Bolton NHS Foundation Trust – Board Meeting September 25th 2014

Location: Bolton One Seminar room **Time: 0930 – 1230 hrs**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
0900	1.	Patient Story		Verbal	Patient story and learning points noted
	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 July 2014	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
	7.1	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SUIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
1000	8	Integrated Performance Report	Exec team	Report	To note and receive the integrated performance report
	9.	Update on revalidation	Medical Director	Report	
Governance					
1100	10.	Review Standing Orders	Trust Secretary	Standing Orders	To review and approve the Standing Orders
	11.	Governance Review	Trust Secretary	Report	To note the requirement and agree the process for governance reviews
	12.	Board Development	Trust Secretary	Report	To approve the proposed Board Development programme
	13.	Fit and Proper persons test/duty of candour	Trust Secretary	report	To note the new CQC requirements for Fit and Proper Persons Test and Duty of Candour
	14.	Revision to Risk Management Strategy	DoN	report	To approve a change to the Risk Management Strategy

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
Finance and Strategy					
11.40	15.	Healthier Together - update	Mark Wilkinson	Report	
For Information					
Chair reports of the following sub-committees will be noted – if any member of the Board wishes to raise a question regarding one of these items they should indicate this before the start of the meeting.					
12.10	16.	Finance and Investment Committee – Chair Report			
	17.	Quality Assurance Committee – Chair Report meetings held 13th August 2014 and 10th September 2014)			
	18.	Audit Committee – verbal update meeting held 18th September 2014			
	19.	Charitable Funds – No meeting held in the reporting period			
	20.	Any other business			
Questions from Members of the Public					
	21.	To respond to any questions from members of the public that had been received in writing 24 hours in advance of the meeting.			
Resolution to Exclude the Press and Public					
12.20	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				
	22.	Review of meeting	Trust Secretary	discussion	

Bolton NHS
NHS Foundation Trust

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Meeting	Board of Directors Meeting
Time	09.00 a.m.
Date	31st July 2014
Venue	Boardroom Royal Bolton Hospital

Present:-

		Abbv.
Mr D Wakefield	Chair	DW
Dr J Bene	Chief Executive	JB
Dr E Adia	Non-Executive Director	EA
Mrs T Armstrong Child	Director of Nursing	TAC
Mr A Ennis	Chief Operating Officer	
Mr S Hodgson	Medical Director	SH
Mr S Worthington	Director of Finance	SCW
Ms S Woolridge	Acting Director Workforce and OD	SW

In attendance:-

Mrs E Steel	Trust Secretary	ES
Mrs H Edwards	Head of Communications	HE
Mr R Sachs	Head of Governance (item 9 only)	RS

Members of the Council of Governors, representatives of the CCG and a representative of the local media in attendance as observers.

1. <u>Patient Story</u>

The CEO introduced Megan Steward, a junior doctor at the Trust who has taken a lead in promoting the "#Hello my name is" movement within the Trust.

"#Hello my name is" is a social media campaign started by Dr Kate Granger a Doctor and cancer patient who is using her own first hand experiences to good effect to change the behaviours of clinicians in their interactions with patients.

As part of the campaign, data had been collected from observations of staff interactions with patients and video recordings had been made of three patients discussing their reflections on the communication they had experienced whilst being treated in the Trust. The data collected showed that contrary to expectations, when looking at whether staff introduced themselves and explained their role, consultants were more likely and staff nurses were least likely to introduce themselves to the patient. The observations will be repeated to measure any improvement.

The video reflections will be used within the junior doctor induction as part of a wider programme to empower junior doctors to be the agents of change. The video will also be used for all inductions and professional training.

Board members were shown the recording from one of these interviews

Megan outlined the proposed next steps for the project including:

- Using the #Hello my name is logo for bed boards to ensure patients are addressed by their preferred name

- Providing a place for patients to jot down questions they want to ask clinicians and nurses
- To introduce ward staff using a photo board on each ward.

Board members discussed the following points raised by the video and presentation:

- The traditional large entourage on a ward round can be uncomfortable for a patient, although there can be an educational element to this the learning does not need to be at the patients bed side. Junior doctors should be empowered to suggest alternatives.
- It should be recognised that conversations at a patient's bedside can be overheard by other patients in a bay; steps should be taken to ensure confidentiality is not compromised by discussing sensitive issues within the hearing of other patients.
- Staff should extend the courtesy of introductions to all and should challenge inappropriate interactions.

Board members thanked Megan for her presentation and the initiative which should be simple to implement and has the potential to deliver good results. Board members asked that their thanks to the patients be recorded and passed on.

2. Apologies

G Ashworth, A Duckworth, C Davies, M Harrison

The Chairman confirmed that the meeting was not quorate and therefore would be unable to formally approve any items unless powers had previously been devolved to individuals.

3. Declarations of Interest

None

4. Minutes of The Board Of Directors Meeting Held on 26th June 2014

The minutes of the meeting held on 26th June 2014 were approved as an accurate record.

5. Action Sheet

The action sheet was updated to reflect progress on agreed actions.

FT/13/103 The action to receive an update on AHSN had been agreed in October 2013. The Trust are currently working with the AHSN on two pieces of work around safety in medicines and an IT initiative for information sharing. Board members discussed the value of these initiatives and the benefits which were felt to be more applicable to large teaching hospitals.

Board members agreed to close the action and for the Execs to continue to work with the AHSN as appropriate whilst ensuring value for money from collaborative working.

FT/14/52 Further to discussion at the Exec team meeting it has been agreed that whilst awards will not be monetary, it is planned to use sponsorship funds to provide a gift or team event.

6. Matters Arising

No matters arising not covered elsewhere on the agenda.

7.1 Chairman's Report

Board Changes

Mark Wilkinson the new Director of Strategic and Organisational Development is due to start with the Trust on Monday 4th August. Suzanne Woolridge was thanked for the cover she has provided for the last eight months.

As announced at the Governor meeting on June 26th 2014 Ebrahim Adia (Ibby) will be standing down at the end of the month. Ibby was thanked for his calm, collected and insightful contribution to Board meetings.

Performance

Despite significant pressure, A & E performance has continued to meet the target

Stakeholders

Healthier Together proposals have now been published; the Trust will issue an organisational response and are encouraging Governors, staff and the wider public to submit individual responses to the consultation. The proposals were discussed at the Overview and Scrutiny Committee earlier in the week although the public attendance at this meeting was poor.

Members of the Board are scheduled to attend a performance review meeting with Monitor on Friday 8th August. This will be the first face to face meeting since November 2013 and it is hoped will provide further information on the journey to come out of breach.

The Chairman advised that he was delighted to be able to report that Dr J Bene, CEO at Bolton NHSFT had been named in the recently published Health Service Journal list of the 50 most inspirational women in the NHS and was cited as leading with calmness that inspires confidence. Board members and observers congratulated Dr Bene on this achievement.

Board members noted the Chairman's update.

7.2 CEO report

Stakeholders

The Trust has recently received a letter from the CCG outlining their concerns relating to the failure of two metrics within the stroke target. An action plan has been developed to address these concerns; this will be overseen by the QA Committee and the Quality Contract meeting.

The latest report on CQC intelligent monitoring places the Trust in band four, this move from band five is largely because the metrics used in the risk assessment have been extended to include Monitor's continuity of service (CRS) rating

Reportable issues

There have not been any reportable issues since the Board meeting held on 26th June 2014.

Board Assurance Framework

Board members noted the BAF summary which is provided monthly. The following points were discussed:

The reduction of risk four - incident reporting was queried; assurance was requested to support the decision to reduce the risk. The Director of Nursing advised that having implemented several of the agreed actions and increased the efficacy of the controls it was felt that the likelihood of the risk should be reduced. All BAF risks will be reviewed at the next Risk Management Committee and the Committee would be asked to review the score in light of the concerns raised.

Risk two - safe and sustainable staffing - Board members queried when the actions to address this risk would have the desired affect; the Director of Nursing advised that the nurses appointed from Spain and Portugal would be joining the Trust in the next few weeks, the risk would be reduced once there was assurance that this recruitment initiative had resulted in the desired impact on safe staffing levels.

Risk 14 - Integrated Care - this risk has remained constant as it is felt too early to say if actions will be timely and effective - this risk is expected to remain at this level until the next financial year.

Board members considered whether the failure of the stroke target referred to earlier should be added as a risk. The COO advised that although this target does not appear on the Board dashboard it is monitored by the operational team and is discussed in the monthly meetings with the CCG. The failure of the target was as a result of pressure in the system with eight stroke patients presenting on one day compounded by problems with flow and increased length of stay.

8 **Integrated Performance Report**

Quality

The Director of Nursing highlighted the following areas on the integrated performance report

The investigation into the two **never events** reported to the June Board meeting is expected to be completed in mid-September. A report was provided to the QA Committee and the regulators outlining the immediate actions taken.

There continues to be a slow and sustained improvement in the prevention of **pressure ulcers**. There have been no incidences of unavoidable grade four ulcers in the quarter, the level 3 and level 4 ulcers reported from community involved very poorly patients on end of life care; both were deemed unavoidable.

The external review of **medication incidents** has now been completed with the draft report expected. The report, recommendations and actions will be reviewed and overseen by the QA Committee.

100% compliance with **WHO checklist**.

There was an increase in the actual number of **falls** in June however falls per 1000 bed days performance has remained constant and the figures for July show a reduction. Board members noted that the heatmap indicated a higher number of falls in some areas, the Director of Nursing confirmed this the Trust has a falls co-ordinator to support ward teams in developing appropriate interventions for the different needs of patients for example on C4 where a significant number of patients have dementia the team will look to address this through environmental changes; on D2 the pattern of falls is different to other areas with most occurring mid-afternoon, the reason for this variation needs to be understood in order to tailor appropriate interventions.

Incident reporting - the Board have recognised that the Trust has been a low reporter of incidents, the appointment of a new Head of Governance and an increased focus on incident reporting has seen a significant increase in the number of incidents reported. Benchmarking indicates that the Trusts that excel in this area report around 16 incidents per 100 bed days.

Operational

The COO highlighted the following areas on the integrated performance report:

Readmissions - The trust are reporting 14% readmissions compared to a national average of 12%. There is concern that an element of this may be over reporting through the inclusion of patients returning for planned procedures which should not be classed as readmission. The majority of readmissions are within medicine, actions are being implemented to address inaccurate coding through the clinical oversight group and to identify where community actions are needed to address this issue.

Mixed sex breaches - The two mixed sex breaches were patients who were not transferred out of HDU/ITU within 24 hours of being clinically fit for step down. The transfer of patients from high dependency areas is an important element of flow through the hospital - operational managers are required to contact the COO if a transfer out of these areas is blocked. Board members asked for assurance that the reduction in beds had not impacted on flow and bed availability. The COO assured Board members that this is not related to the reduction in beds.

Cancer Targets - In response to challenge from one of the Non-Executive Directors, the COO advised that three of the four patients who missed the 31 day target had complex pathways data will be provided to give assurance that the targets were only missed by a few days. Achievement of the cancer targets remains a challenge; it is possible that the Trust will fail the target for July however performance for the quarter should still be achieved.

FT/14/56	Assurance to be provided regarding length of delay to patients who were not seen within the 31 day cancer target	AE

Transient Ischaemic Attack (TIA) - as highlighted in the CEO report, the CCG have raised concerns regarding the achievement of the targets for TIA, the small number of patients treated for TIA means that missing the target for one patient can have a significant impact on overall achievement. The Trust is looking to recruit a second consultant to support this service.

A & E - Unlike the majority of other trusts in the country, the Trust has continued to meet the A & E target. At the request of the Trust, the ECIST have undertaken a further review, the outcome of which is due in the next week. A & E provision at the Trust is now seen as an example of good practice although with increased attendances does remain a challenge. Board members commended the continued achievement of the A & E target and asked for assurance that the achievement of the 95% target would be sustained if attendances continued to increase.

The Chief Operating Officer advised that the increased attendance is a demographic change being seen across the country with all trusts seeing an increase in the number of elderly patients attending; this group of patients typically stay longer in the A & E department and put pressure on the flow.

Although schemes to deflect activity are not yet having an impact the COO confirmed that he was confident that of continued achievement of the target, although significant

improvements have already been made there are still actions that can be taken to improve flow and reduce attendances.

Board members discussed the importance of continued achievement of the A&E target and the implications including financial implications of failing the target. The importance of working with commissioners to understand the increased attendance was recognised with some concern expressed that further progress had not been made with the CCG led implementation of integrated care. These concerns are shared with the CCG at the Joint Transformation Group.

Workforce

The Acting Director of Workforce and OD highlighted the following points on the integrated performance report:

- Turnover excluding staff leaving for MARS and voluntary redundancy is 9.3% (11.5% including MARS etc)
- Sickness has reduced slightly to 4.6% with most progress made in the Acute Adult Division
- Appraisals are showing a reduction in June, there is some anecdotal concerns suggesting that this is a recording issue, this is being investigated further by the Workforce team
- There has been a slight increase against the mandatory training target

Board members noted the performance and discussed whether the target for appraisals should be set at 90%. As the Board was not quorate it was agreed to consider this suggestion at the September meeting.

FT/14/57	Proposal to September Board regarding adjustment to the threshold for the appraisal target	MW

Finance

The Director of Finance highlighted the key points within the finance section of the integrated performance report:

- Overall the Trust is on plan with a year to date deficit of £0.76m.
- Income overall is better than plan in month at £23.48m compared to a plan of £23.2m, with clinical over achieving by £0.26m.
- Pay spend is £16.76m, an over spend of £0.94m.
- Non pay spend is £6.58m, an over spend of £0.39m.
- The overall position is slightly worse than anticipated and the Trust has used £1.1m of Risk Reserve to date in month.
- ICIPs delivered in June total £1.7m. The year to date delivery is £4.8m, which is in line with plan.
- The Trust is still forecasting to deliver the year-end target surplus of £1.6m.
- To manage the risk within the forecast the downside risk management plan has been enacted, consequently the Corporate division has been tasked with bringing forward 2014/15 ICIP schemes to deliver an additional £1.2m and Estates has been tasked with delivering £0.25m in year**.**
- This risk is reflected on the Board Assurance Framework with a risk score of 20

Board members noted the performance and confirmed that this had been discussed in detail at the July Finance Committee, although performance is still in line with the plan, firm control would be required to maintain this position, the delay in closing beds was made for sound clinical and quality reasons but does present a significant risk to financial performance.

Capital spend is behind plan, this does not represent any risk to patients - the phasing of the programme will be reviewed with a view to bringing proposed changes to the September Board meeting.

Although the Continuity of Service Score for June remained at 1 good progress is being made towards a rating of 2 which will be a significant milestone in the transition from breach.

Board members noted the update on quality, financial and operational performance.

9. Mock CQC Inspection

The Head of Governance provided an overview of recently published CQC hospital inspection reports and a summary of feedback from the Trust's "mock CQC inspection"

The mock inspection identified that although there are examples of good practice further work is required particularly with regard to incident reporting and risk registers.

A detailed report will be considered at the August meeting of the Clinical Governance Committee with an action plan to the September QA committee. The exercise will be repeated in October 2014.

Board members noted the feedback from the mock inspection.

10. Infection Control update

The director of Nursing presented the update on infection control providing an overview of performance and actions taken in 2013/14 and themes to address in the coming year.

Board members noted the infection control update.

11 Quarter one compliance declaration

The Trust Secretary presented the proposed quarter one declaration to Monitor. Board members acknowledged that in the event of a non-quorate Board, the Board had delegated the final sign off of the declaration to the Chair and CEO.

Board members noted the proposed Q1 declaration to Monitor.

12 MOU NW Sector

The chief operating Officer presented the NW sector MOU for information. The MOU is intended to formalise joint working between Salford, Wigan and Bolton and will need to be formally approved by a quorate Board.

Board members noted the MOU and asked that it be resubmitted for formal approval in September 2014.

13 Development of a Community Strategy

The Director of Finance presented an update on the development of a Community Strategy. The report presented included a description of the proposed structure and workstreams and a first iteration of a proposed community dashboard to present community information to the Board and its committees.

Board members discussed the proposed metrics and KPIs with consideration given to the development of appropriate measures of quality and integration. The proposed measure of patients with a key worker and a care plan was agreed as a possible indicator of the success of integration, this figure is currently low, but should increase.

The suite of indicators for measuring the quality and effectiveness of community services will be developed with the CCG and through reference to established reports from Community Trusts.

Board members discussed the indicators included in the report and whilst recognising that this is still in development and therefore too early for detailed scrutiny, the following points were noted:

- The Trust provide a wide range of services, this gives visibility across the full range of services
- Sickness absence is a concern in community services
- There appears to be a high level of did not attends, the next report will include information on actions being taken to address this
- Some services are seasonal, the plan needs to be sensitised to reflect this.
- There is increased confidence in data capture and accuracy, although data is not produced with the same rigour as hospital data there is a plan in place to address issues and audit through internal audit.

Board members noted the update on the development of the community strategy.

14. Finance and Investment Committee Chair report (17/07/14)

In the absence of the Chair of the Finance Committee, the Chairman presented the report from the Finance and Investment Committee. The meeting had focused on a detailed review of the IT and Estates plans and month three performance.

15. Quality Assurance Committee Chair report (09/07/14)

The QA Committee received a report on the actions taken to address concerns regarding medicines managements. Committee agreed that the report presented failed to provide the assurance they required and further assurance has been requested from a third party.

16. Audit Committee

No meetings held during the reporting period.

17. Charitable Funds Chair report (25/06/14)

Board members noted the minutes and Chair report of the Charitable Funds Committee.

21. Any other business

None

22. **Questions From Members of the Public**

Question submitted by Kate Cowpe

This week we have read of patients who have been hounded by debt collectors or court proceedings for the recovery of car parking fines linked to visits to hospitals elsewhere in the country. Of course only the stories that tug at the heart strings reach the press. However the claim is that trusts are spending exorbitant amounts to retrieve unpaid parking fines.

Can the trust reassure the people of Bolton that they are not employing the bully-boy tactics that we have read about nor are they spending large amounts of money policing the car-parks of the trust or collecting unpaid fines?

The chairman confirmed that the Trust do not use debt collectors or employ "bully boy" tactics to recoup parking revenues. A warning notice is issued for the first offence; tickets are only issued for a second or subsequent offence with an option to pay a reduced settlement if settled promptly.

Question submitted by Jim Sherrington

'Have Bolton Foundation Trust received any complaints about the signage at Bolton One, Moor Lane, Bolton, BL3 5BN.'

The Chairman advised that although there have been no complaints about signage at Bolton One Board members agree that the signage in this area is a concern. Within the Estates Business case funding has been allocated to address signage and this will include Bolton One.

Date And Time Of Next Meeting

25th September 2014 2014 0900

Resolved: 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.

July Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/14/54	26/06/2014	revalidation	three month update on revalidation	SH	Sep-14	agenda item
FT/14/56	31/07/2014	performance report	Assurance to be provided regarding length of delay to patients who were not seen within the 31 day cancer target	AE	Sep-14	verbal update
FT/14/23	24/04/2014	late night transfers	Further report back including three months audit report and comparison with other Trusts	AE	Oct-14	action deferred to allow for results of audit to be collated
FT/14/17	27/03/2014	performance report	TAC to provide update to QA Committee on proposals for volunteers	TAC	Oct-14	action deferred
FT/14/51	26/06/2014	staffing levels	report back to QA Comm to provide assurance that escalation of unfilled shifts is effective	TAC	Oct-14	agenda item October QA committee
FT/14/28	24/04/2014	SUI report data loss	report back to QA committee on review of compliance with new standard operating procedures	AE	Oct-14	agenda item October QA committee
FT/14/49	26/06/2014	CEO report	Board development session on incident and risk reporting	ES	Oct-14	to be incorporated in Board Development programme currently being developed
FT/14/42	29/05/2014	committee reports	review of Board and committee effectiveness as part of wider governance review	ES	Oct-14	Board review agenda item, Audit review complete
FT/14/57	31/07/2014	performance report	Proposal to September Board regarding adjustment to the threshold for the appraisal target	MW	Nov-14	to be incorporated into new workforce strategy
FT/14/53	26/06/2014	reward and recognition	reports to be provided on engagement, behaviours and standards	SW	Nov-14	to be incorporated in Workforce Strategy paper - Nov 2014

Bolton NHS
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Agenda Item No	

Meeting	Board of Directors

Date	25th September 2014

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:
	• Monitor update
	• Stakeholder update
	• reportable issues log
	  ○ coroner communications
	  ○ Never events
	  ○ SUIs
	  ○ Red complaints
	• Board Assurance Framework summary

Next steps/future actions *Clearly identify what will follow i.e. future KPI's, assurance requirements*	The Board are asked to note this update			
	Discuss		Receive	✓
	Approve		Note	✓

This Report Covers (please tick relevant boxes)

Strategy	✓	Financial Implications	✓
Performance	✓	Legal Implications	✓
Quality	✓	Regulatory	✓
Workforce	✓	Stakeholder implications	✓
NHS constitution rights and pledges		Equality Impact Assessed	
For Information		Confidential	

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

All information provided in this written report was correct at the close of play 17/09/2014 a verbal update will be provided during the meeting if required

Chief Executive Update

1. Reviewing and Revising our Trust Strategic Direction

Discussions have commenced between executive directors and divisional teams on how we can work more closely together to improve business and strategic planning across the trust. We have been exploring who our strategy is for, and what is the role of the divisional teams in developing the overall trust strategy. Clear points that emerged included: the strategy is for us (although it also needs to meet regulatory needs), divisional teams would welcome greater involvement as long as the opportunity to influence is authentic and realistic, and much more work is required to disseminate our organisational priorities and underpinning values. This will be the subject of a future report to the Board.

