estimated to increase performance by another 1%

Impact of cancellations (All specialties)

- Cancellation of regular elective activity will increase the risk of delivering the improvement needed. In order to manage this risk cancellations are monitored daily with full weekly oversight on numbers available to all teams. Additionally, the backlog is being monitored weekly for growth

- The plan assumes the backlog will reduce with support of the additional activity. The plan includes growth of the backlog last year and cancellations at the same rate. It is essential that the rate of cancellations does not exceed the previous year. Patients on the admitted pathway within this plan require day care bed provision in the main, or have protected elective capacity (T&O); this supports the management of cancellations for non-clinical reasons.

- There is currently slippage of 165 patients within the plan across all specialties. The backlog, progress and slippage will be monitored on a fortnightly basis.

The table below demonstrates the profile of cancellations included in the growth assumption.

	2016/17												2017/18												2018/19	
Month	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Jan-17**	**Feb-17**	**Mar-17**	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**
Cancelled Day Before No Bed Found	***42***	***42***	***52***	***24***	***15***	***44***	***64***	***83***	***43***	***32***	***29***	***49***	***72***	***28***	***23***	***37***	***15***	***39***	***24***	***42***	***41***	***16***	***26***	***37***	***15***	***20***
Emergencies / trauma			2		1								8	6	5	9	7	6	11	5	4	4	13	13	7	9
Other		4	3				6		1		2		14		3	9			6	5					3	
Ward beds unavailable	42	38	47	24	14	44	58	83	42	32	27	49	50	22	15	19	8	33	7	32	37	12	13	24	5	11
Cancelled Day Before Outright	***59***	***62***	***54***	***62***	***49***	***55***	***42***	***59***	***57***	***110***	***40***	***54***	***75***	***63***	***51***	***32***	***49***	***70***	***64***	***60***	***101***	***24***	***69***	***92***	***45***	***86***
Emergencies / trauma	23	12	12	16	18	23	7	16	7	6	7	19	28	29	16	16	22	20	17	6	23	2	24	36	16	24
Other	5	14	9	6	28	6	6	9	12	33	20	10	9	16	13	13	17	13	18	23	23	7	19	35	25	24
Ward beds unavailable	31	36	33	40	3	26	29	34	38	71	13	25	38	18	22	3	10	37	29	31	55	15	26	21	4	38
Cancelled on Day	***35***	***51***	***76***	***69***	***66***	***37***	***60***	***60***	***49***	***36***	***24***	***57***	***38***	***46***	***38***	***21***	***26***	***30***	***38***	***51***	***43***	***20***	***31***	***44***	***43***	***27***
Emergencies / trauma	1	8	6	1	1	1	3	1		1	1	4	3	24	2	4	3	2	2		5		3	7	7	2
Other	13	23	39	38	55	20	16	25	22	18	13	30	24	15	29	14	19	23	31	33	20	12	22	20	27	18
Ward beds unavailable	21	20	31	30	10	16	41	34	27	17	10	23	11	7	7	3	4	5	5	18	18	8	6	17	9	7
Total	**136**	**155**	**182**	**155**	**130**	**136**	**166**	**202**	**149**	**178**	**93**	**160**	**185**	**137**	**112**	**90**	**90**	**139**	**126**	**153**	**185**	**60**	**126**	**173**	**103**	**133**

Notes

Caveats

- Likely impact on support services to be evaluated on an ongoing basis to check support staff can firstly deliver the additional activity also needed and that secondly there is no impact DM01 or cancer performance
- General surgery and gynaecology currently looking at theatre dates. Delivery of activity will be subject to theatre, ward, day care, pre-op staffing. Dates currently canvassed with theatre teams. General surgery lists currently the biggest challenge.
- Additional activity for outpatients is subject to room availability, ABC, records and support services being able to deliver the activity. Very few staff on the bank so reliant on existing bank staff / substantive staff doing extra. Agency will be an option but quality may be substandard. Rate of pay for support services. All support staff to be offered overtime rate. There is a risk that regular work currently undertaken on the bank will be unfilled
- Radiology is unable to go to agency due to amount of agency radiographers already supporting department. Again, they will be reliant on existing staff. Theatres can use agency staff, but again there are limitations on the number that can be used on each shift. Some of the challenge will be dependent on when the clinicians across the different specialties are all looking to do their lists.
- We need to consider that some pre-op staff, theatres, recovery etc. will be working for NWSS directly. This limits the number of staff available to do other overtime to cover lists for other specialties. These staff are paid very well and may cause disharmony in the department and make it difficult to cover the other shifts.
- Pharmacy and therapies tried to use agency staff over winter. Again this was unsuccessful so they are likely to be reliant on internal teams doing more.

3. Proposals for sustained improvement

Initial discussions have revealed proposals for sustainable improvement in RTT performance in four key areas: endoscopy, general surgery, ophthalmology, and trauma and orthopaedics. An initial outline is set out below. Further detailed work is required in each area to develop, cost and make the case for any additional requirements.

Specialty	Issues	Current plans	Additional requirements	Notes
Endoscopy	▪ Workforce to fully staff new capacity ▪ Future growth in demand	▪ Plans in development to fully staff 4th room	▪ Business case to be developed for further capacity to manage future demand (5 or 6 rooms) by Alison Marsh by August 2018	
General surgery	▪ Pressure on colorectal outpatients ▪ Pressure on bowel surgery	▪ Address job plans of current consultants	▪ Business case for additional colorectal consultant to be developed by Alison March by August 2018	Need to coordinate business cases for additional consultants to take into account demand on theatres, other estates, anaesthetics and support services
Ophthalmology	▪ Annual capacity gap of ca. 10,000	▪ Additional capacity of 3,000 at Waters Meeting ▪ Capacity of 2,000 to be released by efficiency ▪ 5,000 gap remains	▪ Business case for additional consultant – CCG support in principle – business case by Lucy Currie by August 2018 ▪ Plans for further extension of non-medical roles ▪ Referral refinement/referral gateway explored	
Trauma and orthopaedics	▪ Pressure on lower limb surgery		▪ Business case for lower limb consultant to be developed by Sam Carney by June 2018 ▪ Alongside job plan review for trauma ▪ NB: CCG may look to BMI for additional capacity	

Agenda Item No

Meeting	Board of Directors
Date	Thursday 28th June 2018
Title	Sustainable seven-day services for transient ischaemic attack (TIA)
Executive Summary	The three Foundation Trusts (FTs) in the North West sector of Greater Manchester all provide services for TIA patients. Each provider is challenged in providing the seven-day services that TIA patients need to ensure that the number of them who go on to have a stroke is minimised as far as possible. The purpose of this paper is to present to the Bolton, Salford and Wigan Partnership a proposal for the development of sustainable seven-day TIA services across the partnership. A clinical working group from across Bolton, Salford and Wigan has come together, with the support of the Greater Manchester Stroke Operational Delivery Network, to begin to set out possible solutions and the work needed to develop them. The development of the working group has been coordinated by NHS Bolton Clinical Commissioning Group (CCG) on behalf of the partnership.
Previously considered by	

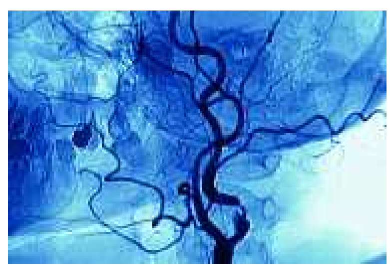
Next steps/future actions				
	Discuss	x	Receive	x
	Approve		Note	x
	For Information	x	Confidential y/n	

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

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

Prepared by	C. McPeake Deputy DDO AAC (Acting)	Presented by	Andy Ennis Chief Operating Officer

Sustainable seven-day services for transient ischaemic attack (TIA)



Version 0.3

June 2018

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Acronyms

CCG	Clinical Commissioning Group
FT	Foundation Trust
TIA	Transient ischaemic attack
WWL	Wrightington, Wigan and Leigh NHS Foundation Trust

1. Background

1.1. Transient ischaemic attack

Transient ischaemic attack (TIA) is defined as an acute loss of focal cerebral or ocular function with symptoms lasting less than 24 hours and which is thought to be due to inadequate cerebral or ocular blood supply as a result of low blood flow, thrombosis or embolism associated with diseases of the blood vessels, heart, or blood.

TIA is associated with a very high risk of stroke in the first month after the event and up to one year afterwards, and all suspected cerebrovascular events need to be investigated and treated urgently.

1.2. TIA services in Bolton, Salford and Wigan

The three Foundation Trusts (FTs) in the North West sector of Greater Manchester all provide services for TIA patients. Each provider is challenged in providing the seven-day services that TIA patients need to ensure that the number of them who go on to have a stroke is minimised as far as possible.

1.3. Purpose of this proposal

The purpose of this paper is to present to the Bolton, Salford and Wigan Partnership a proposal for the development of sustainable seven-day TIA services across the partnership.

A clinical working group from across Bolton, Salford and Wigan has come together, with the support of the Greater Manchester Stroke Operational Delivery Network, to begin to set out possible solutions and the work needed to develop them. The development of the working group has been coordinated by NHS Bolton Clinical Commissioning Group (CCG) on behalf of the partnership.

2. The case for change

2.1. National guidelines

In October 2016 the Royal College of Physicians published its fifth edition of the *National clinical guideline for stroke* on behalf of the Intercollegiate Stroke Working Party. The guideline includes a range of recommendations around the diagnosis and treatment of TIA but notes as a key recommendation that:

> 3.2.1A Patients with acute neurological symptoms that resolve completely within 24 hours (i.e. suspected TIA) should be given aspirin 300 mg immediately and assessed urgently within 24 hours by a specialist physician in a neurovascular clinic or an acute stroke unit.

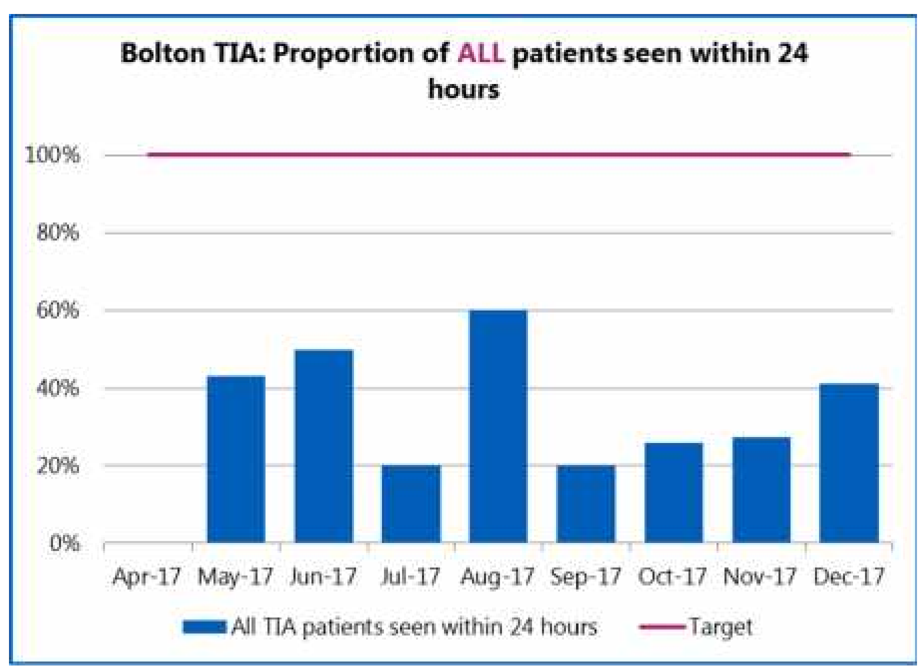
This is a change from the previous national guidance, which recommended that only those TIA patients considered *high-risk* should be seen within 24 hours.

2.2. Current performance in Bolton, Salford and Wigan

While our TIA providers deliver services that are largely in line with national guidelines, each of them has difficulty in meeting this key recommendation to ensure that all patients have the urgent specialist assessment that they need within 24 hours.

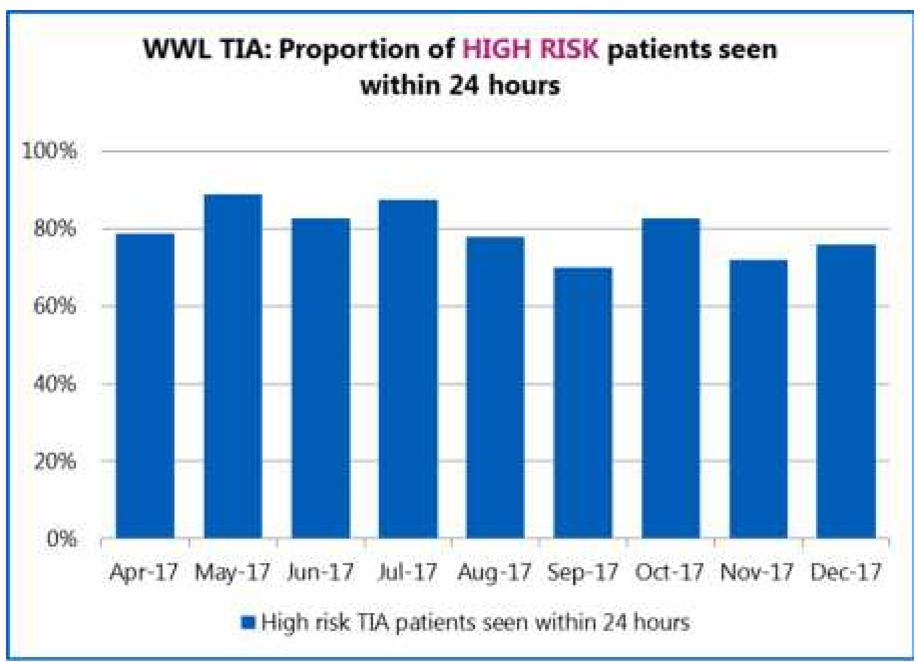
The performance of all three services in 2017/18 to-date is set out below.

The performance of the Bolton service has been regularly in the range of 20-50% of TIA patients being assessed within 24 hours. The best monthly performance was 60% in August 2017.



Salford FT is the only provider of services in the sector not to include TIA performance in the performance scorecard for its Board of Directors, with current information not provided

Wrightington, Wigan and Leigh (WWL) FT do include TIA performance in the board scorecard but continue to report performance against the old clinical guidelines. It reports the proportion of **high risk** patients assessed within 24 hours against a local target of just **60%**. The service reported performance regularly in the range of 70-90% of this limited cohort of patients over the year so far.



The RCP guidelines for the diagnosis and treatment of TIA state that **ALL** patients should be seen within 24 hours which is the standard that Bolton FT measure against – as yet this is not implemented at WWL.

2.3. Why performance is challenged

It is likely that there are improvements that can be made to the performance of the weekday TIA services in each of the three sector providers. Further data is needed to understand this. It is already clear though that the delivery of services at the weekend is a particular issue in all three providers. Only two sites run some weekend services currently but none of them have the workforce and diagnostic facilities (particularly seven-day Doppler ultrasound) to be able to deliver any or the same level of service that is offered on weekdays.

2.4. Our TIA providers and their weekend services

The number of patients that present with TIA at the weekend is low. A recent audit by the Greater Manchester Stroke Operational Delivery Network showed that 50 patients present with TIA every weekend across Greater Manchester. As Bolton, Salford and Wigan contain around 31% of the population of Greater Manchester this would equate to around 15 cases of TIA in our sector each weekend.

More detailed data are clearly needed and the three TIA providers were asked to conduct an audit during March and April 2018 of the referrals received over the weekend and the service that these patients receive, data is available from Bolton demonstrating that 15 patients were referred over a 10 weekend period – an average of 1.5 patients per weekend. The average time to be seen for

these patients was 96 hours. Data from WWL and SRFT has to date not yet been provided to the group. In the meantime the details of the TIA providers in Bolton, Salford and Wigan and the weekend services that they provide are set out below.