2. Stakeholders

2.1 Better Care Fund -

Bolton's Health and Well-being Board will, by the time of the board meeting, have submitted the latest iteration of the Better Care Fund to NHS England.

The Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. It is one of the most ambitious ever programmes across the NHS and Local Government in creating a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The total value of Bolton's fund is £12.1m in 2014/15 rising to £20.7m in 2015/16. The Fund is being designed to deliver integrated health and social care services for the adult population of Bolton - 230k people as at 30th June 2014. We believe that services should:

- Aim to keep patients well physically and mentally and independent and in their own homes (recognising the importance of family and community in promoting wellbeing).
- Provide a good health and social care experience for patients and their families and result in better outcomes.
- Meet the challenges of rising need for health and social care services within dwindling resources.
- Be centred around the needs of the individual.

Key aspects of this new approach in service terms include: Integrated Neighbourhood Teams, intermediate tier services, a Care Coordination Centre, services for people with complex lifestyles, and the promotion of staying well.

Recent policy changes mean that the Fund now comprises a performance element which will see £1.6m of investment in the fund conditional upon reducing non-elective admissions. This was introduced in response to concerns that this money would be lost to the NHS (the CCG is placing a proportion of its existing allocation into the Fund i.e. no new money), at a time of increasing pressure particularly for providers of acute services.

2.2 Monitor

Monitor have been on site twice in recent weeks as part of the process to assess the bid for funding to support the IT and Estates business cases.

Over the next few weeks Monitor will continue to review what we have said and the vast amount of information we have given them.

The Board will be going to a meeting with Monitor on the 20th October to discuss our financial plans and the case for investment in estate and IT.

Monitor will decide whether they support our case for investment on or about the 19th November; there will then need to be some further process with the DH.

2.3 Healthier Together

The Trust have continued to work with stakeholders including commissioners and neighbouring trusts on an organisational and a sector response to the consultation which closes on 30th September 2014

2.4 Care Quality Commission

The Trust remains in band 4 of the CQC intelligent reporting.

2.5 5 to 19 tender - Bolton Local Authority has announced their intention to tender the contract for the provision of services for 5 to 19 year olds. We will be submitting a bid for both the Health and Wellbeing Service and the Health Targeted Health Intervention Service. An update will be provided to the part two meeting of the October Board.

3. <u>Reportable Issues Log</u>

Issues occurring between 31st July 2014 and 17th September 2014

3.1 Serious Untoward Incidents

There have been no SUIs since the last Board meeting.

3.2 Never Events

There have been no new never events since the last Board meeting.

3.3 Coroner Prevention of future Deaths (PFD) reports

There have been no coroner notices issued since the last report

3.4 Red Complaints

There has been one red rated complaint since the last Board meeting.

3.5 Reputational Issues

None of significance

3.6 Whistleblowing

There have been no concerns raised by whistle-blowers

4 Board Assurance Framework

4.1. Introduction

The BAF is the framework setting out how the Board are assured that the Trust will achieve its strategic objectives - the Annual Plan for 2014/15 builds on the five year strategic plan submitted in September 2013 - the strategic objectives have not been changed and the majority of the risks to achieving these objectives also remain and will be carried forwards onto the new BAF.

The BAF is used by the Board of Directors to ensure that all significant risks have been identified; information on control, performance and assurance is timely and relevant; and to provide leadership on risk management.

The BAF is reviewed on a monthly basis by the Executive team who finalise the list of strategic risks, confirm actions being taken and check assurances

The process of assurance mapping to provide an overview of controls and assurances is now underway - an update report was provided to the Audit Committee on September 17th 2014

BAF scores are a composite of impact and likelihood, the impact for the majority of these scores is major or catastrophic and most are deemed to have likelihood of either 3 or 4 as defined on the table below:

Level	Descriptor	Definition	% of risk
1	Rare	Difficult to believe that this will ever happen / happen again.	<10%
2	Unlikely	Do not expect it to happen / happen again, but it may	10 – 40%
3	Possible	It is possible that it may occur / recur	40 – 60%
4	Likely	Is likely to occur / recur, but is not a persistent issue.	60 – 90%
5	Almost certain	Will almost certainly occur / recur, and could be a persistent issue	>90%

3.2. 2014/15 Assurance Framework

		lead	May	June	July	Sept
1	Failure to control healthcare acquired infections	DoN	10	10	10	10
2	failure to provide appropriate skill mix for “safe and suitable” staffing	DoN	20	20	20	20
3	non-compliance with CQC standards	DoN	12	16	16	16
4	Failure to ensure the safe management, statutory reporting, internal reporting and learning from incidents	DoN	12	12	9	9
5	failure to provide an adequate timely response to the deteriorating patient	MD	16	16	16	16
6	failure to meet the A&E target	COO	12	12	12	12
7	failure to meet the RTT target	COO	12	12	12	12
8	Failure to comply with standards for information governance	COO	12	12	12	12
9	loss of IT access in community settings	COO	12	12	12	12
10	failure to provide efficient fit for purpose estate	COO	16	16	16	16
11	Failure to influence commissioners in shaping future scope of services	CEO	15	15	15	15
12	failure to address Monitor concerns and return to green for governance	CEO	10	10	10	10
13	To fail to achieve planned surplus of £1.6m	DoF	20	20	20	20
14	Failure to achieve integrated care in Bolton	CEO	15	15	15	15
15	Low levels of staff engagement	HR	16	16	16	16

Report

TRUST BOARD

Subject **Integrated Performance Report – September 2014**

Prepared By **Performance and Information Team**

Approved By **Executive Management Team**

Presented By **Chief Executive – Bolton NHS Foundation Trust**

Purpose

This report sets out the Trust's integrated performance against leading national and local targets and draws attention to key areas for specific review by the Trust Board.

Driven by the Trust's strategic objectives this report is underpinned by a strong platform of integrated governance and assured data quality controls allowing the Trust Board to make effective decisions and demonstrate its commitment to delivering high quality healthcare for the people of Bolton.

To Receive	●
To Approve	

Trust Objectives

Quality and Safety	Valued Provider	Financially viable and sustainable	Great place to work	Fit for the future	Well Governed
●	●	●	●	●	●

Executive Summary

Please see the High level Executive Summary section at the beginning of the report

Key Recommendations

The Board are asked to receive the report and give approval.

Acronyms/Terms used in Report

Appendix A

Report change log

Appendix B

Contents

Executive Summary

This executive summary provides an integrated overview of the Trust Board Performance Report. Supporting the Trust's Strategic Objectives it orientates executives quickly to the areas that have been escalated, are of particular note or political significance. The accompanying High-Level Dashboard and narrative gives further analyses. Compliance levels with the Monitor Risk Assessment Framework and CQC (Care Quality Commission) are also shown.

Improving the Quality of Care and Safety of our patients

- ☒ Complaints responded to within timescale reduced to 77.5% in August. The lowest performance this financial year.
- ☒ There was 1 avoidable Pressure Ulcer in the Hospital and none in the Community during August 2014.
- ☑ The C.Diff occurrence rate is reducing and has a projected out-turn of 24 cases, 50% below the end of year target.

A great place to work

- ☑ Staff Turnover has now been below the 10% target every month this financial year.
- ☒ Local induction attendance is down for the fourth month in a row to 68.1%
- ☒ Sickness has reduced to 4.57% across the Trust
- ☒ Appraisals completed dropped slightly in August 2014 to 77.4%

Valued provider of Integrated Services

- ☑ A+E performance has maintained a level over the 95% threshold for the fourth consecutive month.
- ☑ The percentage of patients who spend 90% of their hospital stay on the stroke unit has regained performance in August 2014 reporting at 86.8%.
- ☒ Diagnostic waits longer than 6 weeks rose to 1.7% due to failure of the endoscopy washer.

Our Patients

Fit for the future

Healthier Together consultation. The Trust will respond individually as well as collectively across the NW sector.

Integration - The Better Care Fund. Trialling integrated neighbourhood team working underway.

All CQUIN targets are on plan for Quarter two

Independent review of Data Quality and Board Level Quality Indicators is being presented to the Audit Committee in September.

Financially viable and sustainable

- ☑ Year end forecast surplus of £1.6m is on plan
- ☑ August's in month deficit is £0.03m and is £0.05m better than plan
- ☑ ICIP delivery is £1.8m in month, which is £0.06m better than plan.
- ☒ Year to date plan is off track by £135k

Well Governed

Monitor Risk Assessment Framework

Governance	Finance - Level 2

CQC

The Trust continues to be licensed to carry out regulated activities with no conditions imposed on our registration status

The Trust has been awarded a band 4 weighting by the CQC

All data correct and verified - Tuesday 16th September 2014

All data correct and verified - Tuesday 16th September 2014

High Level Executive Dashboard

Improving The Quality Of Care And Safety Of Our Patients	Plan 14/15	Plan YTD	Actual YTD	Monthly Actual	Monthly Change	On Plan Off Plan
Total number of new SUIs received within the month	0	0	2	0	↑	☒
Total Incidents reported on Safeguard	10786	4494	4081	841	↓	☒
Never Event	0	0	2	0	→	☒
All Patient Falls (Safeguard)	982	410	390	81	↓	☑
Acute Inpatients acquiring pressure damage (grades 2+)	27	11	27	1	↑	☒
Community patients acquiring pressure damage	76	32	30	4	↑	☒
VTE Assessment Compliance	95.0%	95.0%	97.0%	97.2%	↓	☑
Total number of medication incidents	636	265	464	109	↑	☒
Same sex accommodation	0	0	4	0	↑	☒
C Diff Hospital acquired	48	20	10	1	→	☑
CHKS RAMI (Rolling 12 months)	100	100	80	80	→	☑
SHMI	1.000	1.000	1.072	1.063	→	☑
Surgical WHO Checklist compliance (Elective)	100%	100.0%	97.4%	98.0%	↓	☒
Surgical WHO Checklist compliance (Emergency)	100.0%	100.0%	98.6%	100.0%	↑	☑
Formal complaints from patients	240	100	251	54	↑	☒
Complaints responded to within the time period %	95.0%	95.0%	92.2%	77.5%	↓	☒

Valued Provider Of Integrated Services	Plan 14/15	Plan YTD	Actual YTD	Monthly Actual	Monthly Change	On Plan Off Plan
A&E 4 hour target	95.0%	95.0%	95.7%	96.5%	↑	☑
RTT Admitted Clock Stops %	90.0%	90.0%	94.6%	93.4%	↓	☑
RTT Non-Admitted Clock Stops %	95.0%	95.0%	97.3%	96.8%	↓	☑
RTT: Incomplete pathways within 18 weeks %	92.0%	92.0%	94.6%	95.7%	↑	☑
Diagnostic waits >6 weeks %	1.0%	1.0%	0.7%	1.7%	↓	☑
% of patients who spend 90% of their stay on the stroke unit	80.0%	80.0%	82.3%	86.8%	↑	☑
% Readmissions within 30 days of discharge	12.6%	12.6%	14.3%	13.8%	↑	☒

Financially Viable And Sustainable	Plan 14/15	Plan YTD	Plan Actual YTD	Monthly Actual	Monthly Change	On Plan Off Plan
Forecast year end deficit - FYE	1.6	1.6	1.6	0.0	0.0	0.0
Forecast year end income and cost improvement - FYE	22.2	22.2	22.2	0.0	0.0	0.0
Actual position against plan - YTD	1.6	-0.4	-0.5	0.0	-0.3	-0.1
Actual Income and Cost Improvement -YTD	22.2	8.1	8.0	1.7	0.2	-0.1
Capital Expenditure YTD	-17.5	-3.5	-0.9	-0.1	-0.2	2.7
Cash Position YTD	1.1	2.0	7.1	7.1	-0.6	5.1
Continuity of services rating	2.0	2.0	2.0	2.0	0.0	0.0

Developing Our Staff	Plan 14/15	Plan YTD	Actual YTD	Monthly Actual	Monthly Change	On Plan Off Plan
Completion of local induction system (starters in the last 12 months)	100%	100%	78.1%	68.1%	↓	☒
Substantive Staff Turnover Headcount (rolling average 12 months) <=10%	10%	10%	9.4%	9.4%	↑	☑
Appraisals completed %	80%	80%	79.0%	77.4%	↓	☒
Sickness days % of days lost	3.75%	3.75%	4.76%	4.57%	↑	☒
Mandatory Training Compliance %	100%	100%	85.3%	85.2%	↓	☒

Cancer Treatment Targets (7) reported 1 month retrospectively	Plan 14/15	Plan YTD	Actual YTD	Monthly Actual	Monthly Change	On Plan Off Plan
Patients 2 week wait (all cancers) %	93.0%	93.0%	93.0%	98.4%	↑	☑
Patients 2 week wait (breast symptomatic) %	93.0%	93.0%	93.0%	97.6%	↑	☑
31 days to first treatment %	96.0%	96.0%	96.0%	99.0%	↓	☑
31 days subsequent treatment (surgery) %	94.0%	94.0%	94.0%	100.0%	→	☑
31 days subsequent treatment (anti cancer drugs) %	98.0%	98.0%	98.0%	100.0%	→	☑
62 day standard %	85.0%	85.0%	85.0%	93.3%	↑	☑
62 day screening %	90.0%	90.0%	90.0%	100.0%	→	☑

Well Governed	Status
Monitor Risk Assessment Framework	☑ On Plan
CQC Intelligent Monitoring Report	☑ On Plan
CQC Essential Healthcare Standards (5)	☑ On Plan
CQUINS: National Clinical Quality Indicators	☑ On Plan
Report to prevent future deaths	☑ On Plan
Litigation	☑ On Plan
Formal Contract Notices	☑ On Plan
Formal Performance Notices	☑ On Plan
Contract Fines/Penalties	☒ Off Plan

Fit for the Future	Status
Board Assurance Framework	☑ On Plan
Patient Experience Strategy	☑ On Plan
Risk Management Strategy	☑ On Plan

↑ Performance improved but off target in month

↓ Performance deteriorated and off target in month

↑ Performance improved and on target in month

↓ Performance deteriorated but on target in month

The On Plan / Off Plan Columns represent a projected Year End position. The status columns represents the current status of the initiative detailed

All data correct and verified - Tuesday 16th September 2014

Monitor Risk Report 2014-15

Indicator (All measured/reported Quarterly)	Threshold	Weighting	Quarter 1 Actual	Jul-14	Aug-14	Quarter 2 Actual
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	94.9%	94.7%	93.4%	94.1%
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	97.5%	97.2%	96.8%	97.0%
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	96.6%	95.5%	95.7%	95.6%
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	95.5%	95.4%	96.5%	96.0%
All cancers: 62-day wait for first treatment from:						
(from urgent GP referral) - post local breach re-allocation *(Amended)*	85%	1.0	90.7%	93.3%		93.3%
(from NHS Cancer Screening Service referral) - post local breach re-allocation *(Amended)*	90%		100%	100%		100%
(from urgent GP referral) - pre local breach re-allocation *(New)*			93%	95%		95%
(from NHS Cancer Screening Service referral) - pre local breach re-allocation *(New)*			100%	100%		100%
All cancers: 31-day wait for second or subsequent treatment						
Surgery	94%	1.0	100%	100%		100%
Drug treatments	98%	1.0	100%	100%		100%
From diagnosis to first treatment	96%	1.0	99%	99%		99%
Cancer: two week wait from referral to date first seen, comprising:						
Cancer 2 week (all cancers)	93%	1.0	97.5%	98.4%		98.4%
Cancer 2 week (breast symptoms)	93%		95.6%	97.6%		97.6%
C.Diff due to lapses in care *(Amended)*	12	1.0	8	1	1	2
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review) *(New)*			8	9	10	10
C.Diff cases under review *(New)*			0	0	0	0
Certification against compliance with requirements regarding access to health care for people with a learning disability		1.0	100%	100%	100%	100%
Community care:						
Referral to treatment information completeness	50%	1.0	99.4%	99.4%	99.4%	99.4%
Referral information completeness	50%		100.0%	100.0%	100.0%	100.0%
Activity information completeness	50%		100.0%	100.0%	100.0%	100.0%
Risk of, or actual, failure to deliver Commissioner Requested Services			No	No	No	No
CQC compliance action outstanding (as at time of submission)			No	No	No	No
CQC enforcement action within last 12 months (as at time of submission)			No	No	No	No
CQC enforcement action (including notices) currently in effect (as at time of submission)			No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)			No	No	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)			No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration			No	No	No	No

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High level Executive Report September 2014

Harm Free Care

- Incidents reported in August were lower than July with 841 incidents; however, it does remain high compared to the first quarter of 2014. The Governance team continue to raise awareness with the clinical and support teams in relation to the importance of timely and accurate reporting of incidents.

- The reduction in performance for complaint response has been discussed at the Integrated Performance Management Meeting on the 27th August and at the Clinical Governance and Quality meeting on 3rd September. The Head of Governance is responsible for the development of a recovery plan and is hosting a meeting to establish the root causes of this unexpected fall in performance, the initial review suggests the reasons are multi factorial. The Complaints Management Policy is being reviewed to enhance complaint response performance and this will be presented to the October Clinical Governance and Quality Committee on 1st October. The recovery plan will outline how the Trust will have no outstanding complaint responses by the end of September, though it should be noted that performance will not be back on track for September due to some complaints being carried forward from August.

- There were 81 reported patient falls in August an increase of 4 over July's numbers. The table below shows the areas with the highest numbers of falls:

Ward	*Number of Falls*
Intermediate Care Residential	11
Ward B1	8
Ward C1	8
Ward D1-AMRU	8

Pressure Damage

- There was one avoidable in patient Pressure Ulcer and none in the Community during August 2014. There were four unavoidable Pressure Ulcers in the Community of which three were grade 3 and one was a grade 2.

Acquired Infection

- No MRSA infections were reported in August. As of August 31st August there had been no cases reported by the Trust for 240 days.
- 1 C. Diff case was reported in August which was attributed to a high risk patient known GDH (Glutamate Dehydrogenase) positive and managed in a side room throughout their stay. Antibiotic management was appropriate according to clinical need.
- The Trust is on target to meet both its external year end C. Diff target of 48 and the internal target of 28. There were 10 Trust apportioned cases to the end of August against a trajectory of 20 cases (external objective) and 12 cases (internal objective). There have been no clear themes from case reviews although there is on-going work on timely specimen collection and antibiotic prescribing.
- The Healthcare Associated Infections (HCAI) reduction action plan has been presented to the Divisions at the Infection prevention & control (IPC) committee and there is on-going work aligning the objectives in the plan with the Divisional work streams.
- A second substantive microbiology consultant has been recruited and has started in post. Working with the assistant Director of Infection Prevention and Control and the antibiotic pharmacist, a gap analysis is being undertaken and a comprehensive training needs assessment that will be presented to the IPC committee.
- There was a C Diff related death certificate Part 1. This case is currently being reviewed by the Medical Director and will be subject to feedback through the IPC committee.

Valued provider of Integrated Services

National Targets

- The A&E 4 hour target was achieved again in August with a performance of 96.5%. The target of 95% has been achieved for the last four months.

- There are no Ambulance handover figures available for August at the time of writing. This is due to a software problem relating to the NWAS handover screen. NWAS are aware and are liaising with the software company to roll out new software across all the Trusts in the North West.