Weekend TIA services in Bolton, Salford and Wigan

	Bolton FT	Salford FT	Wrightington, Wigan and Leigh FT
Number of specialist stroke physicians	1 2 Urgent Care	8	1
Weekend clinics delivered by	None	On-call stroke physician	3 geriatricians
Weekend arrangements	None	Patients managed in ward setting on outpatient basis	Regular clinics staffed as additional clinical capacity
Capacity to deliver seven-day Doppler ultrasound	✓	✘ Currently use CT; option of commissioning Doppler service	✘
Seven-day administrative support	✘	✘	✘
Method of referral receipt	Email	Fax	Fax

Whilst SRFT have the largest number of Stroke Specialists they are currently not job planned to provide weekend TIA services above and beyond the current scope of their on call duties.

2.5. Clinical pathways

In addition to the lack of workforce and diagnostic facilities in individual providers to deliver seven-day TIA services it is also recognised that there are slight variations in the clinical pathways that are in operation across the sector. As part of the development of sustainable seven-day services the clinical pathways in place for each service should be reviewed and a single set of sector-wide clinical pathways should be agreed. This work should include agreed definitions of the workforce and skill mix required to deliver the pathway.

3. Options

3.1. Options for consideration

There are a number of options that could be pursued in order to develop sustainable seven-day TIA services across Bolton, Salford and Wigan. The five main options for consideration are set out below, with two of those options having distinct variants for consideration.

1. **Do nothing**, with individual sites continuing to strive to meet guidelines on their own
2. Develop a single clinical rota to deliver a weekend service on **three sites**

3a. Develop a single clinical rota to deliver a weekend service on **two fixed sites**
3b. Develop a single clinical rota to deliver a weekend service on **two sites on rotation**

4a. Develop a single clinical rota to deliver a weekend service on **one fixed site**
4b. Develop a single clinical rota to deliver a weekend service on **one site on rotation**

5. Create a **single seven-day TIA service** for Bolton, Salford and Wigan

Work is underway to start to understand the workforce that may be available across the sector to staff a single rota if this is the preferred option. When this is known the working group can begin to add detail to these options so that a proper appraisal can be made of them. As yet there is not enough information available across the sector to provide any recommendations.

3.2. Criteria for option appraisal

There are seven criteria by which these options will be appraised. First and foremost will be an assessment of each option's ability to **meet national guidelines and deliver seven-day services** and **make efficient use of the available resources**.

These two criteria, economy and safety in the table below, are therefore 'gateway' criteria. Only if an option meets the required threshold for economy and safety will it go on to be assessed in terms of five further criteria: access, workforce, flexibility, strategic fit, and timeframe. The assessment of each option will also be weighted according to the relative importance of the different criteria as set out in the table below.

Criteria for option appraisal

Criterion		Description	Weighting
1	Economy*	- Makes efficient use of available resources: funding, workforce, estates and equipment	20%
2	Safety*	- Meets, or has the potential to meet within an agreed timescale, the relevant care standards - Improves the resilience of the service	20%
3	Access	- Supports the principle of care closer to home and minimises the impact on patients and carers - Can be delivered with minimal disruption to current service delivery	15%
4	Workforce	- Creates a working environment that will encourage recruitment and retention - Provides a dynamic working environment that supports research and development	15%
5	Flexibility	- Meets future service requirements within the north west sector of Greater Manchester over a five-year period - Provides flexibility in function and capacity as demands change	15%
6	Strategic fit	- Aligns to the views of patients, the public and stakeholders	10%
7	Timeframe	- Provides a model of care that can be implemented and yield benefits on a short to medium term basis (within three years)	5%

**Gateway criteria*

Through the upcoming audit the clinical and operational teams will understand better the practical considerations that will need to be taken into account when implementing a service change in future. This might reveal other factors that need to be included in the final options appraisal.

3.3. Option appraisal

The template for the ultimate assessment of the different options is set out in the appendix.

3.4. Financial appraisal

In addition to the option appraisal, work will be undertaken to understand the cost implications and the financial implications across the sector. This work will take into account the differences in the contract models in place between providers and commissioners across the partnership.

4. Recommendation and next steps

The timescale for a model to be fully developed is currently estimated to be six to nine months. The next meeting of the clinical working group is currently being determined with support from the NW sector.

It is recommended that the Bolton, Salford and Wigan Partnership note the initial work carried out to date and approve the continuation of this work in line with the plans highlighted in this paper.

Appendix – option appraisal template

	Economy*	Safety*	Access	Workforce	Flexibility	Strategic fit	Timeframe
1. Do nothing, with individual sites continuing to strive to meet guidelines on their own							
2. Develop a single clinical rota to deliver a weekend service on **three sites**							
3a. Develop a single clinical rota to deliver a weekend service on **two fixed sites**							
3b. Develop a single clinical rota to deliver a weekend service on **two sites on rotation**							
4a. Develop a single clinical rota to deliver a weekend service on **one fixed site**							
4b. Develop a single clinical rota to deliver a weekend service on **one site on rotation**							

**Gateway criteria*

Agenda Item No : 18	
Meeting	Board of Directors

Date	28th June 2018

Title	Sickness Absence Update Report - 01 Jun 2017 to 31 May 2018
Executive Summary	1. The purpose of this sickness absence report is to update the Trust Board on the current sickness absence rate, together with the actions that have been taken throughout the Trust to reduce sickness absence rates to an acceptable tolerance level. This paper follows the paper presented to Trust Board in February, 2018. 2. The Trust sickness absence rate currently sits at 4.72% (May, 2018). This is a significant reduction from January, 2018 when the sickness rate went as high as 6.14%. Colleagues will note the positive trend line indicating an improving position. Trajectories to deliver 4.2% on a sustained basis are included within the paper. 3. Reducing sickness absence continues to be a high priority within the Divisions. It is recognised that low sickness rates are essential to maintaining safe staffing and reducing the associated cost of staff absence which will help the Trust achieve financial stability.
Previously considered by	Not Applicable

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:	Jane Seddon James Mawrey	Presented by:	James Mawrey

Introduction / Summary

1. The purpose of this sickness absence report is to update the Trust Board on the current sickness absence rate, together with the actions that have been taken throughout the Trust to reduce sickness absence rates to an acceptable tolerance level. This paper follows the paper presented to Trust Board in February, 2018.

2. The Trust sickness absence rate currently sits at 4.72% (May, 2018). This is a significant reduction from January, 2018 when the sickness rate went as high as 6.14%. Colleagues will note the positive trend line indicating an improving position. Trajectories to deliver 4.2% on a sustained basis are included within the paper (Appendix 1).

3. Reducing sickness absence continues to be a high priority within the Divisions. It is recognised that low sickness rates are essential to maintaining safe staffing and reducing the associated cost of staff absence which will help the Trust achieve financial stability.

Performance and Underlying Causes

1. Appendix 1 shows the Trust sickness absence performance, together with the trajectories that were set in order to deliver the tolerance level of 4.2% by September, 2018. Colleagues will note the considerable improvement that has been made since January, 2018.

2. The most up to date benchmarking we have for sickness absence is for February 2018, which is taken from the Ewin tool that forms part of the ESR system (HR NHS Information system). As follows:-

Greater Manchester	Jan	Feb
The Christie NHS Foundation Trust	4.5%	3.9%
Pennine Acute Hospitals NHS Trust	5.0%	4.0%
Stockport NHS Foundation Trust	4.5%	4.1%
Salford Royal NHS Foundation Trust	5.2%	4.4%
Manchester University NHS Foundation Trust	5.6%	5.0%
Pennine Care NHS Foundation Trust	6.1%	5.1%
Bolton NHS Foundation Trust	6.2%	5.1%
Wrightington, Wigan and Leigh NHS Foundation Trust	5.9%	5.2%
Tameside Hospital NHS Foundation Trust	5.9%	5.3%
GM West Mental Health NHS Foundation Trust	7.0%	6.4%

3. The sickness absence rate per Division is detailed in Appendix 1 & 3. Colleagues will note that sickness absence rates have been falling throughout the Trust, however, worthy of note is that the Adult Acute Division and Community Services Division remain a cause for concern. To this end the Trust has recently agreed to introduce an 'Attendance Matters Team' approach within these Divisions for a 6 month period. After this date it is anticipated that this additional support will have had a material impact with the Division moving off an 'escalation' approach. Further details of the activities the Attendance Matters team will be undertaking can be found at Appendix 2.

4. The Workforce & Organisational Development team undertake a deep analysis as to the reasons for staff taking time off sick in order to identify where to focus their interventions. High levels of stress & anxiety reported has fluctuated and remains high. We will continue to review the support within our health and well-being offer to support staff suffering from stress and anxiety.

Actions taken since last update to Trust Board in February, 2018.

The Workforce Directorate have worked with the Operational teams and Staff-side Partners to ensure a sharpened focus on the management of sickness. Actions since the last Board update include (non-exhaustive):-

1. Divisional trajectories have been set at both a Trust and Divisional level. Performance against these trajectories are monitored at Trust level (via Workforce Assurance Committee) and at a Divisional level (via Divisional Management Teams). Please see Appendix 1.

2. Linked Issues: There are a number of issues which were impacting on the levels of sickness absence and these linkages have been reviewed.

   a. Inconsistency of application of the attendance management policy across the trust. The Workforce & Organisational Development team undertake 'spot audits' within the Divisions to review delivery against the Trust policy. Findings of these reviews are then escalated at both Divisional and Trust level. Where necessary corrective action is taken.
   b. Deployment protocols & e-rostering. Work is underway to ensure the Trust is maximising the benefits of e-rostering (both Medical and Non-Medical staff). For example a more effective approach to levelling of annual leave will likely have a more positive impact on sickness absence rates.
   c. To support the Divisions in maximising their roster the Workforce team now produce a regular E Roster Dashboard that breaks down by ward area who is evidencing positive/negative poster management. Findings are then escalated at both Divisional and Trust level. Where necessary corrective action is taken.
   d. The Trust has improved the usage of the Exit Interview process to support in a triangulation of key workforce data. All staff leavers will be asked to complete an Exit Interview and the findings are shared at a Divisional and Trust level.
   e. A detailed attendance management report is produced each month to enable divisions to understand the concerns within their areas. These report include quarterly performance data on the deep dive activity and monthly audit reports in relation to sickness absence compliance.

3. Training for Managers: It was noted in the last meeting that to support better implementation of the attendance management policy then additional training will be provided. The operational teams have been very receptive to these training programmes with 193 managers/leaders attending in a four month period.

4. Deep Dives on Long Term absences: The Head of Human Resources and her team have reviewed all long term sickness cases. In January, 2018 there were 162 staff off on long term sick and this has reduced to 115, with the lowest level being 82 in April. The Head of Human Resources now produces a weekly report for the Director of Workforce detailing the number of long term absences by Division, along with any supporting action that is being taken.

5. Quarterly Deep Dive on Top Sickness Areas: The two highest sickness absence areas within each clinical area are identified and a deep dive report has been developed. A performance improvement plan has been compiled by the Head of Human Resources, Divisional Human Resources Manager and the operational leads to target improvement and support within these areas. In areas where this approach has been taken then sickness absence has reduced on average by 1.7%.

6. Rehabilitation & redeployment: Pleasingly it appears that the Trust has been more pro-active in identifying were staff members may be able to return to work earlier - in a role with reasonable adjustments being made or redeployment opportunities offered (both temporary/permanent). It has not been possible to be able to quantify those staff who have returned earlier than otherwise would have without these intervention but this has been 'felt' to support the reduction in long term absences noted above.

7. Occupational Health Service: A review of the Occupational Health service (provided in a Joint Venture Partnership with WWL and LTH) has been undertaken and the findings have been presented to the Workforce Assurance Committee in June. A range of actions / challenges have been agreed with a view to further improving the service offered. Not withstanding this review (and subsequent actions), since the last meeting the Trust has already increased the hours of input from the Occupational Health team to focus on stress/anxiety of our workforce; introduced a Financial Well-being Programme (noting that a number of our staff are absent due to stress caused by financial concerns) and we are in the process of procuring an Employee Assistance Programme. Colleagues will recall that Employee Assistance programmes offer confidential advice and support for personal problems that might adversely impact work performance, health and well-being. EAP generally include assessment, short-term counselling and referral services for employees and can be offered via phone, electronic communication and face to face.

8. Pro-active Health & Wellbeing support: This is an area that has not progressed as well as would have ben anticipated following the last meeting. Further work is required and the Workforce Assurance Committee will receive a Health & Wellbeing plan in Quarter 3. This will set out the steps that will be on this critical agenda item (e.g. alcohol reduction, obesity awareness, social clubs, exercise programmes and more) along with the monitoring and governance arrangements.

Sustaining the improvement in sickness absence rates

1. Whilst Board members may be encouraged about the positive trend in sickness absence rates, it will be critical that the Trust now builds on this success by ensuring we have a range of mechanisms in place to support our staff to have / sustain positive attendance. The

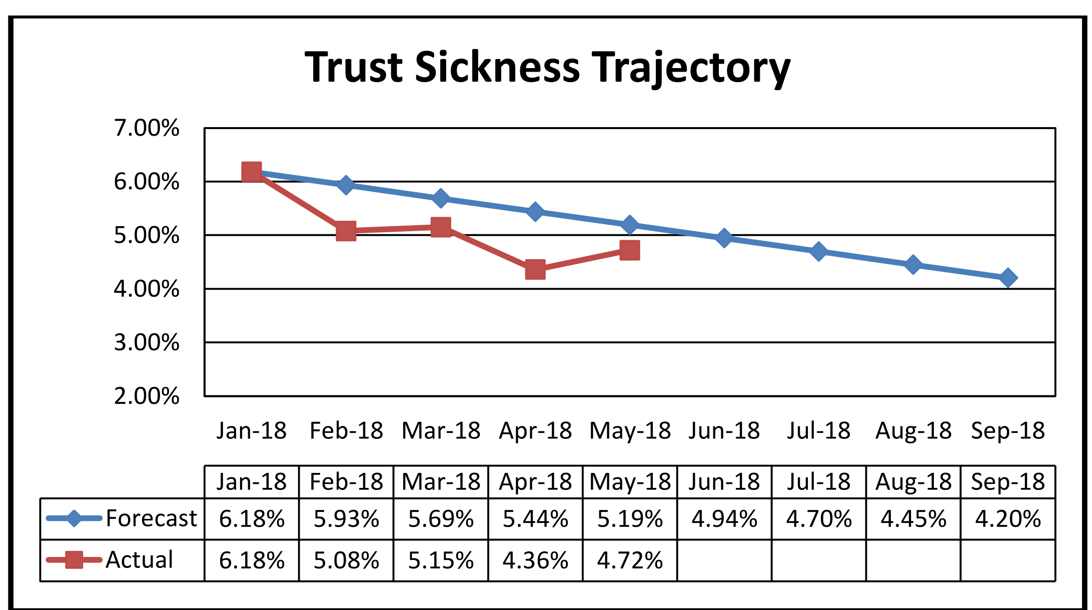
Director of Workforce will be responsible for ensuring there is a sustained focus on attendance levels by both the Workforce team and Operational colleagues.

Recommendations

1. The Trust Board is asked to:
    a. Note the details of the Sickness Absence Exception Report.
    b. Note the actions that have been taken to support a reduction in sickness absence levels. The Trust Board will be updated on the progress being made via the Integrated Performance Dashboard and the Workforce Assurance Committee Chair's report.
    c. Highlight any specific additional assurance / workforce information required.

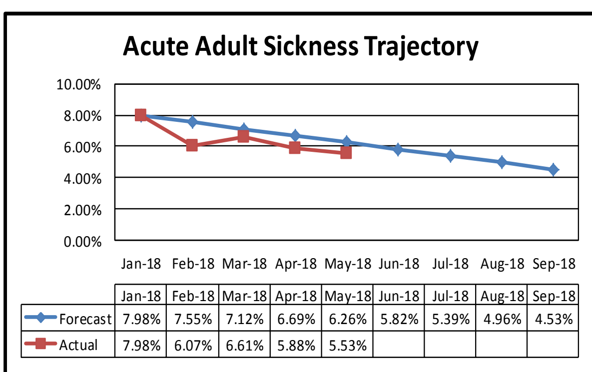
Appendix 1 – Trust sickness absence trajectory

Sickness Absence - Trust Trajectory

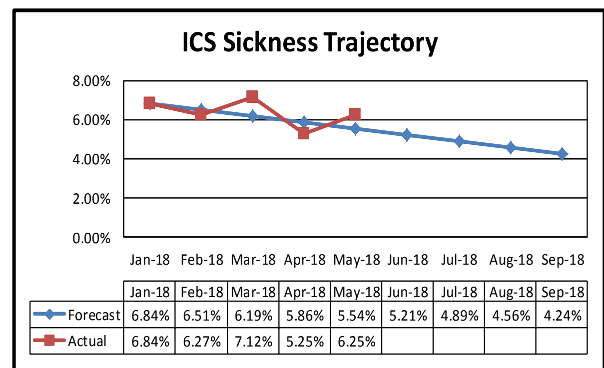


	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Forecast	6.18%	5.93%	5.69%	5.44%	5.19%	4.94%	4.70%	4.45%	4.20%
Actual	6.18%	5.08%	5.15%	4.36%	4.72%				

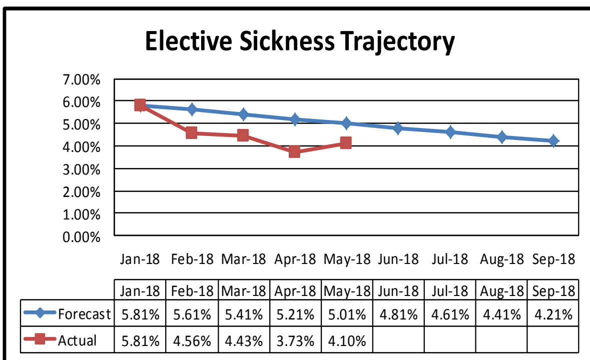
Clinical Divisions



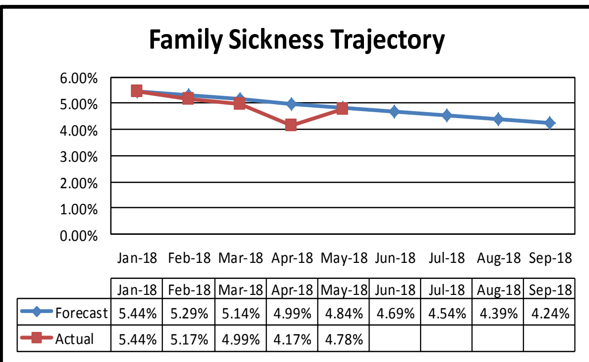
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Forecast	7.98%	7.55%	7.12%	6.69%	6.26%	5.82%	5.39%	4.96%	4.53%
Actual	7.98%	6.07%	6.61%	5.88%	5.53%				



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Forecast	6.84%	6.51%	6.19%	5.86%	5.54%	5.21%	4.89%	4.56%	4.24%
Actual	6.84%	6.27%	7.12%	5.25%	6.25%				



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Forecast	5.81%	5.61%	5.41%	5.21%	5.01%	4.81%	4.61%	4.41%	4.21%
Actual	5.81%	4.56%	4.43%	3.73%	4.10%				



	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Forecast	5.44%	5.29%	5.14%	4.99%	4.84%	4.69%	4.54%	4.39%	4.24%
Actual	5.44%	5.17%	4.99%	4.17%	4.78%				

Appendix 2

Role and Responsibilities of the Attendance Matters Team*

**The Attendance Matters Team do not replace Management accountability for managing team sickness absence. It is a support service to support managers.*

- Take first line calls for all teams on sickness absence escalation via the dedicated phone line.
    - Discuss the reason for absence to provide guided support in relation to:
        - Self Care (send out help leaflets via email/post
        - Discuss visiting pharmacy/GP
        - Provide guidance from recognised Health sites
        - Sign post health and well being support available via the trust
            - Well being partners
            - Physio
            - VIVUP Portal
            - Employee Assistance Programme
- Report Absence
    - Send via a dedicated divisional e-mail address monitored by divisional admin who will inform the business area, employee's line manager will be copied into this.
    - Record Absence direct onto e-roster and ER Tracker

- Follow up calls to all sickness absence call received out of hours to ensure recording of absence is accurate and to offer employee health and well-being support and guidance.

- Daily follow up calls with staff on short term absence.

- Liaise with line manager to ensure that RTWI have been conducted

- Support the completion of fast track referrals to OH or physio where appropriate.

- Support redeployment where appropriate.

- Liaise with HRA team and manager to support reasonable adjustment conversations.

- To support the completion of sickness absence audits

- Develop sickness absence timelines for sickness cases where appropriate.

- Consistent conversations with all staff (scripts currently being developed)

- Nurse triage/advice for complex cases/conditions.

Appendix 3

Sickness Absence Exception Report - 01 Jun 2017 to 31 May 2018

Divisional (12 month)

	Headcount as at May 2018	Cumulative %	Month only %	Monthly Sickness Trend Line	Lost Productivity	Short Term %	Short Term Trend line	Long Term %	Long term Trend line
Trust	5346	4.99%	4.72%		£6,935,975	1.52%		3.47%	
Acute	1176	6.18%	5.53%		£1,678,541	1.95%		4.23%	
Elective	1947	4.56%	4.10%		£2,293,584	1.42%		3.14%	
Family	1167	4.85%	4.78%		£1,605,250	1.40%		3.45%	
ICS	642	5.77%	6.25%		£1,002,160	1.50%		4.27%	
Corporate	414	2.72%	2.95%		£356,439	1.03%		1.69%	

Staff Group (12 Month)

	Headcount as at May 2018	Cumulative %	Month only %	Monthly Sickness Trend Line	Lost Productivity	Short Term %	Short Term Trend line	Long Term %	Long term Trend line
Add Prof Scientific and Technic	154	3.77%	3.97%		£174,105	1.31%		2.46%	
Additional Clinical Services	1231	7.27%	7.30%		£1,512,557	2.20%		5.06%	
Administrative and Clerical	1042	4.62%	4.06%		£993,695	1.36%		3.26%	
Allied Health Professionals	449	3.12%	3.89%		£480,811	1.29%		1.83%	
Estates and Ancillary	7	13.12%	23.58%		£14,411	2.15%		10.98%	
Healthcare Scientists	113	2.61%	3.39%		£109,278	1.09%		1.51%	
Medical and Dental	358	1.61%	1.60%		£350,225	0.49%		1.12%	
Nursing and Midwifery Registered	1981	5.13%	4.42%		£3,299,654	1.49%		3.64%	
Students	11	0.58%	0.00%		£1,240	0.05%		0.53%	

Top 5 Absence Reasons (12 Month)

Absence Reason	Total No of episodes	Absence Reason	Short Term Episodes	Absence Reason	Long Term Episodes
Gastrointestinal problems	**2,090**	Gastrointestinal problems	**2,001**	Anxiety/stress/depression	**438**
Cold, Cough, Flu - Influenza	**1,562**	Cold, Cough, Flu - Influenza	**1,503**	Other musculoskeletal pro	**147**
Anxiety/stress/depression	**812**	Chest & respiratory problems	**425**	Gastrointestinal problems	**97**
Chest & respiratory problems	**469**	Headache / migraine	**383**	Injury, fracture	**89**
Other musculoskeletal problems	**415**	Anxiety/stress/depression	**374**	Back Problems	**83**

Agenda Item No: 19

Meeting	Board of Directors
Date	28th June 2018

Title	Workforce Annual Report			
Executive Summary	The purpose of the report is to update the Board on the progress made in 2017/18 in respect of the Workforce agenda. The report shows that the Trust made some progress towards achieving some of its Workforce targets as well as continuing to embed the values that underpin staff and patient experience. Board members will note that despite improving trajectories significant work is required in this key work area in 2018/2019 and beyond.			
Previously considered by	Not Applicable			
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:	Carol Sheard, Jane Seddon, Paul Henshaw, Carol Leblanc, James Mawrey	Presented by:	James Mawrey

1. Introduction / Summary

1.1 The Workforce Annual report provides an annual update on the performance against key metrics for the 2017/2018 year, colleagues will note that where performance has not been delivered an overview (non exhaustive) is provided on the actions that are being taken.

1.2 The report supplements separate reports to the Trust Board on progress against the staff engagement agenda; attendance management as well as Trust reporting against Workforce key performance indicators and workforce characteristics. Deeper analysis on Workforce & OD is managed via the Workforce Assurance Committee.

1.3 The report shows that the Trust made progress towards achieving some of its Workforce targets as well as continuing to embed the values that underpin staff and patient experience. The key matters (non-exhaustive) to note are:

1.3.1 Trust sickness absence during 2017/18 remained above the target of 4.2%. Sickness peaked as high as 6.18% in January and ended the year at 5.15%. Further details of actions in place to manage attendance (including trajectories) are contained within a separate report. The current sickness position is 4.36% (April, 2018) and colleagues will note the positive trend / improvement.

1.3.2 Appraisal compliance ended at 82.8% (March, 2018) against a target of 85%. The current appraisal position is 84.5% (April, 2018) and colleagues will note the positive trend / improvement.

1.3.3 Mandatory training compliance ended at 89.9% against a target of 85%. The current mandatory training position is 89.9% (April, 2018).

1.3.4 Statutory training compliance ended at 92.5% against a target of 95%. The current statutory training position is 93.0% (April, 2018).

1.3.5 The 2017 National Staff Survey, showed the Trust had maintained levels of staff engagement and demonstrated a positive performance against comparator Trusts. Further details of actions in place to improve staff engagement levels are contained within a separate report.

1.3.6 Trust values continues to be embedded in HR processes including recruitment, induction, training and appraisal. The staff survey has highlighted areas for further embedding and role modelling of the values and these are being addressed through local action plans.

1.3.7 The Trust continues to monitor the key characteristics of the workforce such as proportions in different staff groups, pay band, age, length of service, protected characteristics, and turnover. Divisional level workforce planning has taken place during 2018 which will be developed further, to integrate finance, activity and workforce planning to support forecasting. Colleagues will be aware that many of these key workforce characteristics are reported in further detail at the Trust Board or Workforce Assurance Committee (e.g. WRES will be coming to the Trust Board in August, 2018).

1.3.8 Overall staffing numbers reduced by 138.2 wte since March 2017 however, when the transfers out due to the creation of IfM are taken into account, there has been an overall increase of 116.7wte. This mainly consists of Nursing and Midwifery (number) and Additional Clinical Services (number) staff groups. There are 7 more Consultants in post than a year ago..

1.3.9 The ‘take up’ of Apprenticeship within the organization did not meet the level (131 apprentices) required under the Apprenticeship Levy. The current apprentice number is 64 and colleagues will note that trajectories have been set to deliver this number by September, 2018 and more recently a positive trend / improvement is being seen.

1.3.10 Agency spend remains a real challenge within the organization. £10,282,045, against an NHSI externally driven target of £6,189,338 (variance of £4,091,620).The reduced sickness absence rates, reduced vacancy rates, closure of escalation wards should be resulting in a downward trend in Agency Spend but as yet this 'knock on' effect has not yet had the material impact. The Finance Committee and Workforce Assurance Committee recently received an update on the steps that are being taken to have a sharpened focus in this area. Further reports being provided to both Committees in July.

1.4 Whilst the report notes that some progress has been made on the Workforce & Organisational Development metrics, and indeed the feedback throughout the organization is becoming more positive regarding the Workforce & OD support to the Divisions, there remains a need to review all the Workforce & Organisational Development activities into a coherent Strategy which sets out a clear vision for our Trust. It is clear that the People Strategy requires a fundamental review and a fresh Workforce & Organisational Development Strategy produced with clear actions, monitoring & governance arrangements in place. This will support this critical agenda and help the Trust in ensuring that we have an effective, sustainable and affordable workforce which puts patients at the heart of everything we do. The Director of Workforce will engage the Trust over the coming months on this Strategy with a view to seeking the Trust Board sign off in August, 2018.

1.5 The Trust Board is asked to:

1.5.1 Note the details of the Annual Workforce Report.

1.5.2 Highlight any specific additional assurance / workforce information required.

2. Trust Workforce Profile

Please note that Appendix 1 provides details on the Trust Workforce profile which is in reference to the section below.

2.1 **Headcount and WTE**

2.1.1 Trust level - As at the 31 March 2018 the Trust employed 5299 staff (4599.7 WTE), this is a headcount reduction of 175 people (138.2 WTE) since March 2017. However this is a skewed picture because the Trust established a private integrated facilities management (IFM) company effective from 1 April 2017 and last year's staffing includes staff who TUPE'd out of the Trust on the 1 April. Excluding these staff there has been an overall increase in headcount by 127 employees (116.7 WTE). Controlling pay-cost spend will of course be critical for the Trust moving forward given the tight financial constraints facing the organisation.

2.1.2 Staffing group – Despite the significant pressures facing the Trust and the NHS more widely it is pleasing to note that there has been an increase within patient facing staffing groups (additional clinical services and nursing and midwifery). Work will continue in 2018/2019 to further develop workforce planning at a Trust and Divisional level to ensure our workforce matches capacity and demand (Appendix 1).

2.1.3 Banding level – It is critical that the Trust's skill mix delivers the care required of our patients at an affordable rate. As with the majority of NHS organization there is a spread of staff within lower banded roles. An analysis will be undertaken on our Banding levels compared with other similar organisations and this will be considered within the Workforce planning developments for 2018/2019 (Appendix 1).

2.1.4 Colleagues will be aware that despite the increases in WTE noted above the Trust continued to carry high Agency costs. The main drivers of the Agency spend for 2017/2018 being: Reliance on Escalation wards (outside of Winter Plan); Sickness levels for 17/18 were very high (discussed later in paper) which will have been a driver for Nursing Agency spend and the Trust carried vacancies in key medical posts.

2.1.5 **Age Profile**

2.1.6 The Trust is aware of those staff members who are potentially coming up to retirement age in order to ensure appropriate plans are in place, in this regard areas of particular concern are Registered Nursing (30% of staff over 50) and Administrative and Clerical (40% of staff over 50). As above these factors will be considered in the Trust's Workforce Planning arrangements in 2018/2019 and the Trust is already committed to the 'working longer initiative'.

2.2 Length of Service

2.2.1 Retention is a strategic objective for the Trust, the table shows that a number of staff leave the Trust within 1-5 years, with a rolling turnover figure of 10.62% it is crucial that we improve engagement with this cohort of staff. The table shows the largest turnover of staff within Estates and Ancillary 22.22% which is attributed to the transfer of staff to IFM and then additional professional, scientific and technical staff at 14.55%. A retention task and finish group has been established to address retention across the Trust, reporting through to the Workforce Operational Committee.

2.3 **Flexible Working**

2.3.1 Almost half of the Trust staff work on a part time basis (45%), many of these have utilised the flexible working policy to enable them to balance work and life commitments. This percentage of part-time staff may appear high but is replicated across the NHS more broadly. Other than the moral and legal requirements to offer flexible working there are lots of benefits to the Trust: It enables better work life balance for staff Improves staff engagement; It helps to reduce the amount of stress/pressure staff feel under; Provides a cost effective way to flexibly meet peaks in demand; Improves recruitment and retention of staff by offering family friendly working options.

2.4 **Equality and Diversity**

2.4.1 The equality, diversity and inclusion agenda is extremely important to the Trust, it is recognised that a diverse staff which reflects the population which we serve is critical to delivering high level patient care. Every effort is made to ensure our practice and policies are developed in a way that considers the impact on all groups and supports all those staff and applicants with protected characteristics. It is recognized from our Workforce Race Equality Standard (WRES) and NHS Staff Survey results that a sharpened focus on this important matter is required moving forward to ensure we more fully work towards a workforce that is more representative of the population we serve. An Equality & Diversity Lead has recently been appointed who will be pivotal in supporting this agenda. The Workforce Assurance Committee will be receiving the Workforce Race Equality Standard (WRES) in August 2018 and this will be recommending stretching aspirations.