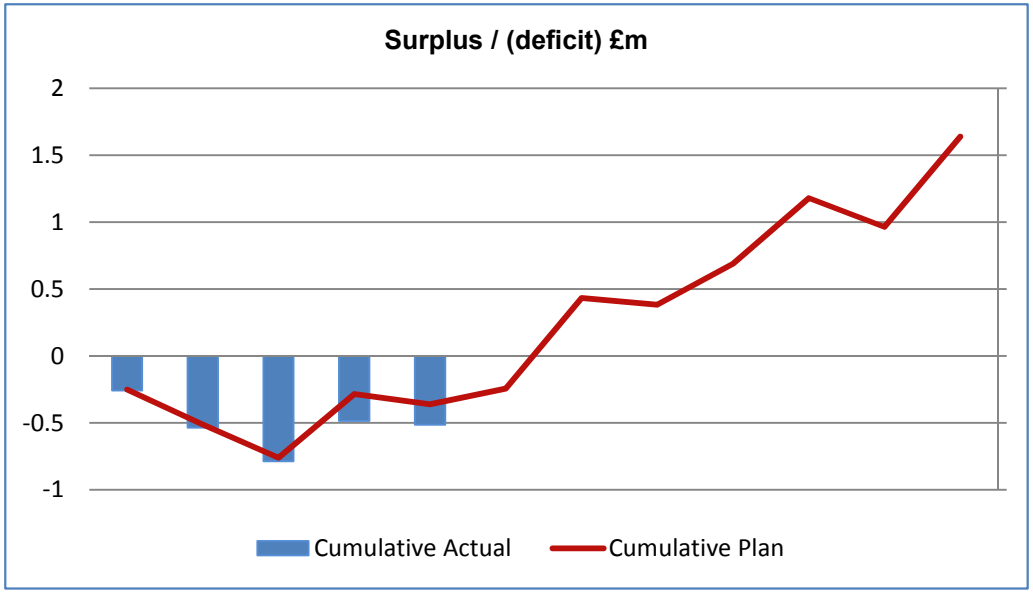
- Diagnostic waits longer than 6 weeks rose to 1.7%, missing the 1% target. This was as a direct result of the endoscopy washer failure. The Senior Management team have met with the company responsible and an action plan to improve requested. Every effort is being taken to recover the position for September.

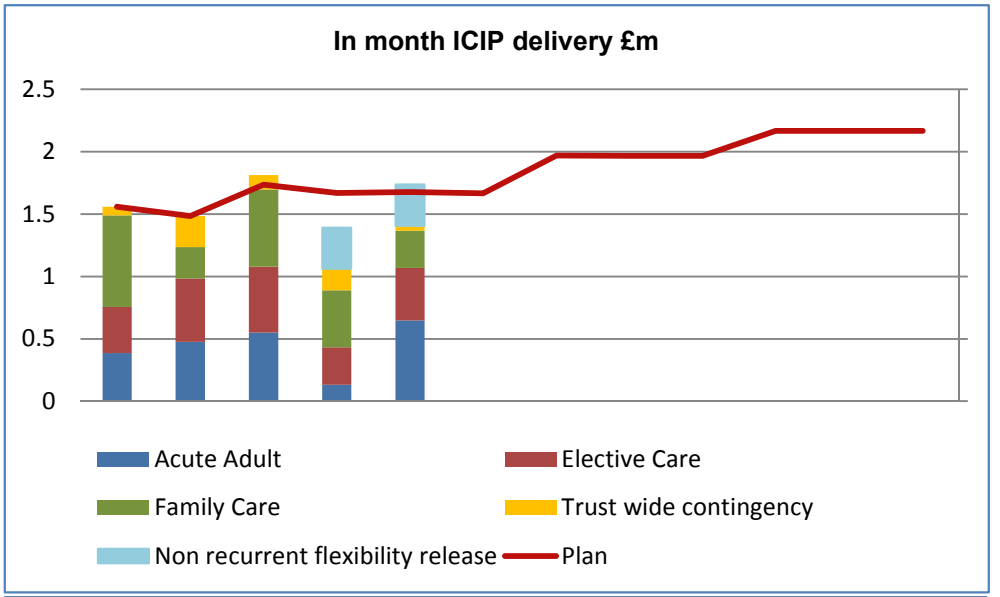
- Stroke performance for the 90% stay target was met in August. This is now back on track following last month's failed performance. There is an action plan in place, as reported last month to ensure this, and the other targets for stroke, are improved. This work is currently continuing.

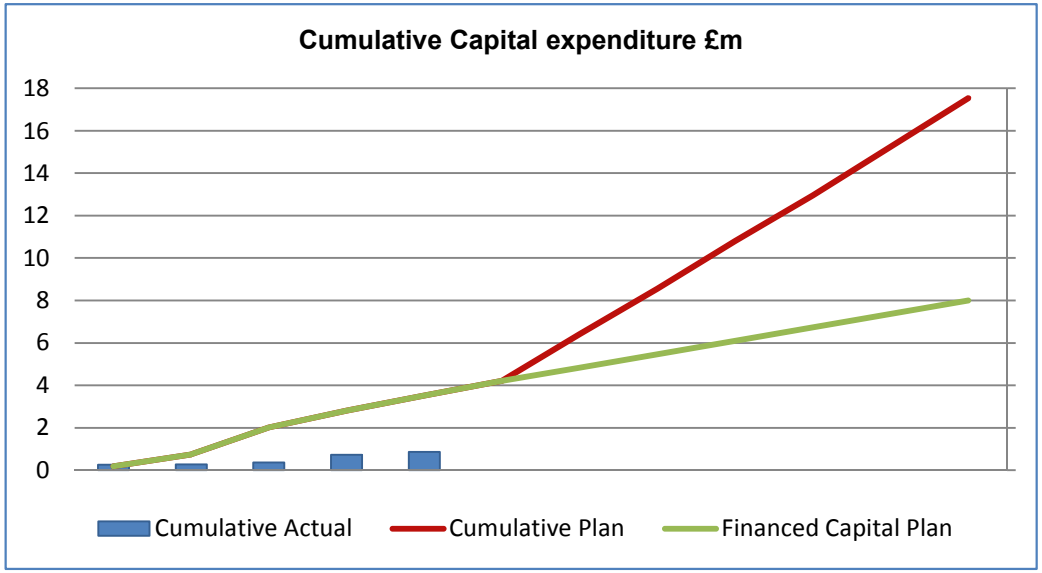
- Cancer targets are reported one month in arrears. In August all cancer targets were achieved.

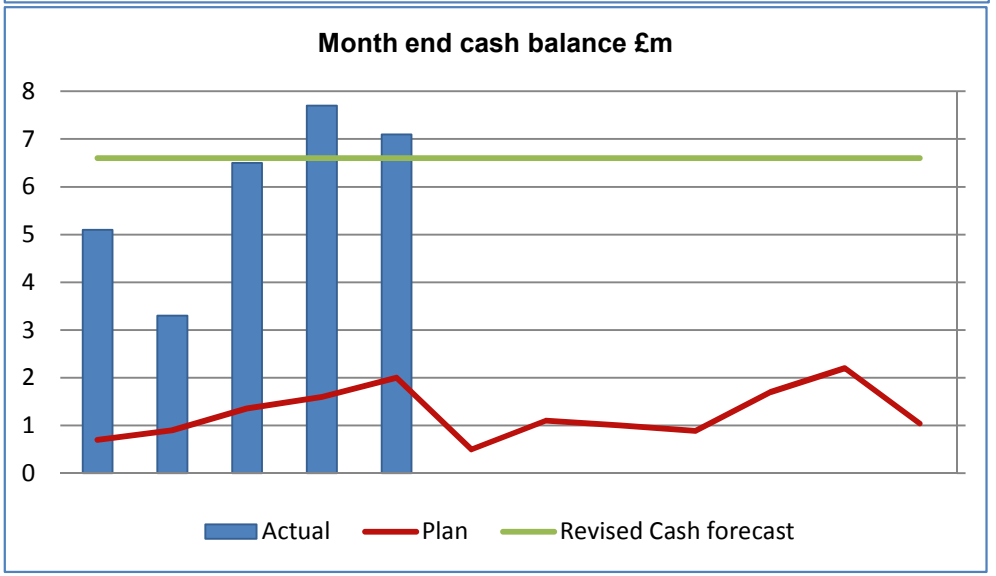
- Referral to Treatment figures during August remains consistent with July's reported figures. The RTT status is achieved for the fifth month, we continue to have no 52 week waiters.

1. Executive Dashboard & Commentary









All data correct and verified - Tuesday 16th September 2014

1. Executive Dashboard & Commentary

Income & Expenditure

Overall the Trust has an adverse variance to plan of £0.14m with a year to date deficit of £0.50m. The August 2014 in month position shows a small deficit of £0.03m against the planned deficit of £0.08m. The August position is made up of:

- Income overall is better than plan in month at £23.56m, compared to a plan of £22.73m, with clinical over achieving by £0.77m.
- Pay spend is £16.65m, an under spend of £0.84m.
- Non pay spend is £6.14m, an under spend of £0.05m.
- The overall position is slightly better than anticipated and the Trust has used £0.03m of Risk Reserve in month. Year to date the maximum available has been utilised.
- The Trust has released, Non recurrently, £0.66m into the position.
- ICIPs delivered in August total £1.7m. The year to date delivery is £8m, which is in £0.1m behind plan.

The Trust is still forecasting to deliver the year-end target surplus of £1.6m, however this will require utilisation of the £6.2m risk reserve, £4.8m being used to mitigate financial risk and £1.4m being used to finance developments. There is a risk range of delivery from a deficit of £6.1m to a surplus of £3.6m and this range will narrow as we go through the year. To manage the risk within the forecast the downside risk management plan has been enacted, consequently the Corporate division has been tasked with bringing forward 2014/15 ICIP schemes to deliver an additional £1.2m and Estates

Cash & Capital

- There was a cash balance of £7.1m at the end of the month. This is higher than the £2.0m plan and is in line with the Trust cash management strategy.

- The Capital budget for the year is £6.1m plus £1.7m of financed developments. Dependent on additional finance being agreed, there is potential for a further £3.2m in developments related to the Estates & IT strategy. The remaining £6.5m of these proposed developments have now slipped into 2015/16.
- At the end of August the Capital programme is underspent by £2.7m against plan.
- The Trust is reviewing the Capital forecast for the year in light of the Estates and IT business cases and steps are also being taken to progress capital spend for M6.

- The Trust Continuity of Service rating remains 2 as planned for Q2.

2.1.1 Trust Income & Expenditure position

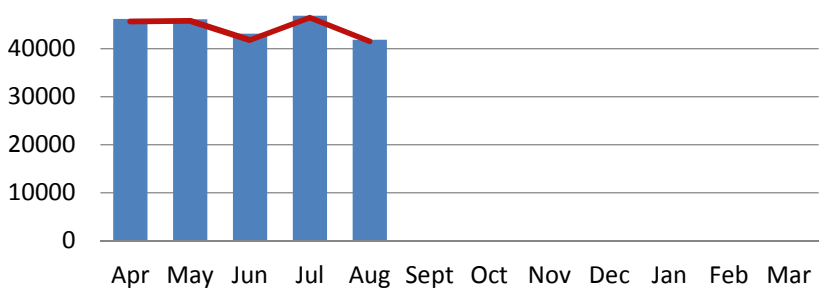
		In Month			Year to Date		
Trust Summary	*Annual budget £m*	*Budget £m*	*Actual £m*	*Var £m*	*Budget £m*	*Actual £m*	*Var £m*
Contract income	254.3	20.6	21.3	0.8	105.3	107.1	1.7
Education and Training Income	8.6	0.7	0.7	0.0	3.7	3.7	0.0
Other income	17.5	1.4	1.5	0.1	7.4	7.9	0.5
Total Income	*280.3*	*22.7*	*23.6*	*0.8*	*116.4*	*118.6*	*2.2*
Direct - Pay	(188.9)	(15.8)	(16.7)	(0.8)	(79.2)	(83.1)	(3.9)
Direct - Non Pay	(74.2)	(6.2)	(6.1)	0.1	(31.0)	(31.9)	(0.9)
Risk reserve	(6.2)	(0.0)	0.0	0.0	(2.7)	0.0	2.7
Total Operational Costs	*(269.3)*	*(22.0)*	*(22.8)*	*(0.8)*	*(112.8)*	*(115.0)*	*(2.2)*
EBITDA	*11.0*	*0.7*	*0.8*	*0.1*	*3.6*	*3.6*	*0.1*
Capital charges	(9.4)	(0.8)	(0.8)	(0.0)	(3.9)	(4.1)	(0.2)
Total Costs	*(278.7)*	*(22.8)*	*(23.6)*	*(0.8)*	*(116.8)*	*(119.1)*	*(2.4)*
Surplus / (Deficit)	*1.6*	*(0.1)*	*(0.0)*	*0.0*	*(0.4)*	*(0.5)*	*(0.1)*

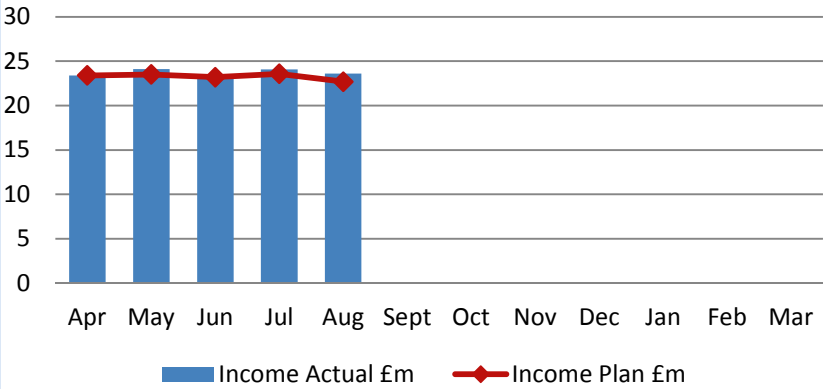
2.3.1 Income Summary position

Areas of Delivery	In Month Movement: Activity Plan	Activity Actual	Activity Var	Income Plan £m	Income Actual £m	Income Var £m	Year to Date: Activity Plan	Activity Actual	Activity Var	Income Plan £m	Income Actual £m	Income Var £m
Unscheduled Care	15,012	14,594	(418)	6.9	7.3	0.4	75,642	77,342	1,700	34.7	35.8	1.1
Scheduled Care	2,744	2,351	(393)	2.7	2.4	(0.3)	13,999	13,358	(642)	13.9	13.1	(0.8)
Outpatient Care	22,881	24,227	1,346	3.0	3.1	0.1	127,032	127,291	260	16.6	16.5	(0.0)
Clinical Support Services	863	652	(211)	0.6	0.6	(0.0)	4,019	3,707	(312)	2.9	2.9	(0.0)
Other & Block				9.5	10.1	0.7				48.3	50.3	2.0
Total £m				*22.7*	*23.6*	*0.8*				*116.4*	*118.6*	*2.2*

Trust Income year to date

- Unscheduled Care - in activity terms we have seen a reduction in month with A&E attendances reducing by 1,00 in month. Non-elective admissions have also reduced in month. The financial impact of this movement has been positive due to a reduction in amount of activity that paid at 30% above the marginal rate threshold, which is calculated on a cumulative basis.
- Scheduled Care - activity and financially we are still behind plan year to date and in month. All of the underperformance is within the elective point of delivery, as the day cases point of delivery remains on plan year to date.
- Outpatient Care - is above plan in the month, but remains slightly below plan year to date. The two main areas of under performance is still antenatal pathways and outpatient follow-up activity.
- Clinical Support Services - this area remains slightly behind plan both in month and year to date. The main area of variation is ECGs which is below plan both in month and year to date.
- Block & Other - is above plan both in month and year to date, the significant movements in month are due to a long stay patient on critical care being discharged and passthrough drugs & devices.
- Penalties & CQUINS - there has been some increases in penalties but we still remain lower than last year and significant better than plan.
  (more detailed information on income is available at appendix 10.03 to 10.05)





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2.4.1 Pay costs position

		In Month			Year to Date		
Pay category	Annual budget £m	Budget £m	Actual £m	Var £m	Budget £m	Actual £m	Var £m
Senior Managers	(5.2)	(0.4)	(0.4)	0.0	(2.2)	(2.0)	0.1
Medical and Dental	(47.8)	(4.0)	(3.8)	0.1	(20.1)	(19.1)	1.0
Nursing, Midwifery And Health Visiting	(71.5)	(5.9)	(5.9)	0.0	(29.9)	(30.1)	(0.3)
Scientific, Therapeutic and Technical	(23.7)	(2.0)	(1.9)	0.1	(9.9)	(9.3)	0.6
Professional and Technical	(4.9)	(0.4)	(0.4)	0.0	(2.1)	(2.0)	0.1
Administrative and Clerical	(21.8)	(1.8)	(1.7)	0.1	(9.1)	(8.6)	0.4
Healthcare Assistants and Other Support Staff	(19.5)	(1.6)	(1.5)	0.1	(8.1)	(7.6)	0.5
Agency Staff	(2.2)	(0.2)	(0.9)	(0.7)	(1.1)	(3.7)	(2.7)
Other Pay Budgets	7.6	0.6	(0.1)	(0.7)	3.0	(0.7)	(3.7)
Total	*(188.9)*	*(15.8)*	*(16.7)*	*(0.8)*	*(79.2)*	*(83.1)*	*(3.9)*

Pay

In total £16.7m has been spent on pay in August compared to a budget of £15.8m, an over spend of £0.8m. This is £0.3m worse than July, mainly on medical staff.

The main areas of overspend in August are

Agency - £0.85m of spend against a budget of £0.20m;

Medical £287k – Radiology (£65k), Complex Care (£49k), Infection control (£29k), Microbiology (£27k), Ophthalmology (£25k) and Neonatology (£28k)
Nursing £201k – Acute Medicine (£38k), Complex care (£43k), General surgery £28k) and Endoscopy (£16k)
Admin £88k
Other £80k – Blood sciences (£30k) and CAMHS (£23k)

The Other Pay Budgets includes the cost reductions (ICIPs) monies that have all been removed from specific specialty budgets, but not yet allocated

2.5.1 Non Pay costs position

		In Month			Year to Date		
Non Pay category	Annual budget £m	Budget £m	Actual £m	Var £m	Budget £m	Actual £m	Var £m
Drugs	(17.5)	(1.5)	(1.7)	(0.2)	(7.3)	(7.9)	(0.6)
Medical & Surgical	(10.1)	(0.8)	(0.9)	(0.1)	(4.2)	(4.5)	(0.2)
Clinical Supplies	(9.2)	(0.8)	(0.8)	(0.1)	(3.8)	(4.0)	(0.2)
Activity Dependent	*(36.8)*	*(3.1)*	*(3.4)*	*(0.3)*	*(15.4)*	*(16.3)*	*(1.0)*
Establishment	(10.5)	(0.9)	(0.9)	(0.0)	(4.4)	(4.6)	(0.2)
Estates & Premises	(11.4)	(1.0)	(0.8)	0.1	(4.8)	(4.5)	0.3
Services from other NHS bodies	(3.2)	(0.3)	(0.2)	0.1	(1.4)	(1.6)	(0.2)
Other Non Pay	(12.2)	(1.0)	(0.8)	0.2	(5.1)	(4.9)	0.2
Other Non Pay	*(37.4)*	*(3.1)*	*(2.7)*	*0.4*	*(15.6)*	*(15.5)*	*0.0*
Total Non Pay	*(74.2)*	*(6.2)*	*(6.1)*	*0.1*	*(31.0)*	*(31.9)*	*(0.9)*
Total Risk Reserve	*(6.2)*	*(0.0)*	*0.0*	*0.0*	*(2.7)*	*0.0*	*2.7*

Non Pay

The total non-pay spend at £6.1m is £0.1m better than plan.

Non pay expenditure against activity dependant items is overspent in month by £0.3m. This is due to expenditure above plan of £0.21m on PbR/FP10 drugs (which has an offsetting income increase). Clinical costs are up in month by £0.1m, with £0.18m on ICD implants (which has an offsetting income).

This is offset by the release of £0.3m of non-recurrent year end flexibilities into the position, along with £0.2m of residual redundancy provision no longer required.