2.5 **Gender Pay Gap**

2.5.1 In line with the national requirement of all NHS Trusts, the findings of the Gender Pay Gap analysis undertaken for April 2016 – March 2017, have been published. The gender pay gap has been identified across the NHS and wider public and private sector and is not unique to the Trust. Bolton NHS Foundation Trust's mean gender pay gap is 15.3% which is slightly lower than that for our sector. Board members will recall a detailed paper in April, 2018 which set out a series of actions aimed at reducing the gap but recognising that the shift will take place over a number of years rather than months.

2.6 **Health and Well Being / Sickness Absence**

2.6.1 Trust sickness absence during 2017/18 remained above the target of 4.2%. Sickness peaked as high as 6.18% in January and ended the year at 5.15%. Further details of

actions in place to manage attendance (including trajectories) are contained within a separate report. The current sickness position is 4.36% (April, 2018) and colleagues will note the positive trend / improvement.

2.6.2 The Workforce Assurance Committee now receive a monthly update on Sickness Management performance at both a Divisional and Trust level. Progress is being made in all areas however, concern remains at the high sickness absence levels in the Acute Division and Community Services Division. To this end an enhanced focus has been agreed in these Divisions via the introduction of the 'Attendance Matters programme'.

2.7 **Occupational Health (OH) Service**

2.7.1 The Occupational Health Service (Wellbeing Partners) was successful in again renewing their Effective, Quality Occupational Health Service **(**SEQOSH) accreditation in 2017/18. A Consultant led service, Well Being Partners is a Joint Venture between ourselves and Wigan, Wrightington and Leigh and Lancashire Teaching Foundation Trusts.

2.7.2 As well as supporting the flu campaign (75.5% of all staff received the flu vaccination) and the management of sickness absence through self and management referrals, other support to the wellbeing agenda has included counselling, mindfulness, health surveillance, stress management and risk assessment, and the mental well-being drop in.

2.7.3 Given the upward trend of staff members going off sick due to Stress & Anxiety a refreshed approached to Health & Wellbeing is being taken and will form part of the Workforce & OD Strategy. Additional investment has already been made in the mental well-being drop in service and the Trust has agreed the implementation of financial well-being support for staff through a specialist organisation, Neyber,

2.7.4 A review of the services provided by the OH service has been commissioned and will take place in Quarter 1, 2018/2019. The findings will be presented at the Workforce Assurance Committee in June.

3. Trust values

3.1 The Trust aims to ensure our people are aligned with our vision. This means ensuring we have engaged, committed colleagues at every point of the healthcare journey that provide the best possible patient experience. Research tells us that there is a positive relationship between staff motivation and wellbeing and patient experience, outcomes and organisational performance.

3.2 Our vision is underpinned by our VOICE values which define the standards of the organisation and individuals within it. Our values are woven into our HR processes including recruitment, induction, appraisal, and training. An evaluation of the implementation of the values was undertaken in October 2017 by Carol Brown of the University of Bolton. This showed that the values were embedded as an 'internal compass' within the Trust, winning the Lotus award in 2017 for organisations that have demonstrably invested in workplace culture. Whilst this feedback is positive a deeper focus on further embedding our values throughout the organization will take place in 2018/2019, this will be included in the Workforce & OD strategy and a specific OD plan will be coming to the Workforce Assurance Committee in Quarter 3.

4. Employee Relations

4.1 A key focus of the team is supporting the Trust to manage employment risks and employee relationships, assisting in communications between employees and management, corrective action and the resolution of workplace disagreements.

4.2 The case work that the HR Services team supported during this period is as follows:

Number of Cases	2016/17	2017/18
Attendance Management (Dismissal Hearing)	6	7
Dignity & Respect at Work	6	10
Disciplinary	47	44
Formal Grievance	7	6
Tribunal	4	1
Capability		1
Grand Total	**70**	**69**

4.2.1 Whilst there is no clear benchmarking data on the expected level of employee relations cases of an organization this size, soft intelligence is that this number if comparative to similar size unisons organizations.

4.2.2 People Management Skills**.** To equip managers to be able to effectively apply the Trust policies the HR Services team develop and deliver a large number of people management skills training. In 2018/2019 there will be a review of the Leadership & Management framework to ensure the training we provide meets the requirements of the service, as part of this wider review the People Management Skills training will be considered. The number of managers that have been trained during this period is as follows:

Training	No. provided	No. Attended
Difficult Discussions	2	18
Dignity at Work	2	15
Disciplinary	1	6
Grievance	3	20
Investigation Skills	3	18
Managing Attendance	55	400
Managing Capability	4	35
Grand Total	**70**	**512**

4.2.3 Colleagues will of course note the significant increase in the number of leaders who have attended the Managing Attendance programmes in February/March, which is in accordance with the Trust's Sickness Management Action plan.

4.2.4 The Trust has responded to the growing need for resilience training for our workforce given the many demands. The number of managers / staff who have accessed this service is 64. Recent discussions with the Divisional management team have noted that the work done has just scratched the surface of the requirements needed. On this basis the Workforce Operational Group are working up a Trustwide resilience programme, with particular focus on hotspot areas to be launched in September, 2018 with an estimated 400 staff being able to benefit from this Trust wide initiative (Acute Divisional focus).

5 Employee Resourcing

5.2 Employee Service Centre.

5.2.1 The Employee Service Centre (ESC) is the Trust department responsible for recruitment support and administration, input of new starters onto the Electronic Staff Record (ESR) system, input of contractual changes onto ESR, production of any contractual changes letters and contracts of employment, staff benefit schemes, and child/adult/parental care schemes.

5.2.2 In the last 12 months the ESC has posted over 1362 individual adverts and the Trust has received over 11,000 applications. Nearly 1162 new starters, including 193 bank, were recruited over that period. Over 2700 establishment changes were received and processed by the ESC – an average of 231 establishment changes per month. 222 applications for maternity, adoption, paternity, or shared parental leave were received and processed. Over the last 12 months average performance from the point of an advert being placed to a new employee commencing employment was 13.24 weeks against a performance target of 15 weeks. More recently work has been undertaken to understand why recruitment timescales may be performing within KPI targets but 'soft' intelligence was that this was not always the case – to this end a weekly report is now distributed which breaks down where posts are in the vacancy cycle (authorization stages) – this has been well received by the Division.

5.2.3 The Employee Service Centre, via a Service Level Agreement, also supports Integrated Facilities Management (iFM) by providing administrative support for recruitment, contractual changes, and child/adult/parental care schemes. During the last 12 months 126 adverts were processed, 129 new starters were recruited, and 11 maternity/adoption/parental leave applications were processed on behalf of iFM.

5.2.4 The Trust has recently agreed to provide Human Resources and OD support to Bolton CCG. This is helpful in forging closer strategic relationships with CCG colleagues.

5.2.5 Colleagues will be aware that a refreshed Recruitment & Retention offering has been discussed at the Workforce Assurance Committee. This offering recognized the need for the service to move from a transactional led service to becoming more deeply engrained within the organization and pro-actively leading the recruitment & retention challenges. The Workforce Assurance Committee have received regular updates on the process being made in this area. The desired outcome being to ensure that Bolton is thought of as the employer of choice for prospective candidates.

5.3 Workforce Deployment

5.3.1 The Workforce Deployment team are responsible for the booking of bank and agency workers for Nursing, Health Care Support, Clerical, Allied Health Professions, and Medical shifts in Accident and Emergency. The team have received a total of 1,475,563 hours to fill in the last 12 months, at an average of 59022 hours per month. Over that period the team have filled an average of 75% of nursing bank shift requests, and 80% of HCA bank shift requests. In addition to managing the temporary staffing function for the Trust the team now offer a centralised medical staffing service. This is fully implemented in the Acute & Family Divisions and is being rolled out in the Elective Division. Some of these duties will include managing absence data, maintaining ESR records, supporting recruitment events, and rota design.

5.3.2 Increased rigor on the management of Agency Spend will be critical for the Trust in 2018/2019 and the interaction between this team and the Division will be critical. In light of the current position increased scrutiny has been put in place since 18th June, 2018, whereby all Agency Spend needs to be approved at Department/Divisional and Executive level.

5.3.3 The team have recently taken over the Administrative management of the E Job Planning System and are currently supporting Medical colleagues in accessing the system & generating reports. As at June, 2018 the majority of Job Plans have been signed off within the Trust. A detailed paper has been discussed at the Workforce Assurance Committee outlining the steps that need to be taken in 2018/2019 to improve focus in this critical area. There is considerable work that needs to be undertaken in the next 1-2 years on both ensuring the Job plans provide consistency and greater alignment with clinical activity.

5.3.4 The team are also responsible for the continued roll-out, and upkeep, of the Trusts e-Roster systems. Currently 90% of Trust departments are using the E-Roster system including most recently, A&E Medical staff. There is a rollout plan to implement E-Roster for Medical staff in Obstetrics & Gynecology, General Surgery, Trauma and Orthopedics and Anesthetics by Sept 2018. E Rostering is helpful in ensuring greater visibility of our workforce matters in real time. Effective rostering support both the quality and financial agenda.

6 Staff Development

6.1 Leadership.

6.1.1 The Trust continues to build on its Leadership and Management Development offer to address the development needs of leaders and managers at all levels from students to senior teams to

deliver transformation schemes and accountability for people management. The OD and Learning department coordinate and provide a host of internal development opportunities throughout the year. Over 700 staff accessed leadership and management development opportunities during 2017/18. These programmes are advertised in the annual Training Directory. The Team also provide bespoke programmes such as team building, self-awareness etc. as requested by Divisions using a variety of tools such as MBTI, Strengths Deployment Inventory (SDI) and others. A total of 14 team events took place, involving 120 staff. The most requested / attended Leadership and Management programmes in 2017-18 were: Resilience Skills; Coaching Skills; Leadership Skills; Performance Management; Appraisal. In line with the Workforce & Organisational Development Strategy a review of the Leadership offering will be undertaken to ensure that our Leaders will have the skills to meet the service demands.

6.2 Multi-Disciplinary Aspiring Senior Leaders Programme.

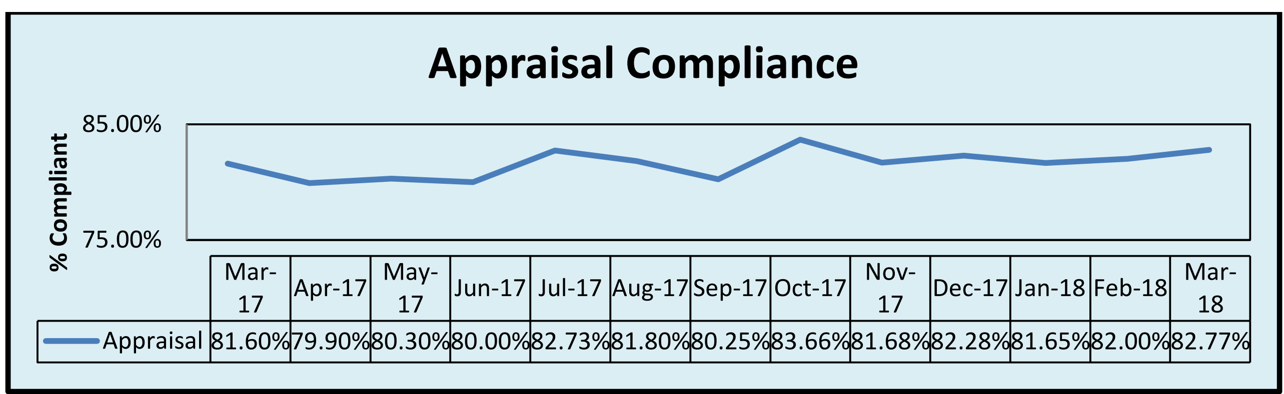
6.2.1 The Programme ran during 2017 and ended in December involving 25 staff from a variety of disciplines across the Trust. It was developed to support medical, clinical and non-clinical learning and development for those in senior leadership roles, irrespective of discipline. The aim of the programme was to raise awareness of leadership and the importance of personal impact in interacting with the immediate and wider team. There was a focus on understanding the strategic view (from Chief Executive and Chief Officer from the CCG) and financial issues and the roles that they as Leaders play, in the delivery of service improvement and quality of care; to understand how to deliver and develop safe and effective clinical practice set against managing targets, finance and systems. The feedback has been positive and has been incorporated into future content.

6.3 External programmes

6.3.1 The Trust seeks to fully utilize the support of the NHS Leadership Academy. In the last financial year 27 staff members accessed external support with the most popular programmes being:- System Leadership Masterclass; Emerging Leaders and Leading with Moral Purpose. Going forward more work will take place to identify longer term return on investment from these programmes.

6.4 Appraisal and Mandatory Training

6.4.1 The Trust appraisal levels for the year increased between 80% and 83.66% against a compliance target of 85%. Levels in the last quarter showed improvement and in April the Trust was very near to reaching the 85% KPI. There is focused work taking place following the introduction of Team Appraisals in place to achieve full compliance against the Trust target, during summer 2018. Further work is taking place to triangulate local performance on workforce KPIs, including mandatory and statutory training and appraisal, against quality standards as measured by the BOSCA.



6.4.2 The Mandatory Training levels delivered against the 85% KPI and were very close to delivering the 95% KPI for Statutory Training. There is focused work taking place following to achieve full compliance against the Trust target, during summer 2018.

Statutory and Mandatory Compliance Rates Apr 17 to Mar 18

Compliance Data	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Statutory Trg. Compliance	92.6%	92.8%	93.1%	93.8%	92.9%	92.2%	92.4%	91.9%	92.9%	92.6%	92.6%	92.5%
Mandatory Trg. Compliance	88.7%	89.3%	89.6%	90.7%	89.0%	88.7%	89.3%	89.2%	90.2%	90.0%	90.4%	89.9%

6.4.3 The OD&L department have been actively involved in the GM streamlining project where Mandatory Training Subject Matter Experts (SMEs) have ensured training meets the Core Skills Training Framework (CSTF) requirements. Each Trust is required to align the minimum requirements to their training. Our own SMEs have participated in GM events to review training materials to give additional assurance. As CSTF compliant training is undertaken, the relevant competency is attached to the employee’s ESR record. This is then transferrable to and recognised by, other NHS organisations which supports staff mobility and removes duplication of in-date Statutory/Mandatory training requirements. The Trust estimates that over a 12 month period this will release 750 days back into the Trust.

6.5 Team Development

6.5.1 There has been a substantial investment of time during the year into team development. Over 14 team events were held over the year using MBTI, SDI tools or bespoke involving over 100 staff. Use of the MBTI tool for individuals has increased with over 100 individuals receiving one to one feedback using an expanded resource of 9 trained facilitators. Whilst the tam development sessions evaluate well, further work will be done in 2018/19 to evaluate longer term impact on team performance and delivery. Relationship and team development continue to be a growth area for the Trust.

6.6 Coaching

6.6.1 The Chartered Management Institute Level 5 Programme completed in July 2017 between WWL, Wigan Hospice, Wigan Council and Bolton NHS Foundation Trust staff delivered by Boo Coaching culminated in 9 trained internal coaches. This initiated further work with Boo Coaching and Consulting – a local provider, resulting in supporting the development of the Trust Synergy Coaching Programme and the 2 day coaching for leaders programme. As well as supporting individual performance improvement and resilience, the evidence base for coaching, supports service improvement and further work will take place to follow up coaches subsequently to assess service impact.

6.7 Cadets

6.7.1 The third cohort of 13 cadets joined the Cadet programme, delivered in partnership with Bolton College. This programme is for 16 to 18 year olds who wish to start their career journey into Nursing.