2.6.1 Capital Charges

Trust Position	Annual budget £m	In Month Budget £m	In Month Actual £m	In Month Var £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Var £m
Dividends	(3.2)	(0.3)	(0.3)	0.0	(1.4)	(1.3)	0.0
Interest Paid	(0.9)	(0.1)	(0.1)	0.0	(0.4)	(0.3)	0.1
Interest Received	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
Depreciation	(5.2)	(0.4)	(0.5)	(0.0)	(2.2)	(2.5)	(0.3)
Total	*(9.4)*	*(0.8)*	*(0.8)*	*(0.0)*	*(3.9)*	*(4.1)*	*(0.2)*

£m Values	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Dividends	(0.3)	(0.3)	(0.3)	(0.2)	(0.3)								(1.3)
Interest Paid	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)								(0.3)
Interest Received	0.0	0.0	(0.0)	0.0	0.0								0.0
Depreciation	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)								(2.5)
Total	*(0.8)*	*(0.8)*	*(0.8)*	*(0.8)*	*(0.8)*								*(4.1)*
Plan	*(0.8)*	*(0.8)*	*(0.8)*	*(0.8)*	*(0.8)*								*(3.9)*
Variance to Plan	*(0.0)*	*(0.1)*	*(0.1)*	*(0.0)*	*(0.0)*								*(0.2)*

Capital charges

Depreciation charges are £40k per month above plan, this is being investigated.

A proportion of the risk reserve has been set aside to cover the increased depreciation on Community IT, the budget transfer will be made in due course.

4.1 Statement of Financial Position year to date

£m Values	Mar-14	Aug Plan £m	Aug Actual £m	Var to plan £m	Year end Plan £m
Non-current assets					
Intangible assets	0.5	0.3	0.5	0.2	0.3
Property, plant & equipment	131.4	126.1	129.8	3.7	137.1
Trade & other receivables >1 year	0.7	0.9	0.6	(0.3)	0.9
	132.6	*127.4*	*130.9*	*3.5*	*138.4*
Current assets					
Inventories	1.6	1.6	1.7	0.1	1.6
Trade receivables	5.4	3.3	3.0	(0.3)	2.8
Other receivables	0.8	0.8	2.2	1.4	0.8
Accrued income	1.8	2.8	3.7	0.9	2.8
Prepayment	1.3	1.7	2.0	0.3	1.5
Cash & cash equivalents	0.4	2.0	7.2	5.2	1.0
	11.3	*12.2*	*19.8*	*7.6*	*10.5*
Total assets	*143.9*	*139.6*	*150.7*	*11.1*	*148.9*
Current liabilities					
Loans due < 1 year	(1.4)	(2.8)	(1.4)	1.4	(2.8)
Trade payables	(7.3)	(9.2)	(11.1)	(1.9)	(8.8)
Accruals	(4.6)	(4.6)	(6.1)	(1.5)	(4.6)
Payments on Account	(0.4)	(0.6)	(0.2)	0.4	(0.6)
Leases due < 1 year	(0.1)	(0.1)	(0.1)	0.0	(0.1)
Other current liabilities	(8.1)	(9.5)	(11.2)	(1.7)	(7.7)
	(21.9)	*(26.7)*	*(30.1)*	*(3.4)*	*(24.6)*
Net Current assets / (liabilities)	*(10.6)*	*(14.6)*	*(10.3)*	*4.3*	*(14.1)*
Non-current liabilities					
Loans due > 1 year	(18.5)	(16.5)	(17.9)	(1.4)	(25.5)
Provisions	(0.3)	(0.3)	(0.3)	0.0	(0.3)
Leases due > 1 year	(0.1)	(0.3)	0.2	0.5	(0.7)
	(18.9)	*(17.1)*	*(18.0)*	*(0.9)*	*(26.5)*
Total assets employed	*103.1*	*95.7*	*102.6*	*6.9*	*97.7*
Taxpayers Equity:					
Public dividend capital	102.0	102.0	102.0	0.0	102.0
Retained earnings	(35.3)	(35.7)	(36.1)	(0.4)	(33.3)
Revaluation reserve	36.4	29.0	36.4	7.4	29.0
	103.1	*95.4*	*102.3*	*6.9*	*97.7*

Summary

- As at month 5 the Trust had net current liabilities of £10.3m an improvement from Month 4 of £0.4m and better than plan by £4.3m.
- The Trust's current assets are £7.6m above plan.
- The Trust's current liabilities of £30.1m compare with a plan of £26.7m. The variance of £3.4m relates to:-

Tax	0.3
Accruals	(1.5)
Provisions	(1.0)
Trade payables	(1.9)
Loans*	1.4
Other liabilities	(0.7)

* Loans current liability variance is offset by the non- current liabilities variance (1.5m). This is due to a change in repayable term since the plan was submitted.

- The plan was submitted prior to a revaluation of the Trust's assets therefore the property, plant and equipment variance is due to the impact of the revaluation.

All data correct and verified - Tuesday 16th September 2014

5.1 Cashflow Source and Application year to date

£m Values	Mar-14	Aug Plan £m	Aug Actual £m	Var to plan £m	Year end Plan £m
Income	24.4	23.1	23.0	(0.1)	283.0
Payments					
Salaries / Wages	(10.3)	(9.5)	(8.9)	0.6	(110.2)
Tax, NI & Superannuation	(4.4)	(3.7)	(6.0)	(2.3)	(71.2)
Capital	(3.3)	(0.8)	(0.1)	0.7	(15.5)
Non Pay	(12.2)	(8.7)	(8.5)	0.2	(90.1)
Loan repayment	(0.1)	0.0	0.0	0.0	(1.4)
Loan interest	(0.0)	0.0	0.0	0.0	(0.7)
PDC Dividend	(1.6)	0.0	0.0	0.0	(3.2)
PDC cash support	7.5	0.0	0.0	0.0	9.8
Total payments	*(24.4)*	*(22.7)*	*(23.6)*	*(0.9)*	*(282.4)*
Cashflow	(0.0)	0.4	(0.6)	(1.0)	0.6
Opening balance	0.5	1.6	7.7	6.1	0.4
Closing balance	*0.4*	*2.0*	*7.1*	*5.1*	*1.1*

Summary

- In month 5 there was a cash outflow of £0.6m with a closing cash balance of £7.1m.
- Cash is above plan by £5.1m at month 5.
- Block payments from Public Health Commissioning of £0.9m relating to month 5 activity were not received in month 5. These monies have since been received and steps have been taken to ensure prompt payment in future. Clinical Excellence and Greater Manchester West SLA monies are also anticipated to come in during September totalling £0.6m.
- The Trusts plan is showing a cash inflow of £0.6m for the year with a planned balance of £1.1m at 31st March 2015 this is based on the approved Budget / Annual plan. The Trust would look to maintain an improved cash balance during the year and improve on the year end position. On the assumption the I&E plan delivers a cash balance of £6.6m should be achievable by the year end.

6. Capital Expenditure position

Capital schemes	Annual budget £'000	In Month Budget £'000	In Month Actual £'000	In Month Var £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Var £'000
Plant and Equipment	2,037	88	16	(72)	920	283	(637)
Property - Maintenance	3,350	365	125	(240)	1,235	378	(857)
Plant and Equipment - Information Technology	713	85	0	(85)	486	23	(464)
Sub Total	6,100	538	141	(397)	2,641	683	(1,958)
Funded Developments	1,743	176	0	0	880	180	0
Schemes plus funded developments	***7,843***	***714***	***141***	***(573)***	***3,521***	***864***	***(2,658)***
Other Developments	9,693	0	0	0	0	0	0
GROSS CAPITAL EXPENDITURE	***17,536***	***714***	***141***	***(573)***	***3,521***	***864***	***(2,658)***

Capital Expenditure

- The Trust Capital plan is £6.1m plus £1.7m of financed developments. The further developments of £9.7m relate to Estates and IT strategy and are dependent on additional finance being agreed. Part of these strategies has now slipped into 15/16 with £3.2m remaining to be spent in 14/15.
- At the end of month 5 Capital Expenditure was £2,658k underspent.
- The main areas of underspend are Defibs, main walkway duct, M1 replacement windows and community IT with a total of £1.7m underspend against plan to month 5.
- The Trust has spent 25% of the year to date Capital plan, this is below the 85% Monitor threshold.
- Forecast Capital Expenditure is £11.0m with £6.5m now planned for 15/16. The forecast assumes £3.2m of this years developments will be funded via loans.

(*more detailed information on planned capital spend is available at appendix 10.09*)

6. Capital Expenditure position

Capital schemes	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Plant and Equipment	245	(10)	8	23	16								283
Property - Maintenance	7	31	60	155	125								378
Plant and Equipment - Information Technology	0	0	23	0	0								23
Sub Total	***252***	***21***	***91***	***178***	***141***								***683***
Funded Developments	0	0	0	180	0								180
Schemes plus funded developments	***252***	***21***	***91***	***358***	***141***								***864***
Other Developments	0	0	0	0	0								0
GROSS CAPITAL EXPENDITURE	***252***	***21***	***91***	***358***	***141***								***864***
Plan	***176***	***568***	***1,259***	***805***	***714***	***684***	***2,208***	***2,138***	***2,258***	***2,142***	***2,292***	***2,292***	***3,521***
Variance to Plan	***76***	***(547)***	***(1,168)***	***(446)***	***(573)***								***(2,658)***

7. Income & Cost Improvement Programme

			In Month			Year to Date		
Division	*Savings type*	*Full year target £'000*	*Forecast £'000*	*Actual £'000*	*Var £'000*	*Forecast £'000*	*Actual £'000*	*Var £'000*
Adult Acute	Pay	3,646	276	137	(139)	1,192	456	(736)
	Non Pay	700	52	297	245	246	(28)	(274)
	Income	2,822	222	89	(133)	1,273	411	(862)
	Corporate share	1,394	116	116	0	582	581	(1)
	Contingency	(1,184)	(148)	0	148	(814)	0	814
	Benefit of Risk reserve usage	0	0	8	8	0	772	772
Total Adult Acute		7,378	518	647	129	2,479	2,192	(287)
Elective	Pay	1,815	158	100	(58)	772	327	(445)
	Non Pay	1,017	84	(115)	(199)	422	(608)	(1,030)
	Income	4,720	394	227	(167)	1,968	970	(998)
	Corporate share	1,277	107	106	(1)	533	532	(1)
	Contingency	(1,104)	(138)	0	138	(759)	0	759
	Benefit of Risk reserve usage	0	0	4	4	0	708	708
Total Elective		7,725	605	322	(283)	2,936	1,928	(1,008)
Families	Pay	3,468	288	45	(243)	1,447	256	(1,191)
	Non Pay	618	52	69	17	254	636	382
	Income	2,968	248	98	(150)	1,237	490	(747)
	Corporate share	955	79	80	1	397	398	1
	Contingency	(912)	(114)	0	114	(626)	0	626
	Benefit of Risk reserve usage	0	0	7	7	0	578	578
Total Families		7,097	553	298	(255)	2,709	2,357	(352)
Trust wide Contingency		0	0	138	138	0	846	846
Trust wide Non Recurrent		0	0	333	333	0	666	666
Total ICIP Delivery		*22,200*	*1,676*	*1,738*	*62*	*8,124*	*7,989*	*(135)*

Cost Improvement Programme

- The Trust has released £666k non recurrently year to date, and with the divisions' releasing of risk reserves the overall delivery against ICIP plan is £135k adverse year to date.
- The corporate division has generated a surplus against the year to date plan, giving an overall value reported as Trust wide contingency to date.

8. Forecast outturn for year

Trust Summary	Annual budget £m	Forecast £m
Contract income	254.3	257.7
Education and Training Income	8.6	8.5
Other income	17.5	17.8
Total Income	***280.3***	***284.0***
Direct - Pay	(188.9)	(194.9)
Direct - Non Pay	(74.2)	(75.2)
Risk reserve	(6.2)	(2.9)
Total Operational Costs	***(269.3)***	***(273.1)***
EBITDA	***11.0***	***11.0***
Capital charges	(9.4)	(9.4)
Total Costs	***(278.7)***	***(282.5)***
Surplus / (Deficit)	***1.6***	***1.6***

Forecast outturn for year

- The Trust is forecasting that the £1.6m planned surplus for 2014/15 can be delivered
- Taking into account the Divisional forecast and allowing for 'optimism bias' within the Divisional Forecasts the Trust is forecasting that the £1.6m planned surplus for 2014/15 can be delivered by fully utilising the risk reserve of £6.2m
- To manage the risk within the forecast the Corporate division has been tasked with bringing forward 2014/15 ICIP schemes to deliver an additional £1.2m and Estates has been tasked with delivering £0.25m in year.

9. Continuity of Service Risk Rating (CSRR)

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Capital Service Cover rating	1	1	1	2	2							
Liquidity rating	1	1	1	1	1							
Continuity of Service Risk Rating - Actual	*1*	*1*	*1*	*2*	*2*							
Continuity of Service Risk Rating - Plan			*1*			*2*			*2*			*2*

Continuity of Service Risk Rating

- The Capital Service Cover rating is a 2 and the Liquidity rating 1, giving an overall Continuity of Service Risk Rating of 2.
- This is as per plan for quarter 2.

Workforce

- The sudden drop in reported performance in the number of completed Consultant Job Plans and Specialty and Associate Specialist Doctors, is due to the significant number of annual job plans that were completed in September 2013 and have now expired. The last round of Consultant job plans were signed off during the first half of 2013 rather than all in January 2013. A plan is currently being developed by the Medical Director in relation to this year's job planning round. This plan is due to commence in November 2014 so these indicators will remain low for a number of months.

- Medical staff changeover and seasonal factors have affected performance this month in Local Induction Attendance

Fit for the Future

Healthier Together

- The "Healthier Together - Question Time" event on Tuesday 2nd September held at the University of Bolton, was attended by more than 50 members of the public who attended to find out more about Healthier Together and question the panel. Topics covered included; the language used in the consultation, transport links, and services at GP surgeries. The deadline for Healthier Together questionnaire responses is the 30th September.

Well Governed

Independent Review of Data Quality and Board Level Quality Indicators

- The follow-up review, requested by the Trust, to give assurance that all of the recommendations relating to data quality and Board level quality indicators have successfully been implemented, is due to go to the Audit Committee in September.

Penalties

	Plan	Actual
	£'000	£'000
Penalties	(576)	(64)
C-Diff	0	0
TOTAL	(576)	(64)

- At month 4 we reported no penalties across some areas, all of these were validated as correct, but the final validated figures increased the value estimated for 18 weeks breaches in T&O. The estimated value for never events also increased slightly on validation.

- In month 5 reporting we are predicting the following penalties changes:

  - The validation reduction is where we can't charge for any activities that cannot be coded by the deadline; we have included an estimate for month 5 which is increasing from previous months.
  - Re-admission penalty is a set amount based on an audit; this value may change once we've completed a new audit of all emergency re-admissions within 30 days of original discharge. The audit looks at a sample of patients and determines how many of them could have been avoided if better primary/social care services existed.
  - The 18 weeks referral to treatment penalties are estimated to continue for T&O and Plastic Surgery.
  - There has also been another 28 binding date breach, this is where we have been unable to re-book a cancelled operation within 28 days of the cancellation. The penalty is non-payment of the patient episode.
  - Another mixed sex accommodation breach was reported during the month, the penalty is a set amount of £250 per breach.
  - Two never events have been recognised within the position this month. The penalty for never events is non-payment of the patient episode and an estimate has been used to derive the penalty.
  - We are predicting 18 week RTT penalties for Plastic Surgery again as well as T&O, the penalty is based on the previous month. The penalties are calculated based on the number of patients below the threshold times £100 for non-admitted breaches and £400 for admitted breaches.

Board Assurance Heat Map Staffing August 2014

INDICATORS	Acute Frailty Unit	B2	B4	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	Darley Court	H3 (Stroke Unit)	HDU	ICU	DCU (Daycare)	EU (Daycare)	E3	E4	F3	F4/F6 (Combined wards)	G3/G3TSU	G4	G5	H2 (daycare)	UU (Daycare)	E5 (Paed HDU and Obs)	F5 (Short Stay Paed Ass Unit)	M1 and Assessment	EPU	M2	CDS	M3 (Birth Suite)	M4/M5	NICU	Total
Number of Beds	22	26	26	25	26	26	27	10	14	26	22	27	27	34	24	10	8	15	15	25	25	24	27	23	25	13	10	4	38	7	16	6	16	18	5	44	38	774
Exception indicator	✓ ↑	✓ ↑	✗ →	✓ ↑	✗ →	✗ ↓	✗ →	✓ →	✗ ↓	✗ →	✗ →	✗ ↓	✗ →	✗ →	✓ →	✓ →	✓ →	✓ →	✓ →	✗ →	✗ →	✗ →	✗ →	✓ →	✗ ↓	✓ →	✓ ↑	✓ →	✓ →	✓ →	✓ →	✓ →	→	✓ →	✓ →	✓ →	✓ →	✓ →	
Friends and Family Net Promoter Score																																						78.6
Safety Express Programme Harm Free Care (%)	90.00%	92.31%	96.15%	92.00%	80.77%	100.00%	77.78%	88.89%	NA	100.00%	94.44%	80.77%	96.30%	85.19%	95.24%	100.00%	85.71%	NA	NA	100.00%	96.00%	100.00%	100.00%	85.00%	100.00%	NA	NA	NA	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	100.00%	100.00%	93.55%	94.19%
Weekly KPI Audit %																																						95.00%
Hand Washing Compliance %	100.00%	100.00%	100.00%	100.00%	83.89%	95.00%	100.00%	100.00%	98.33%	97.00%	100.00%	98.75%	100.00%	100.00%	97.00%	97.00%	99.00%	80.56%	99.00%	97.00%	92.92%	85.00%	99.00%	92.50%	95.67%	100.00%	100.00%	90.33%	100.00%	100.00%	98.00%	NA	98.33%	NA	100.00%	94.00%	98.33%	96.76%
1.60 - Monthly New pressure Ulcers (Grade 2+)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.01 - All Patient Falls (Safeguard)	8	4	5	8	6	1	5	1	2	8	2	0	2	0	5	0	0	0	0	2	3	0	0	1	1	1	0	0	2	0	0	0	0	0	0	0	0	67
1.13 - Infection Control (C. Diff)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
1.39 - MRSA HA aquisitions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.20 - VTE Assessment Compliance (June 14)	97.78%	75.00%	NA	100.00%	54.55%	83.72%	75.00%	98.31%	99.18%	99.03%	97.74%	96.00%	86.96%	NA	94.23%	100.00%	100.00%	94.31%	97.39%	100.00%	94.74%	99.55%	99.46%	97.87%	94.74%	95.38%	98.99%	100.00%			99.31%		98.94%	96.39%	91.08%	93.10%		96.97%
ESSA Assessment	**	**	*	***	**	***	*	**	**	**	*	***	*	*	**	***	***	N/A	N/A	INFORMATION NOT SUBMITTED	***	INFORMATION NOT SUBMITTED	*	***	***	***	N/A	N/A	**	N/A	***	N/A	***	***	***	***	***	
1.27 - Number of complaints received	1	2	0	0	0	1	1	0	1	2	1	2	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	0	0	1	1	1	1	1	2	1	23
Budgeted Nurse: Bed Ratio (WTE)	1.41	1.16	1.16	1.21	1.16	1.16	1.22	2.75	1.43	1.53	1.59	1.12	1.12	0.94	1.37	4.00	6.57	1.75	1.96	1.18	1.17	1.62	1.40	1.46	1.48	1.48	2.87	4.02			1.73							1.40
Actual/Current Nurse: Bed Ratio (WTE)	1.22	1.06	1.06	1.22	1.23	1.02	1.06	2.48	0.99	1.37	1.60	0.97	1.05	0.93	1.33	4.05	6.25	1.58	1.90	1.14	0.98	1.39	1.23	1.56	1.18	1.42	2.96	3.72			1.51							1.29
% Qualified Staff (Night)	95.0%	98.4%	100.0%	100.0%	98.4%	101.6%	100.0%	98.4%	95.2%	90.1%	87.9%	100.0%	100.0%		98.4%	94.6%	93.0%			100.0%	100.2%	88.1%	74.4%	106.5%	77.3%	88.6%			82.3%		100.0%		98.5%	89.4%	78.0%	93.5%	100.0%	94.26%
% un-Qualified Staff (Night)	119.1%	189.8%	201.1%	140.4%	100.7%	216.1%	193.5%	100.0%	103.2%	125.8%	109.7%	119.4%	121.0%		135.5%	100.0%	0.0%			117.7%	122.3%	108.3%	82.9%	126.3%	99.8%	80.3%			67.7%		95.2%		100.0%	115.6%	71.0%	68.8%	96.7%	114.27%
% Qualified Staff (Day)	93.5%	90.2%	84.3%	95.8%	98.7%	86.1%	87.1%	98.8%	94.6%	82.5%	79.4%	83.4%	85.7%		96.2%	88.7%	88.1%			84.8%	83.3%	78.5%	68.5%	74.5%	80.8%	86.5%			81.6%		78.8%		97.5%	90.3%	92.6%	88.8%	109.4%	87.64%
% un-Qualified Staff (Day)	110.4%	178.7%	145.9%	117.3%	99.8%	168.0%	135.3%	142.1%	47.2%	97.9%	107.0%	115.7%	108.2%		98.5%	88.6%	75.9%			107.0%	116.6%	98.0%	75.7%	143.1%	100.2%	80.1%			54.6%		91.6%		91.3%	77.4%	70.0%	64.4%	77.9%	102.81%
AUKUH Acuity/Dependancy (WTE)			0.40	2.65	-4.40	-0.81	1.84	N/A	6.82			0.68		-9.05		N/A	N/A	N/A	N/A	-2.08	1.05	12.84	16.98	6.69	-1.62	6.23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
1.07 - Total Incidents reported on Safeguard	17	7	21	14	12	7	18	5	9	22	16	6	5		8	10	10	22	13	9	13	7	12	11	9	9	0	5	21	6	21	1	5	64	11	12	24	**462**
SUIs in Month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Current Budgeted WTE (From Ledger)	31.02	30.22	30.22	30.22	30.23	30.22	32.87	27.53	19.97	39.65	35.05	30.23	30.24	32.02	32.88	39.96	52.54	26.23	29.42	29.40	29.35	38.77	37.90	33.61	37.07	19.23	28.74	16.08	65.21		27.60					109.34	**1,083.02**
Actual WTE In-Post (From Ledger)	26.87	27.54	27.56	30.58	31.93	26.52	28.61	24.75	13.92	35.60	35.19	26.25	28.33	31.62	31.87	40.47	49.96	23.77	28.51	28.53	24.42	33.37	33.13	35.83	29.39	18.45	29.57	14.88	60.12		24.18					95.66	**997.38**
Actual Worked (From Ledger)	31.66	31.51	30.22	31.70	35.58	31.73	34.14	24.78	15.46	38.53	34.60	28.93	29.44	35.99	34.50	36.58	46.60	25.11	28.23	29.11	23.33	37.31	37.12	38.08	35.64	19.52	30.58	15.21	60.33		24.82					92.02	**1048.36**
Pending Appointment																																						**0**
Current Budgeted Vacancies (WTE)	4.15	2.68	2.66	-0.36	-1.70	3.70	4.26	2.78	6.05	4.05	-0.14	3.98	1.91	0.40	1.01	-0.51	2.58	2.46	0.91	0.87	4.93	5.40	4.77	-2.22	7.68	0.78	-0.83	1.20	5.09		3.42					13.68	85.64
Sickness (%)	21.41	5.20	4.98	1.26	8.11	6.28	5.17	0.19	9.44	7.59	2.72	6.84	4.46	14.40	1.36	1.49	3.90	4.85	6.87	4.80	2.58	7.79	14.92	6.50	3.83	10.95	4.50	0.00	5.65	5.65	0.00	3.34	3.34	3.34	3.34	3.34	5.82	5.57
4.02 - Substantive Staff Turnover Headcount (rolling average 12 months)	10.34%	6.67%	15.15%	6.90%	8.57%	20.00%	21.88%	6.90%	47.06%	7.50%	14.29%	20.00%	6.67%	14.71%	8.33%	4.65%	10.91%	4.17%	16.67%	3.23%	17.24%	7.89%	19.05%	5.13%	24.24%	19.05%	6.06%	12.50%	8.33%	8.33%	8.70%	0.00%	5.56%	5.56%	5.56%	5.56%	9.48%	11.43%
12 month Appraisal	92.31%	79.31%	54.84%	80.65%	97.22%	82.14%	80.65%	93.10%	33.33%	51.06%	70.00%	100.00%	73.33%	45.71%	60.00%	95.00%	86.00%	100.00%	72.09%	90.00%	83.33%	42.11%	48.48%	77.78%	80.65%	80.00%	33.33%	66.67%	95.77%	95.77%	60.00%	73.10%	73.10%	73.10%	73.10%	73.10%	86.27%	74.39%
12 month Mandatory Training	93.43%	66.07%	69.79%	89.88%	91.12%	91.69%	63.48%	98.24%	77.84%	72.49%	83.25%	96.90%	72.84%	89.41%	90.05%	85.75%	86.26%	93.68%	83.25%	94.67%	83.61%	85.35%	79.44%	73.15%	78.98%	81.70%	79.95%	90.12%	94.30%	94.30%	83.63%	100.00%	81.19%	81.19%	81.19%	81.19%	98.12%	84.80%
Friends and Family																																						

All data correct and verified - Tuesday 16th September 2014

Report Change log

Date	Indicator Code	Indicator Description	Requested by	Change	Authorised by
19/11/2013	Monitor Compliance Governance 1013-14	Monitor Compliance Governance 1013-14 Report	Esther Steel	Remove from Report. No longer used.	Esther Steel
27/11/2013	1.07 - Total number of incidents (Clinical and non-clinical)	This metric is everything reported, patient, staff, visitors, contractors, non person. "Clinical & non clinical" infers just patient incidents.	Eric Porter	Change to 1.07 - Total Incidents reported on Safeguard	Trish Armstrong-Child
04/12/2013	4.02 - Substantive Staff Turnover Headcount (rolling average 12 months)	Labour turnover of substantive contracted employees	Kelly King	This metric previously included turnover relating to contrived reductions in workforce over the course of the year, relating to Turnaround schemes, redundancies (voluntary and compulsory) etc. The data for this metric should be based on "natural" turnover in order to demonstrate a representative picture of the workforce. Retrospective figures have replaced the previously reported figures for the current year (2013/14). The 2012/13 figures have not been adjusted. The target remains at 10%. The metric definition has also been changed.	Louise Ludgrove
13/12/2013	1.39 - MRSA HA acquisitions	N/A	Julie Dziobon	This is a duplicate of metric number 1.38 - MRSA Bacteraemia post-48 Hours admission	Trish Armstrong-Child
13/12/2013	1.37 - MRSA Bacteraemia pre-48 Hours admission	No of pts identified as having MRSA presenting complaint 48 hrs before admission	Julie Dziobon	All pre cases are now the responsibility of the CCG, for both CDT & MRSA bacteraemia cases, so despite having 4 pre cases of MRSA bacteraemia for the current year– none of them have been attributed to the Foundation Trust. **Action:** To remove this metric .	Trish Armstrong-Child
17/01/2014	1.50 Infection Control Level 1	National Qualification	David Wakefield	Not Reportable	David Wakefield
17/01/2014	1.51 Infection Control Level 2	National Qualification	David Wakefield	Not Reportable	David Wakefield
14/02/2014	1.36 Surgical WHO Checklist compliance (Emergency)	Checklist to reduce surgical morbidity and mortality	Mike Steele	Metric added	Jill Patterson
19/02/2014	1.10 - pt incidents that resulted in severe harm or death %	Number of incidents involving pts that resulted in severe harm or death	Trish Armstrong-Child	Target changed to 0%	Trish Armstrong-Child
19/02/2014	1.27 - complaints received	Total number of complaints received into trust	Trish Armstrong-Child	change target to 10% reduction on last years outturn	Trish Armstrong-Child
11/03/2014	1.25 - NICE Guidelines Adoption of Technology Appraisals	% of Technology appraisals applicable to the Trust that are adopted or adopted with caveat	Steve Hodgson	Use the percentages based on total adopted technology appraisals	Steve Hodgson
03/04/2014	4.13 - Qualified Nurse to bed ratio	Compares the number of contracted WTE nurses against in the number of occupied beds in the most recent month	Nigel Moloney	Remove from Report. Replaced by 'Budgeted Nurse: Bed Ratio' and 'Actual Nurse: Bed Ratio' in the Board Staffing Assurance Heat Map	Suzanne Woolridge

Report Change log

Date	Indicator Code	Indicator Description	Requested by	Change	Authorised by
03/04/2014	1.33 - Compliance of 6 access criteria for learning disability %	to ensure equality of access and equity for all people with learning disabilities	Mike Steele	After reviewing the 13-14 and 12-13 data there were incorrect figures in (83%). We were 100% compliant in year 12-13 and also in 13-14. Data changed to reflect this	Bev Tabernacle
07/05/2014	2.46 - Readmissions within 30 days of discharge % - National	scorecard to have a line to show the national rate of readmissions along with the Trust's performance.	Esther Steel	Added Line to scorecard and series into 2.40 - Readmissions within 30 days of discharge % Chart	Simon Worthington
14/05/2014	1.01, 1.02, 1.03, 1.04, 1.52, 1.56	(All falls and pressure damage grade 2)	Trish Armstrong-Child	a 5% reduction in year 2013/14 target applied to 2014/15 targets	Jill Patterson
14/05/2014	2.40 - Readmissions within 30 days of discharge %		Joanna Warburton	Readmission % for Feb14 reported last month has changed from 12.8% to 13.3% due to natural changes in data on LE2.2. The figure has still come within the ranges of previous month's figures reported.	Mike Steele
10/06/2014	1.13 - Infection Control (C. Diff)		Mike Steele	Metric duplicated by 1.45	Jill Patterson
13/06/2014	2.40 - Readmissions within 30 days of discharge %		Simon Worthington	Target of 8% replaced by average of last years Readmission data = 12.6%	Jill Patterson
02/07/2014	Total number of patient incidents (clinical and non-clinical)	Total number of patient incidents	Mike Steele/Richard Sachs	Number better represented by metric 1.07	Richard Sachs
15/07/2014	4.13 - Substantive Staff Turnover Headcount (Contrived) (rolling average 12 months)	This includes redundancies and MARS but still excludes junior doctors, flexi retirements and TUPE transfers	Nigel Moloney	New metric	Suzanne Woolridge
17/07/2014	1.34 - No of CQUIN targets achieved in month	CQUINs are reported Quarterly to the CCG. This metric should reflect this position.	Mike Steele	Revise from monthly reporting to quarterly.	Jill Patterson
01/08/2014	N/A	Added new metrics into Monitor Risk Report	Mike Steele	New Metrics added to reflect new and amended metrics in the "Monitor Declaration of Risk" return	Mike Steele
26/08/2014	1.07 - Total Incidents reported on Safeguard	Total number of all incidents, patient, staff, visitors, contractors etc	Trish Armstrong-Child	The QA committee has agreed that we need to increase our incident reporting and to get us in the top 20% of reporting nationally. New annual target of 10,786 added inorder to double our incident reporting per 100 admissions ratio from 6.26 per 100 to 12.60 per 100.	Trish Armstrong-Child
27/08/2014	1.09 - Total number of patient incidents reported per 100 admissions	Total number of patient incidents per 100 admissions within the month	Richard Sachs	as above	Trish Armstrong-Child
11/09/2014	4.05 - Local Induction Attendance (starters in the last 12 months)	Number of local (department) induction packs divided by the number of new starters in the most recent 12 month period	Mark Wilkinson	4.05 - Completion of local induction system (starters in the last 12 months) - More accurate metric description.	Suzanne Woolridge

Sample Community Heatmap

INDICATORS	North DN Teams	Avondale Team 1	Avondale Team 2	Avondale Team 3	Breightmet Team 1	Breightmet Team 2	Crompton Team 1	Crompton Team 2	Crompton Team 3	Egerton & Dunscar Team 1	Egerton & Dunscar Team 2	Waters Meeting Team 1	Waters Meeting Team 2	South & West DN Teams	Farnworth Team 1	Farnworth Team 2	Farnworth Team 3	Great Lever Team 1	Great Lever team 2	Horwich Team 1	Horwich Team 2	Horwich Team 3	Pikes Lane Team 1	Pikes Lane Team 2	Westhougton Team 1	Westhougton Team 2	Evening Service	Total
Safety Express Programme Harm Free Care (%) *		93.75%	95.00%	NA	100.00%	100.00%	95.00%	94.00%	NA	90.91%	88.24%	100.00%	85.00%		100.00%	97.50%	100.00%	100.00%	100.00%	86.67%	100.00%	100.00%	92.59%	100.00%	100.00%	100.00%	NA	96.30%
Hand Washing Compliance %																												
1.60 - Monthly New pressure Ulcers (Grade 2+) **		0			0		0			0		1			0			1		2			0		0		0	4
High Dependency Patients (40 Minutes >)		123	162		149	75	124	89		83	62	39	32		88	164		64	45	152	102	117	214	192	389			2465
Medium Dependency Patients (21 Mins >)		311	340		322	329	1054	725		471	372	266	239		247	1011		554	712	243	289	232	796	819	819			10151
Low Dependency Patients (< 20 mins)		439	326		309	464	524	473		400	152	651	583		112	126		551	517	155	116	133	34	51	855			6971
Number of Home Visits		39	33	205	703	537	758	155	651	731	882	784	319		226		1019	2182		332	153	362	130	1249	786		2947	15183
Current Budgeted WTE		8.64			11.28		17.42			8.70		9.99			15.93			11.34		12.02			11.60		8.72			
Actual WTE In-Post		8.65			8.67		16.94			8.17		9.99			16.17			9.81		13.08			10.50		10.72			
Actual WTE Worked		7.65			9.03		17.13			8.32		10.83			16.75			9.86		13.16			11.21		10.63			
Pending Appointment		0	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0	0	0	0	0
Current Budgeted Vacancies (WTE)																												
Sickness (%)																												
Total WTE WITH 19.81% Headroom (Sickness, Training etc)																												
4.02 - Substantive Staff Turnover Headcount (rolling average 12 months)																												
12 month Appraisal																												
12 month Mandatory Training																												
12 month Staff Survey/ Temp checks																												
1.27 - Number of complaints received												1																
1.07 - Total Incidents reported on Safeguard		5			5		5			1		10			8			8		6			1		5			54

* - Harm Free Care is from the Monthly Safety Thermometer showing percentage of patients with no harm recorded within District Nursing Domiciliary.

** - Pressure Ulcers are not broken down by team 1 or 2. For this reason, pressure ulcers have been recorded under the relevant Health Centre Name.

All data correct and verified - Tuesday 16th September 2014

Bolton NHS
NHS Foundation Trust

Agenda Item No 9

Meeting	Board of Directors

Date	25th September 2014

Title	Bolton FT Revalidation System Status

Executive Summary • *Why is this paper going to the Board* • *To summarise the main points and key issues that the Board should focus on including risk, compliance priorities, cost and penalty implications, KPI's, Trends and Projections, conclusions and proposals*	Three-month update on revalidation as requested at the June 2014 Board of Directors meeting. With the introduction of a robust appraisal policy and implementation of electronic appraisal we will have the resources to achieve full compliance with GMC standards for revalidation; benchmarking with Salford and Wigan will enable us to examine our current processes in identifying and responding to concerns.

Next steps/future actions *Clearly identify what will follow a Board decision i.e. future KPI's, assurance requirements*				
	Discuss	✓	Receive	
	Approve		Note	

Assurance to be provided by:	

This Report Covers (please tick relevant boxes)

Strategy		Financial Implications	
Performance	✓	Legal Implications	
Quality	✓	Regulatory	✓
Workforce	✓	Stakeholder implications	
NHS constitution rights and pledges		Equality Impact Assessed	
For Information		Confidential	

Prepared by	Steve Hodgson, Medical Director/ Responsible Officer	Presented by	Steve Hodgson, Medical Director/ Responsible Officer

Bolton FT Revalidation System Status

In June 2014 asked to give three-month update.

This is best provided by our Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for 2013/14 (appended). This was received in late July and benchmarks Bolton FT self-assessment against the other 630 designated bodies. Note over half are small providers.

In summary, we are fully compliant for 22 indicators, and not fully compliant for 5 indicators (4 indicators were not applicable).

Of the 4 indicators we are not compliant for we are better than peer for 2, same as peer for 1 and worse than peer for 2.

The 5 non-compliant indicators with actions to deliver compliance are:

Worse than Peer

1.13 Has the designated body commissioned an external QA review?
Action: Three party peer review being planned with Salford and Wigan (December 2014/January 2015)

2.3 Every doctor with missed or incomplete medical appraisal has an explanation recorded
Action: Introduction of electronic appraisal system with mandatory fields (November 2014)

Same as Peer

2.2.2 Appraisal role staff grade, associate specialist and specialty doctors
Action: New appraisal policy approval (November 2014)
Implementation of electronic appraisor (November 2014)

Better than Peer

2.2.1 Appraisal rate for consultants

2.2.8 Approval rate for all doctors
Action: New appraisal policy approval (November 2014)
Implementation of electronic appraisor (November 2014)

In summary, with introduction of a robust appraisal policy and implementation of electronic appraisal we will have the resources to achieve full compliance with GMC standards for revalidation. The benchmarking with Salford and Wigan will enable us to examine our current processes in identifying and responding to concerns, the other key component of the Responsible Officer role.

Dr Mike Bewick
Deputy Medical Director
NHS England
5W24
Quarry House
Quarry Hill
Leeds
LS2 7UE

PA Contact Details:
Sally.chapman7@nhs.net
Tel: 0113 825 5067

Our Ref: MB/HR/3099/AOA/4481

25 July 2014

By email:
Mr Stephen Hodgson
Responsible Officer
Bolton NHS Foundation Trust

Dear Mr Hodgson

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for:
4481 – Bolton NHS Foundation Trust

Thank you for submitting a response to the NHS England Annual Organisational Audit (AOA) exercise in April/May 2014. The AOA is one element of the Framework of Quality Assurance launched this year.

I enclose a report, which provides your response to AOA as per your submission, in terms of the systems that your organisation has in place for revalidation. It compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The AOA exercise is designed to help designated bodies assure themselves and their boards or management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place and functioning effectively. Similarly it provides a mechanism for assuring NHS England, as the Senior Responsible Owner for implementation of the Responsible Officer Regulations in England, that systems are functioning, effective and consistent.

On 6 June 2014, the GMC; Care Quality Commission (CQC); Monitor and the NHS Trust Development Authority (NHS TDA) wrote to the chairs, chief executives and responsible officers of NHS secondary care organisations in England to draw their attention to their Board's statutory responsibilities to ensure all doctors are keeping up to date and remain fit to practise. It is clear from the AOA results that substantial progress has been made in these areas but more remains to be done to ensure that these principles are wholly implemented and embedded in all designated bodies.

On reviewing the results presented below, designated bodies should produce an action plan to address any development needs that are identified. Should you need support in improving any element of your system in relation to revalidation, your local regional office (contact details below) can provide assistance.

Board-level accountability for the quality and effectiveness of these systems is important and this report, along with the resulting action plan, should be presented to the board, or an equivalent governance or executive group, and could be included in an NHS organisation's quality account.

Your region	NHS England (North region)
Your regional revalidation lead	Kerry Gardner
Your regional revalidation lead contact details	england.revalidation-north@nhs.net

This letter has been sent to the responsible officer as recorded in the AOA return as of 31 March 2014. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the chief executive of the organisation. If there are any changes to notify, or you have any queries, please contact your regional revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies. A full report with anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

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

Yours sincerely

Dr Mike Bewick
NHS Deputy Medical Director
GMC 2649069

cc: Damian Riley
cc: Kerry Gardner

YOUR ANNUAL ORGANISATION AUDIT

Analysis is based on the total of 645 returns from designated bodies (DBs) to the 2013/14 Annual Organisation Audit (AOA) exercise for the year ending 31 March 2014 which had been received by NHS England by 20 June 2014.

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

Name of designated body:	Bolton NHS Foundation Trust
Name of responsible officer:	Mr Stephen Hodgson
Sector:	Acute hospital/secondary care foundation trust
Prescribed connection to:	NHS England (North region)

Please note:

a) Fields regarding trainees have been removed from this report as they were not reported on via AOA, Health Education England carried out their own analysis.

b) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your regional revalidation lead: Kerry Gardner at england.revalidation-north@nhs.net

c) Only the questions asked are presented below. Please refer to AOA 2013/14 for the full indicator definitions if required.

d) Appraisal rates have been calculated using the following information:
- The total number of prescribed connections to the designated body (question 1.4.8)
- The total number of those prescribed connections who have had an appraisal (question 2.2.8)
- The total number of those prescribed connections who had an unapproved missed/incomplete appraisal (question 2.3.1)

From this information we have been able to deduce how many doctors had an approved missed/incomplete appraisal. We are aware that this may be an assumed figure in some cases. Future audits will request this figure as a separate response.