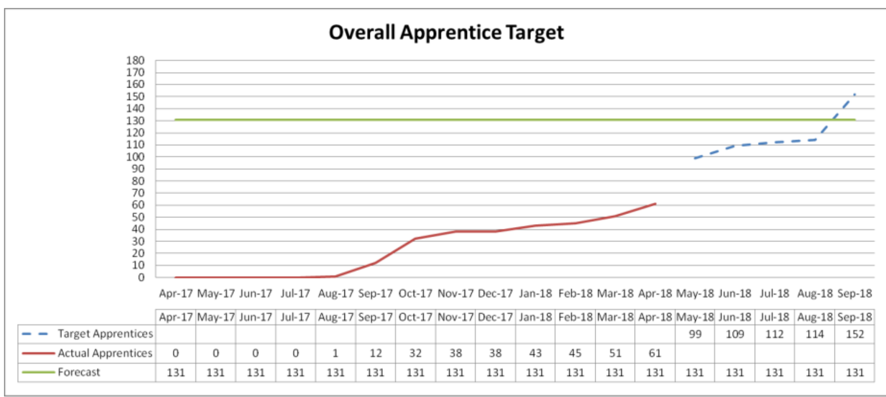
6.8 Pre-Employment Programme

6.8.1 The department continues to support the Pre- Employment programme offering a qualification and 10 week placement in a variety of placements across hospital and community. To date 25 participants have attended the programme, 3 gaining fixed term employment progressing to permanent, 1 obtained an apprenticeship role, others have joined the clinical bank. Due to the

success of the previous programmes the next will focus on Administration; Housekeepers and Porters offering a different type of job placement and route into employment.

6.9 Apprentices

6.9.1 We are working to develop the apprenticeship offering within the organisation and see them playing a vital part as a step off from various programmes (e.g. pre-employment) for those who display values aligned to the Trust. Development pathways into the organisation for both clinical and non-clinical roles have been mapped and developed featuring apprenticeships at the heart. The year ended with 51 apprentices in post, there has recently been a sharpened increase with 64 apprentices now working within Bolton. The table below outlines the trajectories we seek to deliver over the coming months to deliver the apprentice levy target of 131 Apprentices.



	Apr-17	May-17	Jun-17	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	Aug-18	Sep-18
Target Apprentices														99	109	112	114	152
Actual Apprentices	0	0	0	0	1	12	32	38	38	43	45	51	61					
Forecast	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131

7 Supporting NHS Careers

7.1 There has been focused engagement with local schools and colleges by attending and offering advice and guidance at a number of careers events. In 2017/18, Trust representatives spent a total of 285 hours volunteering to support 22 school/college events, and engaged with approximately 3000 local students across a number of formats including careers fairs, mock interviews, workshops and assembly presentations. The Trust is an active member of the Greater Manchester Careers Hub where practice is shared and events are coordinated to support improved collaboration.

7.2 The Trust pledged support for the Step into Health Programme in October 2017 for those leaving the Armed Forces and their families. In November 2017, an Insight Event was held at the Trust attended by 22 veterans and family members, providing signposting to internal opportunities.

7.3 A new Pre-Employment opportunity was initiated for students from LifeBridge ASEND, a provision for students aged 19-25 with learning difficulties. 3 students completed a 16 week, one day per week placement within 3 different areas. Plans are in place to offer a further 5 placements during the academic 2018/2019 year.

7.4 Local schools were invited to attend an interactive careers event, this was offered on site in December 2017, involving students using clinical equipment and learning basic life support skills. 30 local students from 5 different schools attended, the event was scored at 9/10 by the students another event is planned for June 2018 in which students and their parents will be invited to attend an interactive event in the Education Centre.

8 Resuscitation Services

8.1 The Resuscitation Services Department provides professional and clinical leadership, guidance and support in all aspects of resuscitation across the Trust and associated agencies. The team delivered a very large number of training programmes throughout 2017/2018 including: Intermediate Life Support 168; Immediate Life Support recertification 82; Paediatric Immediate Life Support 44; Advanced Life Support 88; Advanced Paediatric Life Support 22; Mandatory Resuscitation for Doctors 443.

9 Medical Education

9.1 Our Medical Education Department continue to be recognised for their innovative approaches to education and training. The most recent inspection from Health Education England was in October 2016 and noted a cohesive leadership team and consultant body working together to ensure a positive training experience for trainees and an embedded culture of educational governance. In summary the visiting team documented meeting a happy group of trainees who were positive about their training experiences at the Trust, describing it to be an extremely supportive, friendly working environment. Throughout the visit the team felt it was evident that the Trust values education to the extent where a group of foundation trainees commented on how 'the people make Bolton'. Colleagues will be aware that their key responsibilities include: Ensuring that the duties, working hours and supervision of trainees are consistent with the delivery of high quality, safe patient care; Delivering the requirements set out in the approved curriculum, approved by the General Medical Council (GMC); Supporting trainees to acquire the necessary skills and experience through induction, effective educational supervision, whilst ensuing an appropriate workload and time to learn. The 2017 annual GMC National Training Survey found no particular concerns or ongoing concerns in the learner environment.

10 Library Services

10.1 The past 12 months have been successful for the Library and Information Service (LIS). The department achieved 97% compliance against the Library and Quality Assurance Framework (LQAF) standards. This puts Bolton in the top quartile. Moving forward increased visibility of the Library Services work programme will be considered at the Workforce Assurance Committee. Library Services are often described as a 'hidden gem' as such it will be important for the Committee to receive assurance that the services is accessing all areas of the Trust and building up Knowledge Management throughout.

11 Pre-Registration Education Non-Medical

11.1 During 2017/18, the Pre-Registration team have provided placement support over 95 practice placement areas, across multiple professions, supporting 100-310 students per day and liaising with 1131 mentors/ educators, working across the Trust throughout the year. Health Education North West quality monitoring reported Bolton FT at 92.6% against a GM average of 89% for the quality of placements.

11.2 The Trust is an active participant in the Greater Manchester Project for Nursing Associates, a new role supported by Health Education England. The Trust recruited 23 internal applicants with a healthcare support worker background, three (3) left the programme early due to changes in circumstances and the remaining 20 have successfully continued into their second year of study. The Trust is now part of the second cohort via the apprenticeship pathway.

12 Next Steps

12.1 The Workforce Annual Report provides an update on the Workforce & OD activities that have taken place within the organization. It has been noted in previous meetings that the there is a clear need to review all the Workforce & Organisational Development activities into a coherent Strategy which sets out a clear vision for our Trust. It is apparent that the People Strategy requires a fundamental review and a fresh Workforce & Organisational Development Strategy produced with clear actions, monitoring & governance arrangements in place. This will support this critical agenda and help the Trust in ensuring that we have an effective, sustainable and affordable workforce which puts patients at the heart of everything we do. The Director of Workforce will engage the Trust over the coming months on this Strategy with a view to seeking the Trust Board sign off in Quarter 2 – 2018-2019.

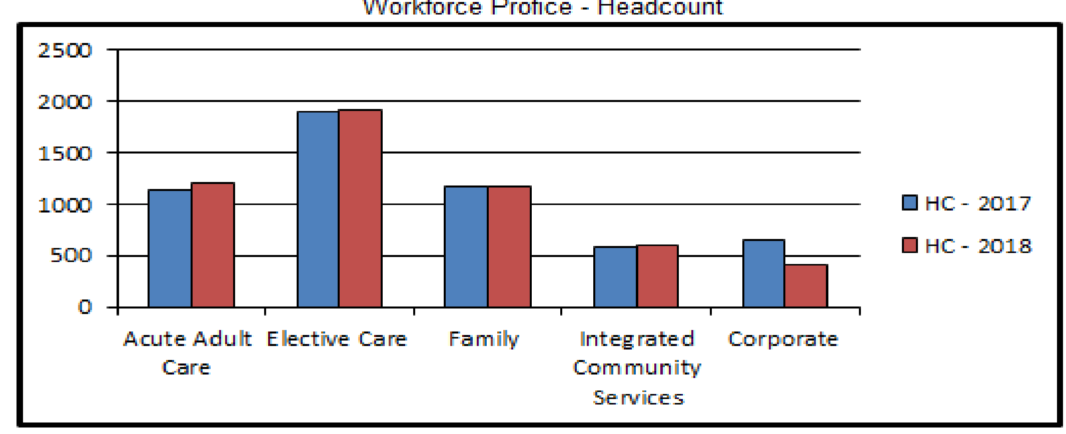
13 Recommendation

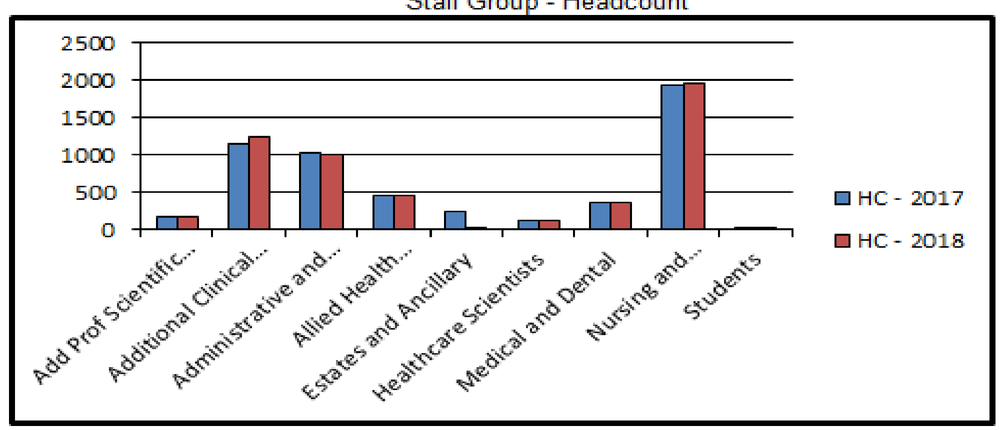
13.1 The Trust Board is asked to:

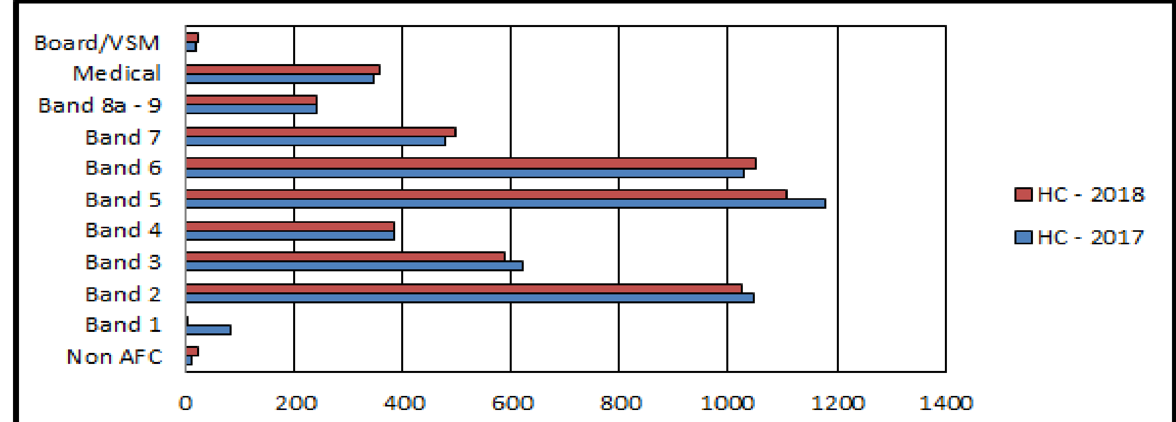
13.1.1 Note the details of the Annual Workforce Report.

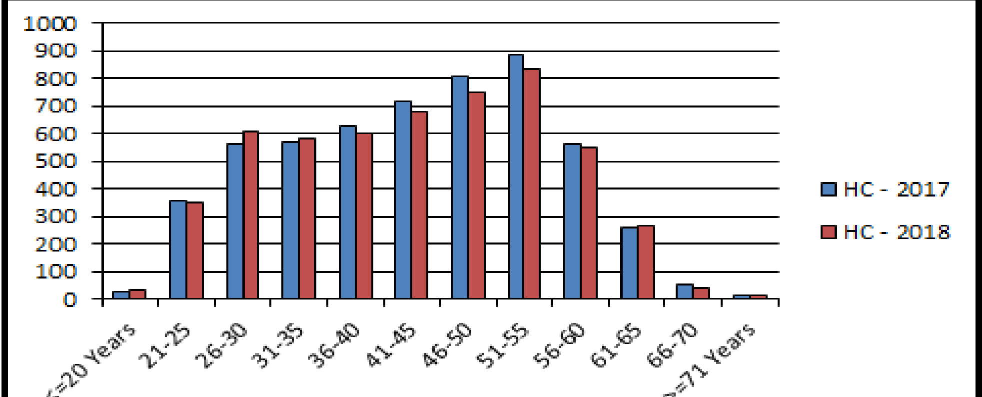
13.1.2 Highlight any specific additional assurance / workforce information required.

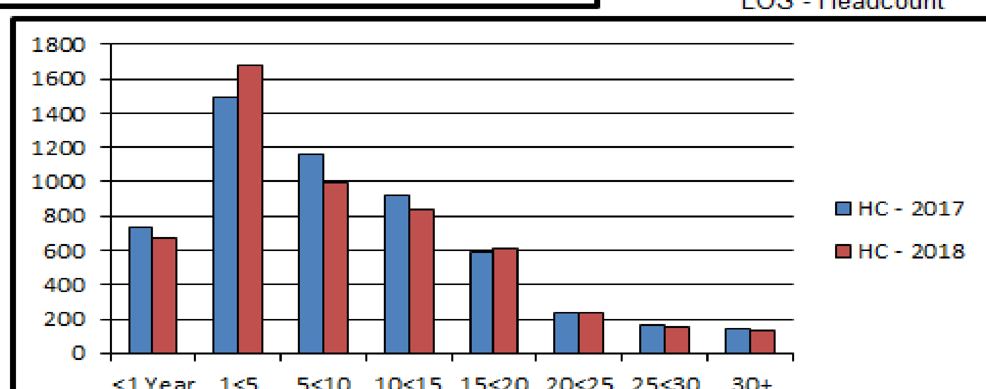
Appendix 1











NHS
Bolton
NHS Foundation Trust

Agenda Item No: 20

Meeting	Board of Directors

Date	28th June 2018

Title	2017 Staff Survey Results Update			
Executive Summary	The purpose of this report is to update the Trust Board on the actions that have been taken following the publication of the findings of the 2017 Staff Survey and the report to the Board in March 2018.			
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:	Carol Sheard, Deputy Director of Workforce	Presented by:	James Mawrey, Director of Workforce

1. Executive Summary

a. Members will recall the paper considered in March 2018 that set out the key findings of the 2017 Staff Survey. This paper outlines the actions and interventions taken at Divisional and Corporate level to respond to the findings of the 2017 NHS Staff Survey.

b. Staff satisfaction and engagement are essential in continuously improving both the staff and patient experience in the Trust and creating a positive workplace culture.

2. Background and context

a. The Survey results are primarily intended for use by local organisations to help them review and improve staff experience, which is accepted as having a direct impact on the quality of care and the patient experience. The Care Quality Commission (CQC) uses the annual Survey results to monitor on-going compliance with essential standards of quality and safety. Used effectively, Survey data are also of value in developing the 'employee voice', alongside the patient voice, and in supporting the delivery of the Trust's quality priorities.

b. All Trusts are obliged to appoint an independent Survey administrator, which is responsible for selecting a minimum sample set of staff, co-ordinating the issue, collation and analysis of Survey questionnaires, and producing a full Survey report. The Survey administrator appointed by Bolton NHS Foundation Trust is Quality Health. The Survey questionnaire covers five key themes relating to the working environment and individuals' experience within the workplace, namely:

   2.1.1 'Your Job'
   2.1.2 'Your Managers'
   2.1.3 'Your Health Wellbeing and Safety'
   2.1.4 'Your Personal Development'
   2.1.5 'Your Organisation'

   The questions associated with each of these themes are determined nationally, and consistency between the questions included in successive Surveys enables comparisons and trend analysis, year on year.

c. The NHS Staff Survey is conducted annually and all Trusts are mandated to participate. The Trust surveyed a random sample of 1,250 substantive staff (the advised minimum sample size for an organisation of this size). The Survey was conducted between late September and early December 2016 and the overall response rate was 43%. Across the Divisions, response rates varied from 29% to 65%.

d. Since reporting the key findings, further analysis has taken place by Division and also by staff group.

e. As well as the statistical analysis the Trust has also considered and shared with Divisions the 'Comments Report' provided by Quality Health that summaries the anonymous narrative comments provided by staff

f. The previous report outlined Bolton's overall staff engagement score against GM Trusts. Further detail has since become available and for completeness is provided at Appendix 1.