2013/14 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: *Acute hospital/secondary care foundation trust* DBs in sector: 102	All sectors: Total DBs: 645
		No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
1.4	Number of doctors with whom the designated body has a prescribed connection as at 31 March 2014			
1.4.1	Consultants	182	21,959	44,598
1.4.2	Staff grade, associate specialist, speciality doctor	51	4,520	10,927
1.4.3	Doctors on Performers Lists	0	3	44,719
1.4.5	Doctors with practising privileges	0	0	1,623
1.4.6	Temporary or short-term contract holders	0	4,778	9,713
1.4.7	Other doctors with a prescribed connection	0	113	5,811
1.4.8	**Total number of doctors with a prescribed connection**	**233**	**31,373**	**117,391**

2013/14 AOA indicator SECTION 1 (cont): The Designated Body and the Responsible Officer		Your organisation's response	Same sector: *Acute hospital/secondary care foundation trust* DBs in sector: 102	All sectors: Total DBs: 645
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in ALL sectors and (%) that said 'Yes'
1.5	A responsible officer has been nominated/appointed in compliance with the regulations	Yes	102 (100.0%)	641 (99.4%)
1.6	An alternative responsible officer has been nominated/appointed where a conflict of interest or appearance of bias has been agreed with the higher level responsible officer	N/A	This question is not applicable to many DBs	
1.7	The designated body provides the responsible officer with sufficient funds, capacity and other resources to enable the responsible officer to carry out the responsibilities of the role	Yes	100 (98.0%)	620 (96.1%)
1.8	The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer	Yes	99 (97.1%)	624 (96.7%)
1.9	The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role	Yes	102 (100.0%)	639 (99.1%)
1.10	The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation	Yes	102 (100.0%)	619 (96%)
1.11	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol	Yes	100 (98.0%)	634 (98.3%)
1.12	The governance systems (including clinical governance where appropriate) are subject to external or independent review	Yes	100 (98.0%)	609 (94.4%)

2013/14 AOA indicator SECTION 1 (cont): The Designated Body and the Responsible Officer		Your organisation's response	Same sector: *Acute hospital/secondary care foundation trust* DBs in sector: 102	All sectors: Total DBs: 645
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in ALL sectors and (%) that said 'Yes'
1.13	The designated body has areas of practice that are considered to be good or excellent in relation to 'The designated body and the responsible officer'	Yes	Comparison data not applicable. This information was gathered to assist higher level ROs in establishing areas of best practice.	
1.13	The designated body has areas of practice that are considered to be good or excellent in relation to 'Appraisal'	No		
1.13	The designated body has areas of practice that are considered to be good or excellent in relation to Monitoring performance and responding to concerns	No		
1.13	The designated body has areas of practice that are considered to be good or excellent in relation to 'Recruitment and engagement'	Yes		
1.13	The designated body has areas of practice that are considered to be good or excellent in relation to 'Has the designated body commissioned an external QA review?'	No	23 (22.5%)	159 (24.7%)

2013/14 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: *Acute hospital/secondary care foundation trust* DBs in sector: 102	All sectors: Total DBs: 645
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in ALL sectors and (%) that said 'Yes'
2.1	There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)	Yes	92 (90.2%)	590 (91.5%)
2.2	Number of doctors with whom the designated body has a prescribed connection on 31 March 2014 who had a completed annual appraisal between 1 April 2013 - 31 March 2014	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.2.1	Consultants	168 (92.3%)	87.1%	86.3%
2.2.2	Staff grade, associate specialist, speciality doctor	39 (76.5%)	78.2%	78.6%
2.2.3	Doctors on Performers Lists	0 (0%)	100.0%	91.6%
2.2.5	Doctors with practising privileges	0 (0%)	0.0%	74.2%
2.2.6	Temporary or short-term contract holders	0 (0%)	46.8%	53.9%
2.2.7	Other doctors with a prescribed connection	0 (0%)	51.3%	67.0%
2.2.8	**Total number of doctors who had a completed annual appraisal**	**207 (88.8%)**	**79.5%**	**83.8%**

2013/14 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: *Acute hospital/secondary care foundation trust* DBs in sector: 102	All sectors: Total DBs: 645
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in ALL sectors and (%) that said 'Yes'
2.3	Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded	No	73 (71.6%)	548 (85%)
		Your organisation's response	Missed appraisal rate for same sector	Missed appraisal rate for ALL sectors
2.3.1	Number of doctors with a missed or incomplete appraisal for whom a postponement of appraisal was not approved in advance by the responsible officer	0	2,126 (6.8%)	6,851 (5.8%)
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in ALL sectors and (%) that said 'Yes'
2.4	There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template	Yes	89 (87.3%)	603 (93.5%)
2.5	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified	Yes	90 (88.2%)	587 (91%)
2.6	The number of trained medical appraisers is sufficient for the needs of the designated body	Yes	97 (95.1%)	627 (97.2%)
2.7	Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice	Yes	91 (89.2%)	591 (91.6%)

2013/14 AOA indicator SECTION 3: Monitoring Performance and Responding to Concerns SECTION 4: Recruitment and Engagement		Your organisation's response	Same sector: *Acute hospital/secondary care foundation trust* DBs in sector: 102	All sectors: Total DBs: 645
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in ALL sectors and (%) that said 'Yes'
3.1	There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection	Yes	100 (98%)	631 (97.8%)
3.2	There is a responding to concerns policy in place, with core content which is compliant with national guidance, which is ratified by the designated body's board (or an equivalent governance or executive group)	Yes	96 (94.1%)	591 (91.6%)
3.3	The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.	Yes	86 (84.3%)	578 (89.6%)
3.4	The designated body has arrangements in place to access sufficient trained case investigators and case managers	Yes	90 (88.2%)	552 (85.6%)
4.1	There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors	Yes	101 (99%)	631 (97.8%)

Bolton NHS
NHS Foundation Trust

Agenda Item No 10	

Meeting	Board of Directors

Date	25th September 2014

Title	Standing Orders

Executive Summary	In line with best practice guidance the Standing Orders are reviewed on an annual basis. The following changes (red test in the paper) are required to bring into line with current practice: • Page 7 update to reflect that Board meetings are now public • Page 15 - the Risk and Assurance Committee is now the Quality Assurance Committee • Page 22 - amendment to the arrangements for the storage of the seal

Next steps/future actions	Board members are asked to note and approve the proposed changes			
	Discuss		Receive	
	Approve	✓	Note	
	For Information		Confidential y/n	N

This Report Covers (please tick relevant boxes)

Strategy		Legal Implications	✓
Performance and Quality		Regulatory	✓
Financial Implications		Stakeholder implications	
Workforce		Risk	

Prepared by	Esther Steel Trust Secretary	Presented by	Esther Steel Trust Secretary

Bolton NHS

NHS Foundation Trust

STANDING ORDERS

~~July 2013~~September 2014

FOREWORD

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

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

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

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

All references to the masculine gender shall be read as equally applicable to the female gender.

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

CONTENTS

INTRODUCTION

Statutory Framework

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

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

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

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

The Health and Social Care (Community Health and Standards) Act 2006 requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Independent Regulator requires NHS Foundation Trusts to adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals.

NHS Framework

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

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

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

Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). That document has effect as if incorporated into the Standing Orders.

1 INTERPRETATION

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

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

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

"TRUST" means Bolton NHS Foundation Trust.

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

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

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

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

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

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

“CONSTITUTION” shall be the Constitution of Bolton NHS Foundation Trust.

“DEPUTY CHAIRMAN” shall be the Senior Independent Director of the Trust.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution section 20.1 for the appointment of the Chairman, section. 20.1 for the appointment of non-executive directors, section 23.1 for the appointment of the Chief Executive and section 23.4 for the appointment of all other directors. Directors for the purpose of SO/SFI and Scheme of Delegation are those reporting directly to the Chief Executive, including executive board members.

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

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

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

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

"OFFICER" means an employee of the Trust.

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

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

2. THE BOARD OF DIRECTORS

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

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

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

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

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

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

The Chairman of the Trust

At least 5 non-executive directors

At least 5 executive directors including:
- *the Chief Executive (the Chief Officer and Accounting Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *the Medical Director*
- *the Director of Nursing*

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

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

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

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

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

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

3. MEETINGS OF THE BOARD OF DIRECTORS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.17 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of

the director who gives it and also the signatures of four other directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within six months, however the Chairman may do so if he considers it appropriate.

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

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

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) A report to the Board by the Chief Executive or.

b) A notice of motion under Standing Order 3.15, such revocation, variation or amendment having to be approved by a number of Directors equal to at least two-thirds (normally eight including the Chairman) of the whole number of Directors of the Board, and provided that any revocation, variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

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

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

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

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

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

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

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

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

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

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

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

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

5. COMMITTEES

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

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

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

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

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

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

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

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

Audit
~~Risk and~~Quality Assurance
Finance
Remuneration
Charitable Funds

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

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

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

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

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

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

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

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

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

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

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

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

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

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

6.5 At the time the interests are declared, they should be recorded in the Board of Directors minutes or Governing Body minutes as appropriate. Any changes in interests should be declared at the next Board of Directors meeting or Governing Body meeting as appropriate following the change occurring. It is the obligation of the Director or Governor to inform the Secretary to the Board in writing within 7 days of becoming aware of the existence of a relevant or

material interest. The Secretary to the Board will amend the Register upon receipt within 3 working days.

6.6 Directors directorships of companies in 6.3(a) above or in companies likely or possibly seeking to do business with the NHS (6.3(b) above) should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.7 Where a director:

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

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

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

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

8. STANDARDS OF BUSINESS CONDUCT

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

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

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

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

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

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

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

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

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

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

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

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

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

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Chairman in a secure place in accordance with arrangements approved by the Board. ~~The Seal shall be secured by two locks, the key of one lock to be kept by the Chairman and the key of the other to be kept in the Trust Safe by the Personal Secretary to the Chief Executive on behalf of the executive directors. The Chairman may entrust his key temporarily to another Non-Executive Director of the Board with authority to such Director to exercise his powers.~~

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

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

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

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

10. SIGNATURE AND INSPECTION OF DOCUMENTS

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

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

10.3 A Director of the Board may for purposes of his duty such as a Director, but not otherwise, inspect any document which has been considered by the Chairman or Chief Executive or senior officers under the terms of their delegated powers, or by the Board, and if a copy is available shall, on request, be supplied for the like purpose which a copy of such document provided that the Director shall not knowingly inspect and shall not call for a document relating to a matter in which he is professionally interested or in which he has directly or indirectly any pecuniary interest, and that this Standing Order shall not preclude the Chief Executive to the Board from declining to allow inspection of any document which is, or in the event of legal proceedings would be, protected by privilege.

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

11. MISCELLANEOUS

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

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

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

Bolton NHS
NHS Foundation Trust

Agenda Item No : 11

Meeting	Board of Directors

Date	25th September 2014

Title	Governance Review

Executive Summary	Monitor published their *Well-led framework for governance reviews*: guidance for NHS foundation trusts in May 2014, outlining their expectation that NHS foundation trusts should carry out an external review of their governance every three years. This paper : • Recognises Monitor's requirements for a formal governance review every three years. • recognises the reviews undertaken to date and • sets out a proposed programme culminating in a formal governance review in quarter 3 of 2016

Next steps/future actions	Board members are asked to discuss and approve the proposed governance review plan.			
	Discuss		Receive	
	Approve	✓	Note	
	For Information		Confidential y/n	N

This Report Covers (please tick relevant boxes)

Strategy		Legal Implications	✓
Performance and Quality		Regulatory	✓
Financial Implications		Stakeholder implications	
Workforce		Risk	

Prepared by	Esther Steel Trust Secretary	Presented by	Esther Steel Trust Secretary

Governance Review

1. Background

Monitor's "Risk assessment framework" serves as guidance for trusts in complying with their continuity of service and governance licence conditions. Under the "Risk assessment framework" and in line with their Code of Governance Monitor expects that NHS foundation trusts carry out an external review of their governance every three years.

Monitor published their *Well-led framework for governance reviews*: guidance for NHS foundation trusts in May 2014. This paper summarises Monitor's requirements regarding governance reviews and sets out a proposed programme culminating in a formal governance review in quarter 3 of 2016

2. Scope

To review how well a Board is operating, Monitor state that organisations should look at four different domains:

- **Strategy and planning** -how well is the Board setting direction for the organisation?
- **Capability and culture** -is the Board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
- **Process and structures** -do reporting lines and accountabilities support the effective oversight of the organisation?
- **Measurement** -does the Board receive appropriate, robust and timely information and does this support the leadership of the Trust?

The approach incorporates and builds on Monitor's "Quality Governance Framework" (2010)

3. The governance review process

Under the "Risk assessment framework", NHS foundation trust boards are required to carry out governance reviews every three years. Trusts are free to schedule when the reviews take place within the three year window, there is no mandatory timetable, as long as the gap between governance reviews is no longer than three years.

As the reviews form a new element in Monitor's regulatory framework, Monitor want to understand the uptake of reviews and when a foundation trust has scheduled a review. Trusts are therefore required to inform their Monitor relationship manager when a review is to be carried out.

In terms of the scope of the review it must cover the four domains. Trusts can however add to the scope or change the emphasis to reflect their knowledge of the organisation.

Additional areas in scope for review may, for instance include results from the findings from internal and/ or external audit findings and information from the Annual Governance Statement and the Corporate Governance Statement.

To gain maximum benefits and assurance from the reviews, Monitor specifies that independent reviewers should be used to ensure objectivity. Generally, Monitor considers reviewers should not have carried out audit or governance related work for the Trust during the previous three years.

While the ultimate choice of reviewer is up to the Board, review teams should be multi skilled and bring different disciplines to the work including:

- Experience of evaluating board leadership and governance arrangements;
- Knowledge of the healthcare sector and
- Specialist expertise, specifically clinical, leadership experience (including culture and board development) and management information systems.

The review is to be commissioned by the Trust for the Trust.

4. Previous Governance Reviews

The following external reviews of governance have been commissioned and received/implemented in the last three years:

Date	Review	Reviewer	comments
June 2012	Governance Review	KPMG	60 recommendations to address governance issues -
August 2012	Review of Financial Performance	PwC	Key recommendations: Address delivery of in year CIP, develop transformational schemes, manage cash needs, appoint a turnaround director and assess the impact of MIB and TCS.
Sept 2012	Financial Governance Review	PwC	Areas for improvement of financial governance identified
May 2013	Financial Governance Review	Grant Thornton	Red rated against all six areas of review (Financial reporting, Financial management, and Internal control, Value for money, Financial planning and Board/Organisational financial awareness.
June 2013	Quality Governance Framework Review incorporating stakeholder review and review of never events	Deloitte	Score of 5 on Deloitte Quality Gov Framework - action plan agreed
June 2013	Data Quality Review	Deloitte	Some elements of good practice identified but also gaps for action to improve data quality
July 2013	Finance Capability and Capacity review	Deloitte	One of the key recommendations from that review were that the Trust consider the finance structure within management accounts with a particular focus on ensuring the right level of senior capacity and capability

5. Suggested Approach to the Review

The review process has been discussed with Monitor and with the Trust's Internal Auditor PwC. Both have indicated agreement that the review of Governance in line with

the well-led framework should be timed to allow actions taken in response to previous governance reviews to be embedded.

The timeline below is proposed.

	Phase	Timescale	Comments
Year one	**PWC review** - review of outstanding recommendations in earlier reports in readiness for certification of compliance with enforcement undertakings	July - Sept 14	Report to be provided to Nov 14 Audit Committee
	Initial Investigation – including Board self-assessment, initial check against Monitor's questions;	Sept 14 - Nov 14	Report to be provided to December 2014 Board meeting
	Actions - action plan to address findings from self-assessment and any residual recommendations from PwC review of earlier governance reports	Dec 14 - Feb 14	
Year two	Self-assessment using **Quality Governance Framework** to inform Board declarations for annual plan	Feb - March 2015	Report to be provided to April 2015 Board
Year three	Self-assessment using **Quality Governance Framework**	Feb - March 2016	
	Identify reviewer	May 2016	
	Scope the Review – using self-assessments discuss scope of review and methods to be used;	May 2016 - July 2016	
	Detailed Review – including Board observations, focus groups, interviews with key internal/external stakeholders;	Sept 2016 - Dec 2016	
	Board Report and Action Planning – including compiling the report with findings of the review, discussions with review team, and	Jan 2017	
	Letter to Monitor – Chairman to write to Monitor to advise the review has taken place and setting out any material issues that have been identified with proposed action plans.	Feb 2017	

6. Monitor and CQC

Monitor and the CQC have committed to ensure that the well-led Governance Reviews and the well-led element of the CQC's new inspection process are aligned, to ensure a strong consistency of approach as recommended by the second Francis Report into the Mid Staffordshire NHS FT.

To this end the CQC's five key lines of enquiry that sit within their 'Are Services Well-Led' area of work have been mapped onto Monitor's 10 key questions that form the basis of the governance review framework. As part of its inspection the CQC will therefore ask providers how they have assured their governance arrangements and may ask for information about any independent reviews and how the findings have been acted upon.

7. Points of Interest from the Pilots

As part of the consultation process on the governance reviews, three Trusts were invited to participate as pilot sites; a large acute Trust, a district general hospital type Trust and a mental health Trust.

The points of interest from the pilots included:-

- The cost ranged between £60k to £80k;
- The reviews took between 3 and 4 months to complete;
- The timing of when the review was held was key to ensuring the organisation had the time to fully engage with the process - avoiding year-end was deemed essential.

8 Recommendations

- Note and approve the proposed timescale and process for reviews over the next three years
- Participate in the initial investigation phase by completing a self-assessment questionnaire which will be distributed following the September board meeting - attached at Appendix A

Esther Steel

September 2014

Board Evaluation

Domain one Strategy and planning

1. Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver this strategy?

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
There is a structured, effective strategic planning process in place	○	○	○	○	○
The planning process takes account of regular engagment with internal and external stakeholders	○	○	○	○	○
The board understands the implications for the Trust of all relevant local health economy factors, and incorporates these in the strategic plan.	○	○	○	○	○
The board understands the internal factors affecting delivery of the plan.	○	○	○	○	○
The senior management team and workforce have the capacity and capability to deliver the plan.	○	○	○	○	○
Quality is embedded in the trust's overall strategy through discrete, well defined goals	○	○	○	○	○

comments

Board Evaluation

plans are designed to cascade initiatives through the organisation.	○	○	○	○	○

comments

Strategic goals have been communicated across the trust and community.	○	○	○	○	○

comments

2. Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
The main risks associated with current and future services are identified, with no significant control issues/gaps and clear responsibilities	○	○	○	○	○

comments

There is an effective process in place to monitor, understand and address current and future quality risks.	○	○	○	○	○

comments

There is a robust framework to develop and assess the impact of initiatives on clinical quality with clinical input.	○	○	○	○	○

comments

The impact of initiatives on quality and financial sustainability is effectively monitored on an ongoing basis	○	○	○	○	○

comments

Domain two Capability and Culture

Board Evaluation

3. Does the Board have the skills and capability to lead the organisation

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
The board is assured that it has the experience, capability and capacity needed to lead the organisation.	○	○	○	○	○

comments

The board is asssured that it recruits and maintains the appropriate experience and skills through effective selection, development and succession processes.

comments

Board members are knowlegeable about quality issues and priorities, quality metrics and quality governance processes and structures

comments

Board Evaluation

4. Does the Board shape an open, transparent and quality-focused culture?

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
The Board communicates a clear set of values and behaviours	○	○	○	○	○
The Board is aware of any cultural differences across the trust and takes these into account in managing the organisation	○	○	○	○	○
The board actively shapes the culture through effective engagement with internal and external stakeholders	○	○	○	○	○
The Board actively leads on clinical quality, promoting staff empowerment and a quality focused culture.	○	○	○	○	○

comments

comments

comments

comments

Board Evaluation

5. Does the Board help support continuous learning and development across the organisation?

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
Quality information is used to improve quality performance	○	○	○	○	○
The Board promotes a strong focus on continuous learning and improvement at all levels of the organisation.	○	○	○	○	○
Staff use information to develop new and imporved quality services for patients	○	○	○	○	○

comments

comments

comments

Domain Three - Processes and structures

Board Evaluation

6. Are there clear roles and accountabilities in relation to board governance (inlcuding quality governance)

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
There are clear structures and comprehensive procedures for the effective working of the Board	○	○	○	○	○

comments

The organisations uses clear, robust and effective structures processes and systems of accountability

	○	○	○	○	○

comments

There are clear, well understood structures and processes for the effective management of any partnerships and shared services

	○	○	○	○	○

comments

Quality recieves sufficient coverage both in Board meetings and in relevant committees

	○	○	○	○	○

comments

Board Evaluation

7. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
The processes provide the board with the insight and the foresight to manage the performance of the Trust	○	○	○	○	○

comments

Processes for escalating performance issues to the Board are clear and are working | ○ | ○ | ○ | ○ | ○

comments

There is a well functioning, impactful, clinical and internal audit process. | ○ | ○ | ○ | ○ | ○

comments

Board Evaluation

8. Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
The Board actively engages with patients and the public especially in relation to quality	○	○	○	○	○

comments

Staff are listened to by the Board and are able to contribute their ideas about the direction and work of the Trust

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
	○	○	○	○	○

comments

The Board is transparent and open with the Council of Governors and relevant stakeholders about the performance of the Trust

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
	○	○	○	○	○

comments

Domain four - Measurement

Board Evaluation

9. Is appropriate information on organisational and operational performance being analysed and challenged?

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
The information the board recieves supports effecive decision making	○	○	○	○	○

comments

The board uses information to hold management to account for the delivery of the plan

	○	○	○	○	○

comments

Board reports reflect the issues and themes that Board members are picking up through other channels of information

	○	○	○	○	○

comments

10. Is the Board assured of the robustness of information

	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
The Board is assured that its decisions and reporting channels are based on robust information.	○	○	○	○	○

comments

There is assurance covering the data collection, checking and reporting processes

	○	○	○	○	○

comments

There is clear evidence of action to resolve audit concerns

	○	○	○	○	○

comments

Board Evaluation

11. Position

- Executive Director
- Non-Executive Director
- Senior Manager
- Governor

12. Time associated with the Board

- Less than six months
- six months - one year
- one year - three years
- more than three years

13. Additional comments

Bolton NHS
NHS Foundation Trust

Agenda Item No : 12

Meeting	Board of Directors

Date	25th September 2014

Title	Board Development

Executive Summary	In line with national guidance and recognised best practice, the Trust should have a development plan to enable the Board to improve its efficiency and effectiveness. The proposed Board development plan will be updated to reflect the findings of the Board effectiveness review

Next steps/future actions	Board members are asked to discuss and endorse the proposed development plan			
	Discuss		Receive	
	Approve		Note	
	For Information		Confidential y/n	

This Report Covers (please tick relevant boxes)

Strategy		Legal Implications	
Performance and Quality		Regulatory	
Financial Implications		Stakeholder implications	
Workforce		Risk	

Prepared by	Esther Steel Trust Secretary	Presented by	Esther Steel Trust Secretary

Board Development

1. Purpose

To review Board Development and agree an outline programme of Board Development for the remainder of 2014/15 and for 2015/16

2. Background

2.1 Theory

The purpose of NHS boards is to govern effectively and, in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands. (Effective NHS boards 2013)

The Healthy NHS Board 2013: Principles for Good Governance – NHS Leadership Academy states that effective NHS Boards demonstrate leadership by undertaking three key roles:

- **Formulating strategy** for the organisation.
- **Ensuring accountability** by holding the organisation to account for the delivery of the strategy, being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- **Shaping a healthy culture** Effective boards shape a culture for the organisation which is caring, ambitious, self-directed, nimble, responsive, inclusive and encourages innovation.

  A commitment to openness, transparency and candour means that boards are more likely to give priority to the organisation's relationship and reputation with patients, the public and partners.

  - **Openness:** enabling concerns to be raised and disclosed freely without fear and for questions to be answered
  - **Transparency:** allowing true information about performance and outcomes to be shared with staff, patients and the public
  - **Candour:** ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it

High performing boards possess the following attributes: (The Centre for Association Leadership)

Strategic time investment: High performing boards are twice as likely to invest substantial board meeting time on strategy.

Commitment to assessment and skills development: High performing boards will set their own performance goals, invest in development activities and engage in formal or informal board self-assessment.

Effective recruitment processes: New board members are more likely to be recruited by, for example, soliciting nominations from outside the board. Their CEOs were half

as likely to report challenges finding board members who had the qualifications they needed and half as likely to report problems keeping the board members they wanted.

High participation levels: High performing boards have reduced issues with attendance at board meetings or leavers before the term has finished.

Formation of a culture of trust and respect: A board is not a collection of individuals and talents but a team. For it to function as such, effective chemistry, candid communication and mutual respect are critical. This ensures that probing questioning, constructive criticism and challenging debate can take place between the NEDs and the executive team.

2.2 Previous board development plans

Although there has been an on-going commitment to board development this has been on a predominantly informal basis without a structured programme.

There was a focus on board development prior to and just after authorisation as a Foundation trust however between 2010 and 2012 board development was on an ad-hoc basis with a focus on individual development rather than development of the board as a whole.

The Good Governance Institute (GGI) was appointed in 2013 to conduct a review of board effectiveness and 360° reviews of Board members. This was followed up with two formal board development sessions however the full programme proposed by GGI was not adopted. Board members may recall that the first session with the GGI focused on the Board maturity matrix - consideration should be given to using this matrix at a future session to review progress.

3. Proposal

3.1 Skills Audit Matrix

To support succession planning, particularly for the recruitment of new Non-Executive Directors the Nomination and Remuneration Committee should agree a skills matrix to inform the recruitment of new Directors with skills to complement existing skills on the Board. The reports provided by GGI as part of the 360° reviews may be useful in completing this review.

3.2 Board development plan

A framework based on the key roles defined in *The Healthy NHS Board* should be adopted for the Board Development Plan 2014 - 2016 to include:

- short seminars within the part two board meeting to include:
    - finance
    - risk management
    - development of joint ventures
    - Equality and diversity
    - Safeguarding
- half or full day development events (suggested two days per year) to include:
    - formulating strategy

    - team building
- Individual development activities including mandatory training, executive coaching and attendance at courses and conferences.
- An induction programme for new Non-Executive Directors

Responses from the board effectiveness review will be used to identify appropriate topics for development sessions.

Session	When	Duration/frequency	Delivered by	For
Developing strategy	tbc	workshop		
Risk management	tbc	workshop		
Forms of Joint Venture	Sept 25th 2014	1 hour board session	dac Beachcroft	Full board
Duty of Candour	Oct 30th 2014	1 hour board session		
Competition	Nov 27th 2014	1 hour board session	Capsticks	
Service line reporting	Jan	1 hour board session		
Budgeting ward to board	Feb	1 hour board session		
Chairing meetings	tbc	Full day		On demand
Equality and Diversity		Annual requirement	e-learning	All board members
Information Governance		Annual requirement	e-learning	All board members
Infection control		Annual requirement	e-learning	All board members
Safeguarding Vulnerable Children and Adults		Annual requirement	e-learning	All board members
Fire training		Annual requirement	Mandatory training / e-learning	All board members
Manual handling		Annual requirement	e-learning	All board members
HFMA induction for new NEDs	Dec 2015	Two day programme	HFMA	On demand
FTN and Monitor induction for NEDs	Feb 2015	Two day programme	FTN/Monitor	On demand

Key	
Board development sessions within Board meeting	Mandatory training
Full/half day Board development sessions	Ad-hoc training for board members

Bolton NHS
NHS Foundation Trust

Agenda Item No : 13

Meeting	Board of Directors

Date	25th September 2014

Title	Fit and Proper person requirements and the duty of candour

Executive Summary	New regulations setting out fundamental standards of care will come into force for all care providers on 1 April 2015. However, for NHS bodies, two of the new requirements – the fit and proper person requirements for directors and the duty of candour –will apply from 1 October 2014 (or very closely after this date subject to Parliamentary approval).

Next steps/future actions	Board members are asked • to note the implications of these requirements • to agree the process for evidencing the fit and proper person requirement • To consider if further information is required

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

This Report Covers (please tick relevant boxes)

Strategy		Legal Implications	✓
Performance and Quality		Regulatory	✓
Financial Implications		Stakeholder implications	
Workforce	✓	Risk	

Prepared by	Esther Steel Trust Secretary	Presented by	Esther Steel Trust Secretary

Guidance on fit and proper person requirements for directors and the duty of candour

Background

New regulations setting out fundamental standards of care will come into force for all care providers on 1 April 2015. However, for NHS bodies, two of the new requirements – the fit and proper person requirements for directors and the duty of candour –will apply from 1 October 2014 (or very closely after this date subject to Parliamentary approval).

Regulation 5: Fit and proper person requirement for directors

Currently, providers have a general obligation to ensure that they only employ individuals who are fit for their role.

The CQC assesses the fitness of 'corporate' providers (that is, all providers other than individuals and partnerships) by focusing on the fitness of their 'nominated individuals'. Providers are able to nominate, for themselves, who will be their nominated individuals. These are usually (although not necessarily) directors of the organisation. When assessing the fitness of the nominated individual, the CQC consider whether the provider has taken appropriate steps to ensure that they are of good character, are physically and mentally fit, have the necessary qualifications, skills and experience for the role, and can supply certain information (including a Disclosure and Barring Service (DBS) check and a full employment history).

The new fit and proper person requirement for directors will have a wider impact, in both the scope of its application and the nature of the test. It makes it clear that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care and, as such, can be held accountable if standards of care do not meet legal requirements.

It will apply to all directors and "equivalents". This will include executive and non-executive directors of NHS foundation trusts. It will be the responsibility of the chair, to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation goes further by barring individuals who are prevented from holding the office (for example, under a directors' disqualification order) and significantly, excluding from office people who: "have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider".

This is a significant restriction. It will enable CQC to decide that a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time, or working outside England.

Regulation 5 sets out the criteria that a director must meet. They must:

- Be of good character
- Have the qualifications, skills and experience necessary for the relevant position

- Be capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010
- Not have been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider
- Not be prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.

Schedule 4, will introduce the good character and unfit persons test. Under Schedule 4 Part 1, a director will be deemed unfit if they:

- Have been sentenced to imprisonment for three months or more within the last five years, although CQC could remove this bar on application
- Are an undischarged bankrupt
- Are the subject of a bankruptcy order or an interim bankruptcy order
- Have an undischarged arrangement with creditors
- Are included on any barring list preventing them from working with children or vulnerable adults.

Under Schedule 4 Part 2, a director will fail the 'good character' test, if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence
- Have been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.

CQC approach to the fit and proper person requirement for directors

CQC will require the chair of the provider's board of directors to:

- Confirm that the fitness of all new directors has been assessed in line with the regulations.
- Declare in writing that they are satisfied that they are fit and proper individuals for that role.

The CQC may also ask the provider to check the fitness of existing directors and provide the same assurance.

The CQC will cross-check notifications about new directors and will have regard to any other information about directors in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'. Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that, there is no time limit for considering such misconduct or responsibility.

If necessary the CQC may use enforcement powers to ensure that all directors are fit and proper for that role, this will normally be done by imposing conditions on the provider's registration to ensure that the provider takes the appropriate action to remove the director.

The changes are included in the draft Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which have now been published.

Proposed approach to the fit and proper persons test

Clause 24 of the Trust's constitution (appendix two) clearly sets out the requirements for Directors of the Trust:

The table below maps the CQC requirements against existing constitutional and appointment criteria:

CQC requirement	**Bolton NHS FT**
Be of good character (The CQC only define how this "test" can be failed)	Tested by application process including references and psychometric testing, interview and through on-going appraisal process.
Have the qualifications, skills and experience necessary for the relevant position	Tested by application, interview and through on-going appraisal process
Be capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010	Tested by application, interview and through on-going appraisal process
Not have been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider	24.8/24.9
Not be prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.	24.7
Not Have been sentenced to imprisonment for three months or more within the last five years, although CQC could remove this bar on application	24.3
Not an undischarged bankrupt	24.1
not the subject of a bankruptcy order or an interim bankruptcy order	24.1
No undischarged arrangements with creditors	24.2
Not included on any barring list preventing them from working with children or vulnerable adults.	24.11
Not have been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	24.13

Proposal

- Implement a formal declaration for all Directors to formally declare compliance with the fit and proper persons test - appendix one
- Ensure all Directors have a current DBS check

Duty of Candour

The aim of the regulation is to ensure that providers are open and honest with patients when things go wrong with their care and treatment.

It means that, from 1 October 2014, if patients and people who use services have been harmed or exposed to significant risk of harm and NHS bodies have not been open and honest, the CQC will be able to move directly to prosecution.

To meet the requirements of the regulation, a provider has to:

- Make sure it has an open and honest culture across and at all levels within its organisation.
- Tell patients in a timely manner when particular incidents have occurred.
- Provide in writing a truthful account of the incident and an explanation about the enquiries and investigations that they will carry out.
- Offer an apology in writing.
- Provide reasonable support to the person after the incident.

The regulations apply to the patient themselves and, in certain situations, to people acting on the patient's behalf, for example when something happens to a child or to a person over the age of 16 who lacks the capacity to make decisions about their care.

If the provider fails to do any of the things above, CQC can move directly to prosecution without first serving a warning notice.

For NHS bodies the regulations adopt the approach suggested by the Dalton/Williams review. Incidents include not only cases of death and severe harm, but also "moderate harm" in line with providers' existing contractual duty under the NHS Standard Contract. This includes unplanned returns to surgery or unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care). Incidents also include cases of "prolonged psychological harm" – that is, continuing, or likely to continue, for at least 28 days.

The duty goes on to require the provider to supply the patient or representative with the results of any further enquiries into the incident and to keep records of all correspondence and notifications in person.

It should be noted that, as well as this specific duty of candour around a particular safety incident, the regulations also include a more general obligation on CQC registered persons to "act in an open and transparent way in relation to service user care and treatment".

This means that the default position should be to be open, honest and candid, unless there are justifiable reasons for not being so – for example because the service user actively says that they do not want further information about the incident. However, these circumstances should be the exception rather than the norm.

Capsticks LLP have offered to provide a Board seminar on the implications of the Duty of Candour regulation.

Appendix one - proposed declaration

Fit and Proper Person Declaration

In line with the requirement for Directors of an NHS Foundation Trust to be a fit and proper person, I hereby declare

Declaration	**Confirmed (yes/no**
I am of good character by virtue of the following:	
• I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence	
• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	
• I have not been sentenced to imprisonment for three months or more within the last five years	
• I am not an undischarged bankrupt	
• I am not the subject of a bankruptcy order or an interim bankruptcy order	
• I do not have an undischarged arrangement with creditors	
• I am not included on any barring list preventing them from working with children or vulnerable adults	
I Have the qualifications, skills and experience necessary for the position I hold on the Board	
I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010	
I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider	
I am not prohibited from holding the relevant position under any other law. e.g. under the Companies Act or the Charities Act.	

Signed	
Name	
Position	
Date	

24. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

24.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

24.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

24.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him;

24.4 a person who is a member of the Council of Governors;

24.5 a person who is the spouse, partner, parent or child of a member of the Board of Directors (including the Chairman) of the trust

24.6 a person who is a member of a local authority's Overview and Scrutiny Committee covering health matters;

24.7 a person who is the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

24.8 a person whose tenure of office as a chairman or as an officer or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for nondisclosure of a pecuniary interest;

24.9 a person who has within the preceding five (5) years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

24.10 in the case of a non-executive director, a person who has

24.10.1 refused without reasonable cause to fulfil any training requirement established by the Board of Directors; or

24.10.2 refused to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for directors.

24.11 on the basis of disclosures obtained through an application to the Disclosure and Barring Service (DBS), they are not considered suitable by the trust's director responsible for Human Resources;

24.12 they are a person who has had his name removed or been suspended from any list (including any performers list maintained by a primary care trust) prepared under the 2006 Act or under any related subordinate legislation or who has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had his name included in such a list or had his suspension lifted or qualification reinstated.

24.13 they have within the preceding five (5) years been:

24.13.1 made subject to a Hospital Order under section 37 of the MHA whether or not subject to restrictions under section 41:

24.13.2 made subject to an interim Hospital Order under section 38 of the MHA;

24.13.3 made subject to a transfer direction under section 48 of the MHA whether or not subject to restrictions under section 49; and/or

24.13.4 made subject to an order under the Criminal Procedure (Insanity) Act 1964 as amended

24.14 they have previously been or are currently subject to a sex offender order and/or required to register under the Sexual Offences Act 2003 or have committed a sexual offence prior to the requirement to register under current legislation.

Bolton NHS
NHS Foundation Trust

Agenda Item No: 14

Meeting	Board of Directors

Date	25th September 2014

Title	Trust Risk Management Strategy – Proposed Minor Addition

Executive Summary	The Trust receives periodic visits from external authorities. A minor revision to the Risk Management Strategy is proposed to make it more explicit as to the expectation of services. Divisional Management Teams to ensure the trust risk register captures the potential risk of failure to meet the standards.

Next steps/future actions	Incorporate changes into Risk Management Strategy			
	Discuss		Receive	
	Approve		Note	
	For Information		Confidential y/n	N

This Report Covers (please tick relevant boxes)

Strategy		Legal Implications	
Performance and Quality		Regulatory	✓
Financial Implications		Stakeholder implications	✓
Workforce		Risk	✓

Prepared by	Richard Sachs Head of Governance	Presented by	Trish Armstrong Child Director of Nursing

Proposed minor addition to the Trust Risk Management Strategy

Introduction

The Trust receives visits from external authorities all the time. Peer reviews, accreditation authorities, screening authorities, inspections from various regulators as well as the local authority all have responsibilities that will mean physical site visits.

Recommendation

It is critical that the Trust has an awareness of all planned visits from any such authority. Whilst Appendix E, 'Identifying Risks' of the Trust Risk Management Strategy makes mention of this:

'Recommendations and reports from external agencies such as NHSLA, HSE, Patient-led Assessments of the Care Environment (PLACE)'

It is the view of the Head of Governance that the expectation needs to be more explicit in the body of the policy as to the expectation of services, as outlined in the following addendum at 4.11.1 'Pro-active approaches to risk management (see also appendix G):

'Where an external inspection with written standards of compliance is known by date and time to the organisation, this should be added to the trust risk register and scored on the basis of the likelihood of failing to meet those standards. Careful consideration should be given to the impact/consequence score in terms of loss of reputation, activity, critical mass, resilience and quality of care etc. Visits should be known to the relevant members of the executive team with as much advance notice as possible so that they can be asked to brief the Risk Management Committee or other recognised authority. Where the risk has been captured in an overarching BAF risk e.g. CQC outcomes it is not necessary to have an additional and separate risk on the risk register.

Typically but not exclusively recording the visit of an accrediting authority or regulator would include: Monitor Governance Reviews, Royal College Peer Reviews, HSE, Local Authority, Local Supervising Authority, and National Screening Services.'

Actions

- For the Risk Management Committee to approve this addition to the Risk Management Strategy
- For Divisional Leadership teams to consider if any accreditation/regulatory visits are planned which might impact on reputation, activity, critical mass, resilience and quality of care and to assess the risk accordingly and document on the divisional risk registers, and escalate if the score is $\geq$15.

Bolton NHS
NHS Foundation Trust

Agenda Item No: 15

Meeting	Board of Directors
Date	25th September 14
Title	Proposed Responses to the Greater Manchester Association of Clinical Commissioning Group's Healthier Together consultation
Executive Summary	The Trust is invited to respond to the public consultation exercise on improved quality standards across the health and care system, and specifically on proposed site changes to A&E, acute medicine, and emergency and high risk surgery services. It is proposed that we make a Trust response arguing that the Royal Bolton Hospital should become a specialist hospital for emergency and high risk surgery. Reflecting our commitment to work with local providers and commissioners, it is proposed that we also endorse a North West Sector Response setting out a plan to achieve higher quality standards whilst retaining local services across the sector.
Next steps/future actions	

Discuss		Receive	
Approve	X	Note	
For Information		Confidential y/n	n

This Report Covers (please tick relevant boxes)			
Strategy	X	Legal Implications	
Performance and Quality	X	Regulatory	
Financial Implications	X	Stakeholder implications	X
Workforce	X	Risk	X

Prepared by	Mark Wilkinson Director of Strategic and Organisational Development	Presented by	Mark Wilkinson Director of Strategic and Organisational Development

Proposed Responses to the Greater Manchester Association of Clinical Commissioning Group's Healthier Together consultation

1. PURPOSE

The purpose of this paper is to secure the approval of the Board to two responses to the Greater Manchester Association of Clinical Commissioning Group's Healthier Together consultation: a Trust response and a North West sector response in association with Salford Royal and Wrightington Wigan and Leigh Foundation Trusts.