3. Action Planning Process

a. The Divisions have engaged with staff locally to develop their action plans and have used a variety of methods including accessing established meetings and forums, sessions in team time outs/ away days as well as specific staff survey events. A number of these continue to run throughout the forthcoming weeks, which keeps staff survey actions and engagement 'alive' and meaningful within the teams.

b. The action plans by Division and Corporate Services were considered by the Workforce Assurance Committee in May 2018 and the Committee were assured both in terms of the staff engagement processes conducted and the ensuing actions. Unsurprisingly there were areas of overlap within these Divisional plans, such as increasing communication between staff and senior management and increasing the level of staff involvement in decisions that affect them . Equally it was evident from these plans that local actions were being taken dependent on need, for example in Acute Division there is a focus on expanding nursing capacity with the aim to increase the number of staff reporting that there are enough staff to do the job properly. Elective Care Division has a focus on incident reporting and improving staff feedback, Integrated Community Services Division a focus on staff health and well-being and attendance; Family Services Division a focus on collaboration and team work.

c. In addition to the local action plans the following actions are underway Trust wide:

    a) A review of the Trust appraisal process and the development and pilot of team appraisals, to improve the quality of appraisal and ensure that staff feel valued. A pilot has been carried out in Families Division and initial feedback has been positive both from staff and managers.

    b) Articulation of the leadership and development offer, particularly to staff that are not directly involved in patient care. Workforce Operational Committee approved the refreshed Leadership framework and plans for the launch were agreed at the June meeting.

    c) The 9 staff engagement questions have been included in the Staff Friends and Family Test from Q1 and will provide an ongoing measure of staff engagement which will be reported through the Divisional Integrated Performance Management (IPM) process, as well as through Workforce Operational and Assurance Committees.

    d) An options appraisal for financial well -being providers for staff has been undertaken and the Trust has engaged Neyber to offer financial support to staff. NHS employees are reported to be in the top 10 professions that use payday loans with interest rates of 1,000 %+. Research shows a negative link between employees who are worried about their personal finances, and their engagement, productivity and retention at work. The Neyber offer is designed to reduce the financial worries of employees and build financial confidence and resilience. It enables staff to borrow sensibly, get out of debt, start saving and plan their money effectively by accessing better value financial products through the workplace via payroll deduction, enabling them to save and to improve their financial health and engagement at work. The scheme will be launched during the Summer.

    e) Establishment and work programme of the Violence and Aggression Task and Finish Group to review and drill down into violent incidents from patients and the public.

    f) Promotion of the role of the Freedom to Speak Up Guardian including the use of locally based champions to support staff in raising concerns, including bullying and harassment and discrimination. The work is being taken forward by the Trust Freedom to Speak Up Guardian in conjunction with managers, HR and staff organisations.

5. Future Developments

Further work is being undertaken by the Workforce & OD team to implement a new approach to staff engagement given the levelling of the staff engagement scores over the last two years. The newly appointed Head of OD will take forward this work through the potential use of the 'Go Engage' model developed by Wigan,

Wrightington and Leigh Foundation Trust which builds internal capacity for staff engagement at local team level.

6. Concluding comments

The local and Trust wide actions provide a clear line of sight between the findings of the staff survey and the areas identified by teams and staff, to secure further improvement. This approach, developed with staff, will put the Trust in a strong position to further improve the survey results for 2018. The potential implementation of 'Go Engage' from the Autumn, will provide a new vehicle to engage with staff on an on-going basis and build local capacity, to support meaningful staff engagement and culture change at team level.

7.0 Recommendations

7.1 The Trust Board is asked to:

1. Note the contents of the report

2. Note that the Workforce Operational Committee will continue to oversee the implementation and continual development of corporate and divisional action planning and the implementation of a refreshed staff survey offer. The Workforce Assurance Committee will of course receive regular update reports.

3. Note that the Staff Friends & Family Test (quarterly) will be used to provide a temperature check on the workforce staff engagement levels. Throughout the year the Staff Friends & Family test will ask all nine questions that make up the overall staff engagement levels which will be included on the Integrated Performance Dashboard.

APPENDIX 1

GM Organisations	Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment			Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver		Key Finding 5. Recognition and value of staff by managers and the organisation		Key Finding 10. Support from immediate managers		Key Finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns		Key Finding 19. Organisation and management interest in and action on health and wellbeing		*Key Finding 20. Percentage of staff experiencing discrimination at work in the last 12 months		Key Finding 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or		*Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months		Overall engagement score	
Trust	2016	2017	Significant change	2017	Significant change	2017	Significant change	2017	Significant change	2017	Significant change	2017	Significant change	2017	Significant change	2017	Significant change	2017	Significant change	2017	Significant change
Bolton NHS Foundation Trust	3.86	3.78	Not significant	4.02	Not significant	3.58	Not significant	3.84	Not significant	57%	Significant increase	3.72	Not significant	9%	Not significant	89%	Not significant	20%	Not significant	3.86	Not significant
Bridgewater Community Healthcare NHS Foundation Trust	3.61	3.51	Significant decrease	3.78	Significant decrease	3.43	Not significant	3.86	Not significant	60%	Significant increase	3.55	Not significant	9%	Not significant	88%	Not significant	20%	Not significant	3.68	Significant decrease
Central Manchester University Hospitals NHS Foundation Trust	3.73	3.75	Not significant	3.84	Not significant	3.42	Not significant	3.72	Not significant	51%	Not significant	3.47	Not significant	13%	Not significant	80%	Significant decrease	24%	Not significant	3.78	Not significant
Greater Manchester Mental Health NHS Foundation Trust		3.68		3.81		3.58		3.89		61%		3.69		15%		87%		21%		3.78	
North West Ambulance Service NHS Trust	3.50	3.54	Not significant	3.89	Not significant	3.01	Not significant	3.44	Not significant	35%	Not significant	3.25	Not significant	23%	Significant increase	67%	Not significant	28%	Not significant	3.45	Not significant
Pennine Acute Hospitals NHS Trust	3.45	3.55	Significant increase	3.90	Not significant	3.36	Significant increase	3.65	Not significant	51%	Significant increase	3.41	Not significant	12%	Not significant	82%	Not significant	28%	Not significant	3.71	Significant increase
Pennine Care NHS Foundation Trust	3.73	3.68	Not significant	3.81	Not significant	3.54	Not significant	3.93	Not significant	64%	Not significant	3.78	Not significant	9%	Not significant	86%	Not significant	20%	Not significant	3.80	Significant decrease
Salford Royal NHS Foundation Trust	3.79	3.78	Not significant	3.83	Not significant	3.43	Not significant	3.76	Not significant	54%	Not significant	3.65	Not significant	11%	Not significant	81%	Significant decrease	23%	Not significant	3.78	Not significant
Stockport NHS Foundation Trust	3.61	3.63	Not significant	3.81	Not significant	3.41	Not significant	3.77	Not significant	49%	Not significant	3.52	Not significant	10%	Not significant	84%	Not significant	22%	Not significant	3.73	Not significant
Tameside and Glossop Integrated Care NHS Foundation Trust	3.91	3.86	Not significant	4.16	Not significant	3.55	Not significant	3.77	Not significant	57%	Not significant	3.77	Not significant	10%	Not significant	88%	Significant decrease	23%	Not significant	3.89	Not significant
The Christie NHS Foundation Trust	4.25	4.19	Not significant	4.01	Not significant	3.59	Not significant	3.89	Not significant	55%	Not significant	3.75	Not significant	7%	Not significant	88%	Not significant	20%	Significant increase	4.00	Not significant
University Hospital of South Manchester NHS Foundation Trust	3.80	3.84	Not significant	3.92	Not significant	3.40	Not significant	3.71	Not significant	50%	Not significant	3.57	Not significant	11%	Not significant	82%	Significant decrease	26%	Significant increase	3.79	Not significant
Wrightington, Wigan and Leigh NHS Foundation Trust	4.03	3.96	Not significant	4.21	Not significant	3.56	Not significant	3.85	Not significant	50%	Not significant	3.78	Not significant	9%	Not significant	84%	Not significant	25%	Not significant	3.95	Not significant

Agenda Item No: 22

Meeting	Board of Directors
Date	28th June 2018
Title	Trust Seasonal Plan
Executive Summary	The paper provides background on progress to date with urgent care performance and a review of Winter 2017/18. The paper also provides assurance on the Trust's seasonal plan for 2018/19.
Previously considered by	Executive Directors

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

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

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

Prepared by	Rae Wheatcroft Deputy Chief Operating Officer	Presented by	Andy Ennis Chief Operating Officer

1 Background

As part of 18/19 planning guidance, planning assumptions for Emergency care are to ensure that aggregate performance against the four-hour A&E standard is at or above 90% by September 2018. All Trusts are to achieve the 95% standard for the month of March 2019. Trusts are also expected to improve on their performance each quarter, compared to their performance in the same quarter the prior year, in order to qualify for STF payments.

Unnecessarily prolonged stays in hospital are bad for patients. This is due to the risk of unnecessary waiting, sleep deprivation, increased risk of falls and fracture, prolonging episodes of acute confusion (delirium) and catching healthcare associated infections. All can cause an avoidable loss of muscle strength leading to greater physical dependency (commonly referred to as deconditioning). Bolton FT have been striving to reduce long stays in hospital to reduce risks of patient harm, disability and unwarranted cost.

In order to develop and deliver our urgent care plan, Bolton FT has been working with the Emergency Care Intensive Support Team (ECIST) since March 2017 during which they have provided weekly on-site support, recommendations, and coaching.

Bolton Health Economy also has an Urgent and Emergency Care Delivery board and plan. For 17/18, Bolton FT Urgent Care plan was formulated in line with a combination of analysis of performance, recommendations from ECIST and priorities set by Bolton Health Economy.

Improvements during 17/18 included:

- Phase 1 of extending the A&E facilities for majors, which reduced the overcrowding in the department.
- The Primary care streaming model – Bolton FT currently has a GP on site for 12 hours a day. Currently approximately 35-40 patients a day are streamed away from A&E. The model has been visited by a number of other Trusts as a beacon of best practice to share learning. There are plans to extend streaming to a wider set of pathways.
- A 'Home First team' was established and is working in A&E supporting admission avoidance and a discharge to assess model is supporting patients getting back to their usual place of residence quicker – 6 patients a day now avoid being admitted.
- Improvements to the process for managing medically optimised patients to reduce the time they spend in the acute setting have impacted on reducing length of stay in patients who have been admitted over 48 hours
- Worked with the ambulance service (NWAS) to make improvements to the handover process which have successfully impacted on reducing the number of patients who wait
- Ran a 'Think Home First campaign' during July & August to introduce a process called Red2Green aimed at reducing delays and End PJ Paralysis which promotes getting patients up and active whilst during their hospital stay to reduce risks of deconditioning.

Winter resilience plans for 17/18, were impacted by challenges in recruiting nursing staff. This meant staffing the additional capacity required to manage winter acuity was difficult.

Unprecedented levels of flu also exceeded forecasts and added additional pressure to the system to ensure safety and quality were not compromised. Bed modelling suggests 32 additional beds were required to manage the flu surge. Managing high

volumes of infected and potentially infected patients had a greater impact on performance, due to the need for side rooms.

Despite additional interventions, the impact of an exceptional flu season meant that only marginal improvement was demonstrated nationally and in Bolton. Performance for 17/18 was 81.88%.

In order to evaluate what worked well and what could be better in terms of winter resilience plans, a number of clinical workshops have been held between March and May to prioritise interventions and ensure learning was captured.

2 Analysis

It is clear that there are key challenges to overcome in terms of achieving the A&E 4 hour standard. The Trust has undertaken analysis which was supported by bed modelling and also ECIST recommendations. The aim of bed modelling is to ensure the number of beds matches demand and seasonal variations to maintain occupancy levels.

The main factors impacting on performance are:

- Bed occupancy being too high leading to delays in admitting patients to a bed when they require acute care. This was influenced by a high prevalence of flu which increased complex admissions
- Overcrowding in A&E resulted in increase in non-admitted breaches and also delays in making decisions to admit.

Based on analysis, bed modelling demonstrated that a length of stay reduction of 0.3 days, coupled with a lower prevalence of flu, would impact on reducing occupancy. A reduction in occupancy reduces the risk of medical outliers into surgery, unplanned escalation beds being opened and also overcrowding in A&E. It is worth noting, that the advice from the Infection Control team suggests that high prevalence of influenza, in two consecutive years, is highly unlikely.

Modelling also demonstrated that flexible bed capacity is required to support seasonal trends and the increased acuity in adults and children during winter. Bed numbers need to increase temporarily from November to the end of March to cope with increased acuity. As an example, studies show every degree drop in temperature below 5 degrees, there is a subsequent 0.8% increase in respiratory admissions in the following weeks.

3 Aims of the Urgent Care Plan

Based on the Trusts analysis of winter 17/18 outcomes, bed modelling and feedback from ECIP, the Trust has worked in line with the Health Economy Urgent Care Delivery board to develop a plan. (See appendix 2)

The aim of Bolton FT urgent care plan is to:

- Focus and align the Trust to deliver initiatives which will directly impact on providing patients safe, high quality, compassionate care that are financially sustainable
- Embed a ‘home first’ mindset across our systems and do everything we can so our patients, particularly older people, can enjoy their lives in their own home environments. We will reduce avoidable admissions, by increasing the volume of Home First admissions avoided to 8 a day
- Continue to develop the physical capacity of the Emergency Department; Resuscitation expansion, ambulance handover bays, streaming area.
- Reduce total Trust level occupancy to less than 83% (all beds)

- Reduce the volume of super stranded patients by 25%
- Consistently achieve less than 120 minutes time to decision to admit
- Improve flow in A&E to support a reduction in non-admitted breaches to less than 1% (zero tolerance for minors breaches)
- Improve ambulance handover times as per national standards.

4 Bolton Urgent Care resilience plan

A - Preventing Attendance & Admission:

1. Increase streaming away from hospital through introduction of new pathways. Aim to stream 100 patients a day away from the Emergency Department
2. Increase the number of patients discharged from the Emergency Department by the 'Home First Team' from an average of 6 to 8 per day.
3. Work with NWAS to develop deflection pathways to avoid 2 further admissions per day.
4. Increase Paediatric Consultant/Middle Grade support to reduce admissions by 10 patients per day.

B - In hospital processes (flow, stranded patients & LOS):

- Reduce length of stay through a number of key actions including;
    - Performance management of the medical assessment units to a maximum of 48 hours length of stay
    - Management and new process for reducing stranded patients (>7 days) and super stranded patients (>21 days) across all wards
    - Development of ward based prescribing pharmacists, continued reinforcement of SAFER, MDT working, Red to Green etc. resulting in 30% of discharges before 12 noon and 70% by 4pm
    - Increase capacity of IV therapy team by 10 visits to meet seasonal demand and contribute to the reduction in length of stay.

- The adult elective programme will be stepped down from 23rd December 2018 to 14th January 2019. This will be achieved through effective scheduling and optimising the use of the day case surgery unit. All Cancer and urgent in-patient procedures will continue.
- There will be a drive to ensure in-patient beds are not used for day cases. This is estimated to release 3 beds per day.
- Increase Paediatric HDU capacity by 1 bed to deal with increased demand.

C- Discharge (safe transfers of care):

- Cohort DTOC/Medically Optimised patients onto A4 ward and staff the ward with greater therapy support and less nursing intervention. The ward will be overseen by a General Practitioner rather than a Consultant.
- Increase discharge to assess at home by 10 patients per week.
- Create additional Intermediate Care capacity at Darley Court by opening 5 additional beds during winter to support acuity
- Continuation of weekly Multi Agency Discharge Events throughout winter resulting in a reduction of Super Stranded 91 to 69 patients.
- Reduce the average length of stay of patients from being medically optimised to discharge from current 7 days to 3.5 days.
- Reduce the super stranded patients (length of stay greater than 21 days) by 25%
- Increase capacity of BART team to support increased respiratory patients in winter.

5 Management of the Plan

- The System Resilience Group, chaired by the Chief Operating Officer, will ensure the effective delivery of the plan and will provide a Chairs report to the Executive Directors. (Appendix 1)
- Weekly assurance led by the Chief Executive.
- The Urgent and Emergency Care Board co-chaired by Su long and Jackie Bene also ensures there is oversight of the health economy plans, which this is a key part of.

6 Risks

There is a risk log and the following risks have been extracted as the highest risk with mitigating actions and controls.

Risk	Mitigating actions	Likelihood	Impact	Risk rating
Inability to recruit to vacancies	• Recruitment and marketing plan • Retention plan	3	4	12
Failure to reduce length of stay	• Detailed length of stay plan supported by ECIST currently underway and monitored	3	5	15
Failure to increase Discharge to Assess at home when Four seasons bed function changes	• Progress of plan being overseen by HE urgent care delivery board with authority to initiate corrective actions i.e. keeping Four Seasons open longer than planned	5	4	20
B2/B4 upgrade is not completed in time	• Robust estates and facilities plan with escalation of delays with mitigating actions • Outlier management plan • Cancellation of electives to maintain occupancy	3	4	12

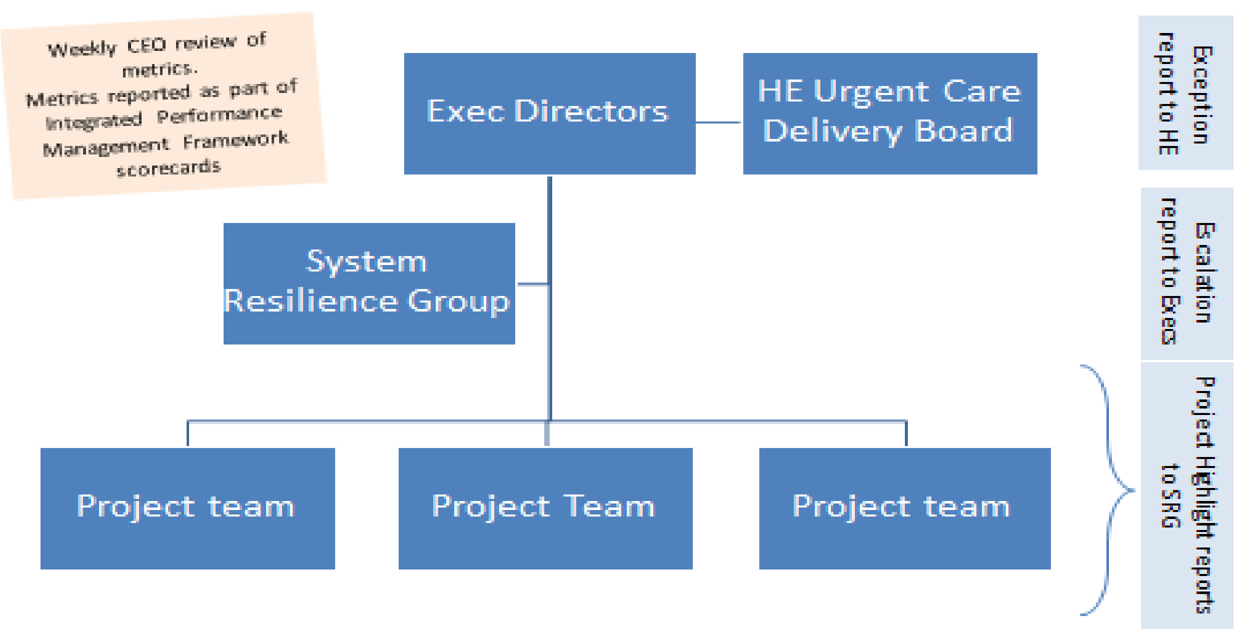
7 Costs

£1.5m of funding has been made available from commissioners to support the costs of system resilience and winter, which includes the provision of Prime-care and the Integrated Discharge Team. The total costs of delivering resilience schemes to maintain safe levels of occupancy and performance has been calculated as £4.3m

8 Next Steps

- Plans have already commenced and are being supported by ECIP.
- Progress being monitored and KPIs tracked at weekly System Resilience Group to monitor outcomes.
- Resilience costing has been completed and is under review by the Director of Finance, this includes streaming model and staffing for flexible bed capacity throughout the year.

Appendix 1: Governance and oversight



Appendix 2: Overarching Urgent care milestone plan (underpinned by plans)

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Streaming – Home First increase admissions avoided from 6 to 8 a day										
Streaming – increase primary care streaming from 30 to 40 a day										
Streaming – increased to ACU from front door including new build										
A&E decision making improvement plan										
New process for stranded patient LOS review										
SAFER flow – MDT approach fully rolled out as part of LOS reduction										
B4/B2 refurb completed										
A&E extension to ambulance bay and resus completed										
Acute ward capacity flexed up for winter (hospital base) and associated increase in support functions and clinical teams.										
Community bed capacity flexed up for winter Intermediate Care										
Increased day case activity to reduce Inpatients as result of Endoscopy/Daycase										
Multi Agency Discharge Events										
Step down elective activity 23rd December 2018 to 14th January 2019										
Increase in paediatric HDU beds										
Increase IV in community to reduce need for acute based care										
Increased pharmacy										

Appendix 3: Costing

Urgent Care plan costs		
	18/19 Cost ‘000’	**Comments**
Winter schemes*		*winter defined as temporary flex up of services to support increase in acuity - (Oct - April)
Additional beds	**1,774**	Increase in acute beds to manage acuity (B4) 26 beds April/May and Oct-Mar (includes medical/nursing/non pay etc)
Respiratory BARTS	**20**	Additional respiratory nursing community/acute for winter period (Nov - March)
Pharmacy (Pilot development)	**142**	D1/D2 pilot - (may require recurrent funding folllowing benefits realisation)
Elective additional support	**201**	Increased diagnostics, T&O, theatres during winter period
Darley Court 5 beds	**120**	Temporary increase in intermediate care beds to manage acuity over winter (Jan - March)
IV therapy	**167**	Increase in community based IV to reduce risk of patients staying in acute beds (Sept - March)
Paeds resilience	**114**	Increase in paediatric medical support and HDU beds to support acuity (Oct-March)
Total winter only	**2,538**	
Full year resilience schemes		
A4 additional therapy	**180**	Additional therapy support for supporting medically optimised patients return to independence
GP - ED	**53**	Additional GP in minors/paeds as part of ED team
Pharmacy	**120**	Pharmacy - increased support to reduce risk of delays to to medication
Integrated discharge team	**279**	Fully staffed integrated discharge team to cover all wards all year
Primecare ambulance	**220**	Additional transport to reduce discharge delays due to transport home
Flexible bed capacity	**300**	Cross divisional 7 beds to support surge management (previous Vascular beds)
Seasonal bed resilience**	**627**	**risk contingency - (B4) 26 beds flexible if required June -Oct to maintain occupancy
Total other resilience	**1,779**	
Total all winter/resilience	**4,317**	

Agenda Item No: 23

Meeting	Board of Directors

Date	28th June 2018

Title	Compliance with condition FT4 (8)

Executive Summary	NHS foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS Provider licence. From July 2017, NHSI will contact a number of FTs to ask for evidence of self-certification either through the templates or through relevant minutes and papers. Although the template has not changed since 2017, the risks and mitigations have been reviewed. Board members are asked to consider the additional risk highlighted within this report

Previously considered by	

Next steps/future actions	To approve the self certification			
	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	Esther Steel Trust Secretary	Presented by	Esther Steel Trust Secretary

Declaration

1. PURPOSE

To inform and support the June declaration to NHS Improvement covering corporate governance and Governor training.

2. BACKGROUND

Bolton NHS FT was authorised as a Foundation Trust in October 2008, since that time declarations have been made on an annual basis with regard to on-going compliance with the *Terms of Authorisation.* NHSI have changed their guidance and a sample of declarations will now be subject to audit

3. DECLARATIONS

The suggested form for the declarations is appended to this paper - for each declaration the Trust must respond confirmed or not confirmed and should provide additional information on risks and mitigating actions.

Corporate Governance Statement	Compliant	Risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Yes	**Risk:** not adhering to accepted standards of corporate governance or best practice **Mitigating actions:** • Well Led review completed in 2017 • Compliance with Monitor's Code of Governance for Foundation Trusts regularly assessed and reported through Audit Committee • The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Trust Secretary who has accountability for its maintenance. • There are no material conflicts of interest in the Board. • All governors elections and by elections held in accordance with election rules. • Trust Secretary in post who holds responsibility for corporate governance. • Systems and controls assurances are obtained via the Audit Committee.

		• Further formal external governance review will take place every three years or as required by NHSI. • More complete explanations about systems of corporate governance are set out in the annual governance statement and the Trust's annual report
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Yes	**Risk**: non-compliance with Monitor's Code of Governance for foundation trusts and other governance guidance issued by the regulator **Mitigating actions:** • Compliance with Monitor's Code of Governance for Foundation Trusts assessed each year as part of the annual reporting process. (February 2018 Audit committee • Any guidance requirements are routinely assessed and implemented as necessary - over view of guidance provided in KPMG Technical Update received at each Audit Committee meeting. Assurance and advice is provided as required by the Audit Committee
3. The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	Yes	**Risk**: Ineffective board and committee structures in place which are not reviewed and updated. Unclear reporting lines **Mitigating actions:** • Well Led review undertaken in 2017 • CQC good for Well Led domain • Board committees established with clear lines of reporting. • Terms of Reference in place for all Board and other committees and groups within the Trust which are regularly reviewed and updated where necessary. These set out remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. • Standardised Chair reports to escalate assurance and concerns in line with reporting structure. • Clear delegation of actions to committees • Annual Governance Statement in place which identifies areas of potential risk

		and mitigating actions.
4. The Board is satisfied that the Licensee effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of	Yes	**Risk:** Lack of systems to assess compliance with Licensing requirements **Mitigating actions:** • Risk Management Strategy in place and regularly reviewed. • Board Assurance Framework • Safeguard risk management system in place. • Use of internal and external audit services to investigate any areas of concern. • Better Care Group monitors compliance with the CQC's standards which is chaired by the Director of Nursing • Inpatient and other CQC surveys utilised with action plans put in place where necessary. • Royal college reviews undertaken where appropriate or necessary. • Contracts for services agreed with clinical commissioning groups. • Finance and Investment Committee considers detailed financial performance report at each meeting • Monthly performance report considered by Board, detailed performance discussed at monthly performance reviews. • Comprehensive agendas for Board meetings circulated to directors at least 3 days before each meeting • Cost Improvement Plans in place which are risk assessed for quality • Standing Financial Instructions and Standing Orders in place • Counter Fraud specialist reports to the Audit Committee • In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high level risks facing the Trust and ways in which these are being mitigated. The four areas are: quality and safety, finance, operations and governance • Points as set out in 1), 2) and 3) above apply.

business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and h) To ensure compliance with all applicable legal requirements.		**Risk**: Potential loss of control through devolution of authority to the Trust's wholly owned subsidiary **Mitigating actions:** • Group Audit Committee and Risk Management Committee • FT Board representation on iFM Board • Contract review process • Group Health and Safety Committee • Deloitte review of iFM Governance • iFM compliance with corporate governance requirements
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with	Yes	• The Medical Director and the Director of Nursing are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity • Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Clinical quality, patient safety & patient experience metrics are reported to the Board monthly. • Quality Assurance Committee – chaired by a NED – Terms of Reference include reporting from Clinical Governance Committee and reports from clinical divisions. • Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to Clinical Audit Committee. Full list included within the Quality Account • Learning from national reports with comparative reports undertaken and action plans devised and implemented. • National reports and benchmarking e.g. NICE guidelines – NPSA safety alerts managed via Clinical Governance Committee • Regular ward and department visits undertake by all Board members

patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		• PLACE • Ward to board heat map • Exec team ward buddies • Board go and see • Processes in place to escalate and resolve issues - risk management committee established with reporting line to the QA Committee
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Yes	• The Medical Director, Director of Nursing and Director of Finance are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • All Executive Directors' performance and competencies are reviewed through annual appraisals. • Collective & individual skill-sets reviewed as part of board development • Chairman receives an annual performance appraisal from the Senior Independent Director, • NEDs receive an annual performance appraisal from the Chairman who advises the governors • NEDs have been appointed by the Council of Governors as advised by the governors' • Nominations Committee. • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance, and, OD. . Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction. • Thereafter, on-going training to develop existing and new skills relevant to the

		NED role is undertaken by attendance at external conferences and workshops as required. • NED progress is monitored by the Chair via one to one meetings including a formal annual appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established. • This is supplemented by a number of Board away days throughout the year to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. • Divisions are led by experienced and capable teams consisting of a Head of Division, a Divisional Director of Operations and a Divisional Director of Nursing. • Nursing levels on wards are reported to Board and are monitored and published on a daily basis on the ward staffing boards.

The training of governors		
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Yes	A Governor training programme has been in place since the election of the shadow council of Governors in 2008. However in response to the formal requirement in the Health and Social Care act and the changes to Governor responsibilities within the same act, the training has been reviewed and enhanced. In 2017/18 Training provided to Governors included: • a full day formal induction for new governors shared with Salford NHS FT • Attendance at staff induction for all new Governors • a quarterly rolling programme for "soft skills" including interview techniques and communication skills • A rolling programme of meetings with members of the executive team for enhanced understanding of director portfolios • The North West Governor forum which in Feb 2018 was hosted by Bolton NHS FT In addition to this other training and development opportunities including regional NW Governor meetings and training sessions provided by Mersey Internal Audit are routinely offered to and taken up by significant numbers of Bolton Governors. A similar programme is in place for 2018/19

4. RECOMMENDATIONS

Board members are asked to consider and debate the proposed declarations for submission to NHSI.

Appendices

declaration

Appendix One

Declaration templates

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		[including where the Board is able to respond 'Confirmed']	Please Respond
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		[including where the Board is able to respond 'Confirmed']	Please Respond
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		[including where the Board is able to respond 'Confirmed']	Please Respond
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and		[including where the Board is able to respond 'Confirmed']	Please Respond

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		[including where the Board is able to respond 'Confirmed']	Please Respond
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature ____________________ **Signature** ____________________

Name ____________________ **Name** ____________________

Further explanatory information should be provided below where the Board has been unable to confirm declarations under

A

Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Please Respond

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Agenda Item No	

Meeting	Trust Board
Date	
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. It is recommended that the Board a) Review the completed template Appendix A. b) Sign Declarations supplied at Appendix B. c) Review and note Evidence to support claim at Appendix C. d) Note the reference document from NHS Resolution supplied at Appendix D. e) Requests that the QAC review progress against the 10 Maternity Safety Actions to ensure that the work remains on course every six months.
Previously considered by	Families Senior Team Meeting Quality & Assurance committee
Next steps/future actions	Once Board Sign off has been received the report will be submitted to NHS Resolution prior to the deadline of Friday 29th June 2018. 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	

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, Programme Manager, PMO Office	Presented at Quality and Assurance Committee by	Karen Bancroft, Head of Division
		Presented at Board by	Paul Settle, Deputy Head of Division and Clinical Lead for Neonatology Val Clare, Head of Midwifery

1. Background

1.1 NHS Resolution have reported that obstetric claims represent one of the biggest area of spend within the NHS (c£500m in 2016/17) with such claims representing 10% of the volume received and 50% of the value.

1.2 In 2018/19 NHS Resolution (NHSR) are supporting the trial of a CNST discount incentive scheme which is available to all Trusts offering Maternity services and is entirely discretionary and subject to available funds. Payment will be based on the information and declaration made in Appendix A.

1.3 Each Trust offering Maternity Services can apply for the discount by submitting evidence to support their progress made to implement all 10 Maternity Safety Actions which has received Trust Board sign off and discussed with CCG.