2. BACKGROUND

Commissioners across Greater Manchester have been working under the Healthier Together banner for a number of years now. This is the first public consultation and was launched in early July for a three month period. Views are sought on wide ranging aspects of health and care (for example, seeking support for higher standards in primary care, what does good care look like?). There are also a set of site specific proposals for A&E, acute medicine, and emergency and high risk surgery.

3. PROPOSALS

A joint response for the North West sector has been produced, in partnership with Salford Royal NHS Foundation Trust and Wrightington, Wigan and Leigh NHS Foundation Trust. A high degree of consensus has been reached across the three Foundation Trusts as to the preferred approach for the sector, though there is still much work to do in translating this into an operational model and there remain some areas of debate, especially in relation to A&E and acute medicine.

In addition, it has been agreed that each of the three Foundation Trusts submit a supplementary organisational response. The proposed response from this Trust is enclosed. As well as reaffirming the Trust's commitment to the Healthier Together case for change, standards and a sector-based approach, the organisational response addresses issues that are more specific to Bolton including our 'site preferences'.

4. RECOMMENDATIONS

The Board of Directors is asked to approve the joint, sector-based response but delegate responsibility to the Chief Executive to finalise the wording through collaboration with her counterparts, and approve this Trust's organisational response.

To: Ian Williamson, Healthier Together Senior Responsible Officer

Cc: Dr Wirin Bhatiani Chair, Su Long Chief Officer, NHS Bolton CCG

Dear Ian

Proposed Response of Bolton NHS Foundation Trust to the Greater Manchester Association of Clinical Commissioning Groups Healthier Together consultation ending on 30 September 2014

Our purpose in writing is to set out one of the Board's two responses to the above consultation. This response was approved at our Board meeting on 25 September 14. We have restricted our comments to the North West Sector as we believe that different solutions may be appropriate across Greater Manchester.

Our response begins with an agreed **statement of shared intent from this Trust, Salford Royal and Wrightington Wigan and Leigh NHS Foundation Trusts:**

'As described in our joint response, we believe that the North West Sector Partnership is best placed to deliver the objectives and standards as set out in the Healthier Together Programme and can go further to deliver a wider range of improvements in quality, outcomes and experience of care for the combined population that we serve. All three Foundation Trusts are fully committed to the delivery of reforms which will ensure achievement of the applicable standards in the three service areas.

We have carefully considered the options set out in the consultation and given the geography of the North West sector we believe that the populations of Bolton, Salford and Wigan would be best served by a sector wide and a joint approach between the three Foundation Trusts.

This variant option has a number of significant and unique advantages over the other options that are set out in the Healthier Together consultation. The three Foundation Trusts serve a contiguous geographical area and by working together we can better support existing population flows. Importantly, this approach builds on a strong history of joint working between the Trusts, as well as clinical and organisational consensus and commitment as to the way forward – this provides an extremely strong foundation for implementation and for the effective transition to the future model of care for hospital services.

Our preferred approach is that the three Trusts work together collaboratively to deliver local and specialist services to our combined population. Rather than focusing on 'specialist hospital site' status we believe the solution for our sector is to create 'Single Service Partnerships' where for the highest acuity patients specialist care will be consolidated onto fewer hospital site(s) to achieve the required standards of care or where we will work collaboratively in other ways to enable standards to be met across our sector.'

Our commitment to the North West Sector is more fully described in our sector level response.

The remainder of this letter sets out the position of the Board, more directly addressing the hospital site based proposals.

In short the Trust……

1. Accepts that change is needed and supports the concept of a single service with specialist and general hospitals for high risk and emergency surgery.

2. Does not believe the same model is necessarily applicable to acute medicine and Accident and Emergency. Neither do we feel that hospital sites should be exclusively either specialist or general.

3. Argues that commissioner justification for designating specialist sites i.e. paediatrics (for Manchester Royal Infirmary) and neurosciences (for Salford Royal) are as applicable to the Royal Bolton Hospital with our obstetrics and paediatric surgery services.

4. Wishes to develop the Royal Bolton Hospital as a specialist hospital for high risk and emergency surgery serving the people of Bolton and Wigan and potentially Bury.

5. Believes that of the sites under review locally, Royal Bolton Hospital is the most accessible location demonstrated by our strong position in this service already and our exceptionally busy A&E.

6. Is clear that our track record of delivery gives confidence to commissioners and the people of Greater Manchester that we will develop a genuine centre of excellence providing care of the highest quality.

Bolton NHS Foundation Trust is a high performing organisation:

- The Royal Bolton Hospital provides excellence in undergraduate and postgraduate education, providing primary and secondary care specialists for the future. Our many areas of excellence, as evidenced by the GMC survey and recent Deanery visit, include emergency medicine, paediatrics, neonatal medicine, obstetrics and gynaecology, acute internal medicine and general surgery. "*All trainees would recommend Bolton as a place to work and train*"[1]

- Uniquely in Greater Manchester we have a practising consultant as Chief Executive. This gives us a particularly strong focus on clinical engagement and quality of care and experience for patients and families. We are compliant with CQC standards and have many examples of excellence, for instance we are the only exemplar site for VTE in Greater Manchester.

- The Trust is one of two Greater Manchester providers of A&E services meeting the four hour operational standard on a year to date basis in 2014/15.

The consultation paper begins by setting out why healthcare in Greater Manchester needs to change. We agree that change is needed; as the paper states 'the quality of care within hospitals in Greater Manchester is inconsistent, and often affected by availability of experienced staff 24/7. These variations in patient outcomes and experience are the most compelling reason for change.'

We also agree that **hospital services need to change to meet the quality and safety standards and provide best care**, that providing specialist care at a smaller number of hospitals will raise standards of care to achieve quality and safety standards,

[1] Health Education North West Report March 2014.

and that doctors and nurses should work in teams that provide care across specialist and general hospitals as part of a single service.

For high risk and emergency surgery in particular, we support the proposed model of care that will see specialist clinicians working together, increasing the critical mass of expertise and availability around the clock, with the formation of 'single services' between collaborating hospital sites, with clinical teams working as together as a team to provide the specialist service on fewer sites whilst also ensuring good local general services. Indeed, we do not believe there is another way to meet quality and safety standards.

In considering what best care looks like we propose that the World Health Organisation[2] definition is used. There are six areas or dimensions of quality and these should be the focus of our improvement efforts: effective, efficient, accessible, patient-centred, equitable, and safe.

A harder question for us to answer has been how can we move from where we are now consistent delivery of the best care?

The Trust supports the development of single services comprising a specialist hospital and up to two general hospitals (in the North West sector). We recognise that, over the medium term, **this means that the Trust's service portfolio is likely to change significantly.**

We have already agreed across the North West sector that – independent of the details of the site / service configuration for emergency and high risk surgery - a single service model[3] will enable the best clinical outcomes and optimise access for the combined population of Bolton, Salford and Wigan.

Taking a broader view, there is an opportunity for commissioners and providers to work together in a stronger collaboration rethinking the way we engage with patients to deliver better services.

The goals of patients are, on occasions, not given enough recognition in treatment choices, and the benefits of shared decision making and patient and carer involvement are not being realized. We also believe communities can offer much more and can add value to healthcare. We can move towards greater patient centredness if we work to create a new culture based on the patient, and support self-care and help the professionals adapt to this.

We recognise the central importance of primary care in the NHS and are fully supportive of the need to invest in it, and particularly encourage a move towards seven day access with improved access to diagnostics. The vast majority of NHS care already takes place outside of hospital, and there is the potential, and indeed the imperative, to increase this further. **Alternative and more cost effective models of care can reduce the volume of treatment in A&E departments, and secondary care based out-patient departments.**

We are however reluctant to provide unreserved support to the proposed primary care standard 'a movement of patient care away from hospitals into local primary and community care services' without clearer evidence of the feasibility and cost effectiveness of such a move.

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[2] http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

[3] NW Sector Emergency General and High Risk Elective Surgery Project Initiation Document

Current evidence, particularly for unplanned admission reduction is scant at best and may even support the view that community based interventions increase hospital activity by uncovering previously unmet need. Consideration of a movement of patient care away from hospitals in absolute numbers would also need to seen in the context of demographic pressures and the increasing incidence people living with long term conditions.[4]

Similarly we are cautious about proposals for 'a joined up health and care system delivered in the community where clinically appropriate' preferring instead that **equal attention is paid to both clinical and cost effectiveness**.

We wish to emphasise that where the evidence exists, we would strongly support a reallocation of care, and associated resources, and we also support attempts to gather the evidence. As an integrated provider we are actively involved in the development of integrated neighbourhood teams with the express aim of reducing non elective admissions.

A critically important task for commissioners will be to develop and weight criteria to assess the options. Where 10 means the criteria is critically important and 0 means it is of no importance, we would score the criteria as follows:

	Score
Quality and safety	10
Travel and access	9
Affordability and Value for Money	10
Transition	7

It is striking that population health need is not quoted as an evaluation criteria – we would be keen to understand how this will be taken account of in decision making.

We now wish to respond to the proposed site options limiting our comments to the development of high risk and emergency surgery services.

The public summary consultation document presents high level advantages and disadvantages of four versus five specialist centres arguing that four centres will be more cost effective. We would contend that a detailed financial appraisal would be required to come to any conclusions on cost effectiveness. The overall cost equation will depend significantly on the current and proposed estate configuration and other currently unspecified service changes – without which five centres would almost certainly be more cost effective.

We also believe that, again contrary to what is stated, lesser change will be quicker and easier to put into practice, thus allowing the benefits to be realised faster.

This Trust wishes to develop the Royal Bolton Hospital as a specialist hospital for high risk and emergency surgery serving the people of Bolton and Wigan and potentially Bury.

We do not support the model of specialist and local hospitals for acute medicine and Accident and Emergency services. Neither do we feel that hospital sites should be exclusively either specialist or general.

[4] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/An-evaluation-of-the-impact-of-community-based-interventions-on-hospital-use-summary-Mar11.pdf

First Choice – Option 5.3 - Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital, Royal Bolton Hospital and Wythenshawe Hospital

Second Choice - Option 5.4 – Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital, Royal Bolton Hospital and Stepping Hill

Third Choice – Option 4.1 - Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital, and Royal Bolton Hospital

Our first and second preferences in respect of the choice between Stepping Hill and Wythenshawe Hospitals reflect no more than the Healthier Together evaluation of these options which ranks Wythenshawe ahead of Stepping Hill.

We have noted the assertion that the existence of neuroscience services at Salford Royal supports the designation of that hospital as a specialist hospital for emergency and high risk surgery. We would contend that the significant volume of paediatric surgery together with the extremely busy A&E department at the Royal Bolton Hospital make our claim to be a specialist hospital as valid as Salford Royal's. Although Healthier Together excludes maternity and paediatric services; as a current provider **we cannot ignore the clinical interdependencies between surgery and high risk obstetrics and emergency paediatrics.**

One of the Secretary of State's four tests for proposed reconfigurations is the clinical evidence base. As both four and five specialist hospitals are viable options, we infer there are no material additional benefits from increasing the scale of specialist hospitals (by reducing their number from five to four). This being the case, it is hard to see additional arguments in support of only four specialist hospitals.

We believe that site based senior decision makers are imperative from a patient safety perspective. Any dilution of this could see more admissions to a specialist hospital. **Maintaining five specialist hospitals is most likely to deliver site based senior decision making.**

Healthier Together reform principles[5] recognise the importance of family and community in supporting health and wellbeing. Retaining five specialist hospitals will facilitate families visiting for patients who can be in hospital for a long period.

More specialist hospitals will facilitate speedier discharge into other local e.g. intermediate care services on the road back to independence. The facilitation of services being delivered in a more joined up way is a Healthier Together reform principle[6].

The NHS Strategy for Sustainable Development describes NHS travel and transport as a carbon hotspot: 'Travel and transport form 13% of the health, public health and social care carbon footprint. Delivering health and care services involve a lot of moving people and goods about. The proportion of travel will vary according to the models of care used….the type of care setting, for instance social care, self-care, primary, secondary or tertiary care will also have an impact. More dispersed services will reduce NHS travel and transport.

It will lead to fewer and shorter ambulance journeys thus assisting ambulance response times. The Nuffield Trust reports that impacts on ambulance services are often overlooked during hospital reconfiguration.

[5] Pre Consultation Business Case Volume 1 Page 9
[6] Reform Principles in Pre Consultation Business Case Page 9

The potential detrimental effect on recruitment and retention at 'local' sites will be felt well beyond the three 'in-scope' services, leading to further diminution in access for the local population. This could lead to the effective downgrading of key sites which currently provide essential access to emergency and specialist care in areas with very high levels of population need. **It is desirable to limit unintended consequences**.

Establishing five as opposed to four specialist hospitals will be significantly cheaper in terms of capital costs, associated estate related revenue consequences and potentially surplus estate unless other service changes are made which will only serve to delay the reconfiguration and the achievement of the benefits.

It should also be less expensive in terms of general revenue expenditure – there are strong clinical connections between high risk and emergency surgery and A&E, paediatrics, and obstetrics. There is a danger that a concentration of services would incur higher costs in the specialist hospitals and create diseconomies of scale in the local hospitals.

Our agreed cost improvement plans assume cost reductions equivalent to 250 beds over five years. This will be achieved by radical improvements in patient flow and will inevitably lead to significant spare capacity on the Royal Bolton Hospital site. We are two successful years into this programme and changes already made (including the relocation of mental health wards) mean that we have capacity today for high risk and emergency surgical patients requiring little or no capital expenditure.

Having made the case for five specialist hospitals we believe there is a clear rationale for the Royal Bolton Hospital to be one of the five.

Our hospital is located within minutes of the motorway network making it very accessible not only to Bolton residents, but parts of Bury, Wigan and Salford. There is also a bus service approximately every ten minutes from Bolton town centre, linking with other parts of Greater Manchester by train and bus.

Bolton's superior accessibility is seen in the fact that currently more patients from Wigan and Salford are admitted to Bolton for non-elective care than vice versa. In addition 10% of Bury patients are admitted to the Royal Bolton Hospital for non-elective care. We are a significant net importer at present representing a clear expression of patient choice.

We are one of the best performing yet busiest Accident and Emergency departments in Greater Manchester, and therefore have a higher number of patients than others needing emergency surgery. A significant number of patients that end up in a specialist centre will be initially seen in A&E.

The number of emergency general surgery admissions resulting in an operation averages 7 per day at the Royal Bolton Hospital, only 4 per day at the Royal Albert Edward Infirmary[7] (it is lower at 3.5 at Salford Royal). **We carry the biggest surgical workload** across the sector.

Commissioners accepted a close connection between paediatrics and emergency surgery in designating Manchester Royal Infirmary as a confirmed specialist hospital. In our sector we have a number of A&E consultants and anaesthetists with recognised expertise in paediatrics, and we currently care for 170 emergency paediatric surgery patients each year.

[7] Reform Principles in Pre Consultation Business Case (p36)

Choosing Bolton means that fewer patients will require a transfer reducing ambulance costs and enabling speedier access to specialist care.

Bolton is close to full compliance with College of Emergency Medicine recommendations on the hours of consultant cover.

One of the proposed outcomes is increased level of patient satisfaction for general surgery patients. Current performance on the family and friends test in patient score is one measure of hospital delivery and Royal Bolton Hospital is second only to Wythenshawe[8].

A number of issues relating to the methodology of the 'Healthier Together' exercise have arisen consistently in the Trust's discussions and which the Board feels must be registered in this formal response. They are as follows:

Terminology - many people have demonstrated to our staff a fundamental misunderstanding of the matters raised in the consultation document because of a confusion about the meanings, in this context alone, of the terms 'local' 'general' and 'specialist' in relation to the future of certain hospital sites. This has led them to make quite misguided assumptions about the relevance or significance of proposals as they relate to services in their area.

General Surgery (Mortality) – the business case states that between 151/289 lives saved per annum per year dependant on the level of relative performance achieved. The Trust believes that a reduction of 289 deaths would be extremely difficult to achieve given demography of Greater Manchester. Furthermore, the Trust believes that the definition of general surgery is still an issue, as yet, unresolved.

Travel Time Calculations - several of our governors commented on recent reductions to bus services and routes. We are aware that detailed work was done on public transport availability and therefore access times, and would request that this is updated before any decisions are made to ensure it is still robust.

Consultation Period - there has been general disappointment about the timing chosen and the length of time allowed for this very important consultation process. The difficulty of summer holiday periods is well-known.

We hope these comments are supportive of the difficult and important work you have embarked upon. We would be delighted to meet you to expand on any of these points and look forward to continuing to work closely with NHS Bolton Clinical Commissioning Group as well as supporting the work of the Greater Manchester Association of Clinical Commissioning Groups. We are committed to working with you to ensure we get the possible outcomes for the people we serve.

Yours sincerely,

David Wakefield
Chair

Dr Jackie Bene
Chief Executive

[8] NHS England's quality dashboard (July 2014)

Name of Committee:	Finance & Investment Committee
Date of Meeting:	19th August 2014
Report to:	Board of Directors
Chair:	Allan Duckworth

Key Issues Discussed

- Month 4 financial performance
- Capital Programme 2014/15
- Indicative Reference Cost Results 2013/14
- Benchmarking of FT Annual Plans
- Developing the 2015/16 Corporate Income and Cost Improvement Plan
- Updating the Long Term Financial Plan and Developing the 2015/16 Budgets
- Healthier Together impact review
- Estates & IT Strategy – Business Case Update

Risks Identified/Further Assurance

The Committee noted the significant delivery risks set out in the Month 4 finance report and agreed actions to reduce the risk range. The forecast impact of these actions will be combined with the Divisions' quarter three self-assessment and the month six actual results to enable the Committee to have a comprehensive review of the plan delivery at its October meeting.

Apologies received from: David Wakefield

Date of next meeting

Thursday 18th September at 9.30am in the Boardroom

Name of Committee:	Finance & Investment Committee
Date of Meeting:	18th September 2014
Report to:	Board of Directors
Chair:	Allan Duckworth

Key Issues Discussed

- Month 5 financial performance
- Divisional Financial Management Framework Update
- Terms of Reference Review – Procurement Strategy
- Long Term Efficiency Strategy
- Healthier Together impact review
- Approval of a business case for the refurbishment of ward facilities
- Tender for 5 to 19 Children and Young People's Health and Wellbeing Service

Risks Identified/Further Assurance

The main risk that the Committee identified was the ongoing concern in regard of a delivery of the financial plan for the year and importantly the recurrent consequences of this in future years. Progress was noted in regard of the planned "deep dive" review of plans to take place in October and the Committee agreed in principle a basis for testing the level of assurance available regarding the potential outcomes for the current and future years. It is intended that the Committee will meet to discuss this prior to the planned visit of the Board to Monitor on 20th October.

Apologies received from: David Wakefield, Jackie Bene, Ebrahim Adia

Date of next meeting

Tuesday 21st October at 9.30am in the Boardroom

Committee Chair Report

Bolton NHS
NHS Foundation Trust

Name of Committee: Quality Assurance Committee

Date of Meeting: 13th August & 10th September

Report to: Board of Directors

Chair: David Wakefield

Key Issues Discussed

August 2014

The Committee received the quarterly updates from the three clinical divisions. Committee members noted the improved quality of divisional reports and the additional assurance this gives regarding the grip divisions now have

Positive assurance was also received on the actions taken in response to CCG concerns about the CAMHS service

An issue was raised regarding a failure of equipment in endoscopy resulting in the washers being out of use for one week and a potential loss of income.

Although a report was presented to give assurance on Medicine Safety the report was rejected and the item removed from the agenda with instructions to provide an appropriate report to the September meeting.

September 2014

The in addition to the routine reports, the Committee received the following reports:

- Quality strategy update
- End of life care update - outlining work following the withdrawal of the Liverpool Care Pathway
- Annual complaints report
- Cleaning audit
- Medication report

Committee members challenged the assurance provided by the medication report and agreed that the report presented did not give the assurance they required. A report has now been commissioned from the Trust's internal audit team to review the actions in response to previous reports and to provide a review of processes and governance in this area.

The complaints report required some amendments and will be presented again at the October meeting

For Escalation to the Board: see above - Medication Management remains a significant concern for escalation to the Board and Audit Committee

Date of next meeting – 8th October 2014