1.4 For Bolton NHS Foundation Trust the discount could equate to c£600k saving and has been included within the 2018/19 ICIP programme to help achieve the 2018/19 control total.

1.5 To qualify for the scheme Trusts are required to complete and submit to Board a completed template along with the evidence used to support the claim. (However, please note that NHSR have requested that the evidence is supplied to Board only and that they themselves will not require this with the final submission).

1.6 It is important for the Board to note that the completed report (supplied as Appendix A) requires evidence which is both self-certified and will be externally validated.

1.7 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). Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board Governance which the external steering group will escalate to the appropriate arm's length body.

1.8 There are specific timescales for applications which are summarised below for reference and a supporting Question & Answer document has been supplied as Appendix E for information.

Step	Date
Completed Board Reports with Board Sign off submitted to NHS Resolution	By End of June 18
National Maternity Safety Champions and Steering Group to confirm Final Results	By End of July 18
Evaluation of scheme and confirmation of approach for 2019/20	By End of July 18
NHS Resolution to confirm and pay discounts	By End of August 18

2. Purpose

2.1 The purpose of this paper it to provide the Board with the completed template along with the supporting evidence which demonstrates Bolton NHS Foundation Trust's position and progress made to implement the 10 Maternity Safety Actions in order to obtain the required Board Sign off in readiness for the submission.

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

2.3 The paper provides a review of position and provides additional relevant actions plans to ensure sustainability.

2.4 The expectation is that the Trust will be able to demonstrate compliance with the requirement to implement all 10 of the actions, as outlined by NHS Resolution and the Department of Health, these have been summarised below:-

1	Use of the National Perinatal Mortality Review Tool to review perinatal deaths – 100% compliant	Achieved
2	Submitting data to the Maternity Services Data Set to the required standard – Minimum submissions criteria met in March 2018 and externally validated.	Achieved
3	Demonstrating transitional care facilities are in place and operational to support implementation of the ATAIN programme - Compliant : The Families Division operates a Transitional care model which facilitates mum and baby remaining together on the postnatal ward in keeping with the ATAIN Approach, including Phototherapy and IV Antibiotics.	Achieved
4	Demonstrating an effective system of medical workforce planning - Required standard of no more than 20% of middle grade sessions on labour ward filled by consultants acting down from other sessions met.	Achieved

	- Self-assessment using the Royal College of Obstetricians and Gynaecologists (RCOG) work force monitoring tool was undertaken and has been sent to the RCOG on time to complete the process in April 2018.	
5	Demonstrating an effective system of midwifery workforce planning - Midwifery staffing is calculated using a recognised systematic and evidence process for safe staffing utilising the BIRTHRATE PLUS® tool - Divisional workplan completed for all services within the Families Division which includes Maternity and Neonatology. - Rosters in place to ensure Ward Co-ordinators have supernummary status	Achieved
6	Demonstrating compliance with the four elements of the Saving Babies' Lives Care Bundle - Quality Improvement programme established around ensuring all elements continue to be implemented and plans in place to ensure sustainability.	Achieved
7	Demonstrating a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership forum, and regularly acting on feedback - MVP Group established with the CCG: Bolton are the only locality so far who have committed the recommended funding of £10k to a MVP - Friends and Family test feedback and compliance rates regularly monitored and tracked	Achieved
8	Evidencing that 90% of each maternity staff group have attended an in-house multi-professional maternity emergencies training session within the last training year - A multi-professional RCOG endorsed PROMPT Programme has been developed which replaced the previous in-house MET programme from the funding received from Health Education England.	Achieved

	- This was a significant change and pivotal to ensuring that training met national maternity safety standards as well as local training needs. - A full roll out plan for a phased approach commenced within this training year and will achieve the 90% compliance by September 2018. - The compliance rates for last year and previous years have been supplied as evidence to show we have consistently achieved the full compliance. - The PEF team (Practice Education Midwife) have a tracking and reporting mechanism in place to remind staff to revalidate and an escalation process for non-compliance when required. - Multi-Disciplinary Skill Drills remain in place for all staff.	
9	Demonstrating that trust safety champions are meeting bi-monthly with board level champions to escalate locally identified issues - Trust safety champions allocated. (Trish Armstrong-Childs (DoN), Nicky Etchels (Midwife) and Funmi Odusoga (Consultant) and Bi-monthly meetings occurring. - Existing Integrated Performance Management Framework also demonstrates escalation of locally identified issues discussed with Executives, Senior Management, Head of Midwifery, and Head of Division.	Achieved
10	Reporting 100% of qualifying 2017/18 incidents under NHS Resolution Early Notification scheme - 100% Compliant - Review of all incidents meeting the criteria has taken place and all cases have been entered retrospectively as agreed within discussions with NHSR directly	Achieved

3. Next Steps

3.1 Once the Board of Directors sign off has been received (Thursday 28th June) the report will be submitted to NHS Resolution prior to the deadline of Friday 29th June 2018.

3.2 It is important to note that non submission will be treated as a nil response and no incentive payment will be made. For this reason and to ensure the deadline is not missed, the Board should be aware that the Quality Assurance Committee was tasked with reviewing the evidence in detail. The QAC completed this task on 20th June 2018.

3.3 It is recommended that the Board of Directors request that QAC review progress against the 10 Maternity Safety Actions to ensure that the work remains on course every six months.

4. Recommendations

4.1 It is recommended that the Board

a) Review the completed template Appendix A.

b) Sign Declarations supplied at Appendix B.

c) Review and note Evidence to support claim at Appendix C.

d) Note the Q&A document from NHS Resolution supplied at Appendix D.

e) Requests that the QAC review progress against the 10 Maternity Safety Actions to ensure that the work remains on course every six months

Appendix A: Evidence of Trust's progress against 10 safety actions:

Board report on Bolton NHS Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Bolton NHS Foundation Trust Maternity services includes;

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

Evidence will be provided to Trust Boards only. The evidential appendix C is not required by NHS Resolution as per the submission instructions.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	Yes Evidence to support has been supplied at:- Appendix C.1 – extract from the NPRT database.	**YES**

2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	The required minimum standard was to achieve compliance in 8 out of the 10 criteria for March 2018. We have confirmed compliance in 9 out of the 10 in March, as requested, and this has been externally confirmed. We have also been submitting to the MSDS every month consistently.	**YES**
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	The Families Division operates a Transitional care model which facilitates mum and baby remaining together on the postnatal ward in keeping with the ATAIN Approach. Antibiotics and phototherapy are provided for babies by Midwives on the postnatal ward. Our Maternity Clinical Educator is leading on the roll out of the ATAIN programme for postnatal staff. However, we consider this programme is relevant for all midwives and not just those on the postnatal ward, as postnatal care starts immediately after birth(e.g. within the 1st hour of birth). This means staff working on our CDS, Birthsuite / Ingleside and Community as well as Postnatal Ward will complete this.	**YES**
4). Can you demonstrate an effective system of medical workforce planning?	Yes. Required standard of no more than 20% of middle grade sessions on labour ward filled by consultants acting down from other sessions has been met. The RCOG templates have been completed and submitted to RCOG, on time, as required and we will be continuing the use of the workforce monitoring tool. Evidence to support this has been supplied at:- Appendix C.2 – Completed RCOG Templates for the Middle Grade Rota submitted to RCOG on	**YES**

	24th May. Appendix C.3 – Copies of the Consultant Rota In addition to the above all Job Plans have been completed for consultants.	
5). Can you demonstrate an effective system of midwifery workforce planning?	Yes. There is a systematic approach used within the Division which looks at the predictive births (via the Monthly Birth Predictor tool) and assessments are made using Birth Rate + to understand the number of staffing required for the services as a whole (including the main site, community and Ingleside). Each month a summary of the Birth Rate + staffing ratio compliance is produced, which has been supplied as supporting evidence. The Trust has an E-Rostering policy in place which is readily available on the Trust Internet site. An electronic roster has been built within the Health-Roster system which allows for the appropriate shifts required and incorporates time for supernummary duties (meaning that Band 7 Midwives have no case load of their own). A staffing rota is produced weekly and distributed to the relevant teams for information (also supplied). In addition to the above a further template is sent out daily to all staff members including matrons and ward /team managers informing them of staffing for low risk births at home, the freestanding maternity unit (Ingleside) and Birth Suite. (Appendix D.5) To ensure that trends and staffing levels are monitored we also produce a Planned vs Actual Roster document for review by Head of Midwifery. We have also included as evidence a copy of the Families Division Workforce plan which demonstrates good practice across Obs & Gynae with Neonates, as requested.	**YES**

	Evidence to support the above has been supplied at:- Appendix C.4 - Template for low risk births staffing (daily) Appendix C.5 – Copy of Maternity Staffing Paper submitted to Board & Minutes (Sept 17). Appendix C.6 – Copy of the Monthly Birth Rate Predictor for April 18, produced by BI. This tool is used to predict the anticipated number of births for the coming months to assist with planning. Appendix C.7 – Copy of the weekly staffing rota for Midwives for May 18. Appendix C.8 – Copy of Birth Rate + staffing ratio summary for April 18 produced monthly by BI used to summarise compliance. Appendix C.9 – Extract from Health Rosters for Band 7 Midwives detailing Supernummary hours. Appendix C.10 - Planned vs Actual Roster Appendix C.11 - Families workforce plan	
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	A Quality Improvement programme is well established around ensuring all parts of all elements are implemented and delivered. Good progress has being made and plans in place to ensure sustainability. Below summarises achievements to date:- Element One: Reduced smoking in Pregnancy: We will be involved in the Baby Clear Project due to commence September 2018 and are piloting a 'platinum pathway' within the community team currently.	**YES**

	Element Two: Risk Assessment and Surveillance: Recently BMI>35 has been included in the additional scanning criteria and actions have already taken place to train and recruit Maternity Midwifery Sonographers. These will be able to perform scanning duties from September 2018. Element Three: Raised Awareness for Reduced Fetal Movement – This has been achieved as the Kick Counts leaflets are readily available and provided to Women. Two audits have been performed to date which measure patients understanding of the information provided and an audit schedule has been produced to ensure monitoring is continued. Element Four: Effective Fetal Monitoring - A full training programme is in place and our Practice Education Facilitator will continue monitoring and tracking compliance to ensure all staff continue to be appropriately trained to provide effective fetal monitoring during labour. Evidence to support the above has been applied at:- Appendix C.12 – Copy of Highlight report Appendix C.13 - SBL Fetal Monitoring Passport (Appendix C25 & 26 also demonstrate presentations to the Board as requested)	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership	Bolton NHS FT Trusts uses many Mechanisms to receive and act upon customer feedback. Working closely with our CCG we have summarised progress below:- • Across GM there is significant variation in terms of MVPs, of which Bolton are the only locality so far who have committed the recommended funding of £10k to a MVP. We held our launch event on 22nd June 2017 and since then many engagements events have taken place. • Bolton MVP has a Facebook page (@BoltonMVP) which currently sits with the communications and engagement team at Bolton CCG. This is something we would want	**YES**

Forum, and that you regularly act on feedback?	the Chair/Co Chair to take the lead on to further engage with women • Since the launch of the MVP and midwives have engaged with the community to capture women's and families experiences. With support from the CCG we are currently looking to recruit an independent chair / co-chairs to lead the MVP as per recommendations. Our next meeting is taking place on Friday 8th June. • Via the MVP we have recruited service users to be part of the interview process for the Head of Midwifery position who will commence in June. • A guidance document for Commissioners was presented by the GMEC Strategic Clinical Network at the GM Children's and Maternity Consortium Meeting in July 2017 to provide a set of recommendations localities on how to set up a MVP • On 27th September and 11th October, two informal engagement sessions took place at Tonge Children's Centre and Great Lever Children's Centre. This included Commissioners, Engagement Leads and Consultant and Community Midwives. Within these sessions we had an MVP stall whereby women were able to provide their contact details for further engagement sessions. Each staff member had a series of prompts to ask women and their families about their maternity care. • Both Commissioning Manager and Engagement Lead also attended a family session called 'Wildchild' at Walmsely Unitarian Chapel to speak to male member so of the family following a theme around information for fathers came out of previous engagement events. Although there were small numbers attending, there was a strong desire for some support for males • On Tuesday 30th January, Commissioners met with two Greater Manchester & Eastern Cheshire (GMEC) Maternity Voices Service User Reps to discuss how Bolton can link with the national work and gain an insight into any areas of good practice. • As part of the Maternity Pioneer work across Bolton, Salford and Wigan, there is an opportunity for an overarching MVP whereby each locality can come together and share learning and experiences of maternity care. This may have a stronger 'case for change' impact as a sector when 3 local MVPs come together. Discussions are on-going around this.	

- On-going discussions have been had with the national MVP team to understand the processes and governance around the MVP membership including a Chair, Co-Chair and admin. We have gained examples of job descriptions to help establish what we would require from Bolton's MVP chair and co-chair. There are further discussions to be had around the administering of the MVP budget and how this can be accessed to cover the expenses of the Chair and Co-chair.
- We currently hold a contact list of 37 women from previous engagement events who are interested in being involved in sharing maternity views. We now need to establish a process on how to nominate a chair for the group and understand the roles and responsibilities from the group
- We have had discussions with the Clinical Lead for Women and Children's services who has put out a request for further interest in the Women and Children's bulletin and we are looking to create a flyer which could potentially go out at the first booking appointment. Posters in GP Practices may also increase interest.

In addition to the above, Maternity at Ingleside has established a Facebook page (@InglesideSalford) for the unit. This page currently has 1650 followers and has been used as a tool to engage with and update women and the local community regarding service developments.

Evidence to support the above is supplied at:-

Appendix C.14 – Copy of MVP Invitation

Appendix C.15 – Notes from MVP meetings held in Sept and Oct

Appendix C.16 – MVP Scoping document from CCG

	Appendix C.17 – MVP Launch event notes Appendix C.18 - GM Children's and Maternity Consortium Meeting Appendix C.19 – Prompt for facilitators from engagement sessions	
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?	A multi-professional RCOG endorsed PROMPT Programme has been developed which replaced the previous in-house MET programme from the funding received from Health Education England. This was a significant change and pivotal to ensuring that training met national maternity safety standards. The compliance rates for last year and previous years have been supplied as evidence to show we have consistently achieved the required compliance. The PEF team (Practice Education Midwife) have a tracking and reporting mechanism in place to remind staff to revalidate and an escalation process for non-compliance when required. Multi-Disciplinary Skill Drills remain in place for all staff. A CNST local training record has been completed for Quarter Four of 17/18 and supplied as evidence, as requested, and this template will continue to be used to record training. Evidence to support the actions taken to date are supplied at:- Appendix C.20 CNST compliance. Appendix C.21 CNST records from Quarter 4 17/18. Appendix C.22 Bolton PROMPT course programme	**YES**

	Appendix C.23 Bolton PROMPT delegate programme Appendix C.24 Bolton PROMPT schedule Appendix C.25 Evidence of Skills Drills	
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?	The Director of Nursing/Deputy Chief Executive meets with the Divisional management team for the Families Division on a monthly basis at the Integrated Performance Management (IPM) meetings and go through a number of key maternity indicators. In addition the maternity team attend Trust Board twice a year to provide an update on quality and safety. The Safety champion meetings have been established and we have provided evidence of the latest meeting that took place. Further meetings are scheduled for:- 2nd August 10:00-11:00 / 4th October 10:00-11:00 / 3rd December 10:00-11:00 Evidence to support is supplied at:- Appendix C.26 – Copy of Board Presentation from January Appendix C.27 - Copy of Board Minutes from January Appendix C.28 – Families Extract from Minutes from IPM from April 2018. Appendix C.29 – Agenda of latest Safety Champion Meetings Appendix C.30 – Latest minutes of meeting of the Safety Champions	**YES**
10). Have you reported 100% of	100% Compliant - Review of all incidents meeting the criteria has taken place and all cases have	**YES**

qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	been entered retrospectively as agreed within discussions with NHSR directly	

SECTION B: Sign-off

…………………………………………………………………………..

For and on behalf of the Board of Bolton NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**

Position: ………………………….

Date: ………………………….

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.

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