Board of Directors

Thu 26 November 2020, 09:00 - 12:30

WebEx

Agenda

09:00 - 09:05
5 min

1. Welcome and Introductions

Verbal *Donna Hall*

01 Agenda Part One Board meeting November 2020_v2.1.pdf (3 pages)

1.1. Bolton a poem by Ibby Ismail

09:05 - 09:20
15 min

2. Patient Story

Verbal *Marie Forshaw*

09:20 - 09:21
1 min

3. Apologies for Absence

Verbal *Esther Steel*

09:21 - 09:22
1 min

4. Declarations of Interest

Verbal *Donna Hall*

09:22 - 09:23
1 min

5. Minutes of the meeting held on 30th July 2020

Minutes *Donna Hall*

5 Board of Directors Minutes - 24.09.2020 copy.pdf (11 pages)

09:23 - 09:24
1 min

6. Action Sheet

Action Sheet *Donna Hall*

6 Board actions September 2020.pdf (1 pages)

09:24 - 09:25
1 min

7. Matters Arising

Verbal *Donna Hall*

09:25 - 09:35
10 min

8. CEO Report

Report *Fiona Noden*

8. CEO report November 20_v2.pdf (6 pages)

09:35 - 10:00
25 min

9. Covid Update and Reset

Presentation *Andy Ennis and Sharon Martin*

9.1. Covid Health and Wellbeing

James Mawrey

9.1 BOD report - Staff HWB update Nov20-v2.pdf (5 pages)

10:00 - 10:05
5 min

10. Flu Vaccination update

Report *Marie Forshaw*

10 Healthcare worker flu vaccination best practice management checklist Nov 20 (2).pdf (2 pages)

10:05 - 10:20
15 min

11. Integrated Performance Report

Report *Andy Ennis*

11. Integrated Performance Report Nov 2020.pdf (50 pages)

10:20 - 10:30
10 min

12. Quality Assurance Committee Chair Report

Chair Report *Andrew Thornton*

12. QA Chair report November Board.pdf (6 pages)

10:30 - 10:40
10 min

13. Finance and Investment Committee Chair Report

Chair Report *Jackie Njoroge*

13 F&I Chair Reports - BoD - Nov 2020.pdf (9 pages)

10:40 - 10:50
10 min

14. People Committee Chair Report

Chair Report *Malcolm Brown*

14. People Committee Chair's Reports October & November Combined.pdf (8 pages)

10:50 - 11:00
10 min

11:00 - 11:10
10 min

15. Safeguarding Annual Report

Report *Marie Forshaw*

15 Safeguarding and LAC Annual Report 2019-2020 final.pdf (30 pages)

11:10 - 11:20
10 min

16. Mortality update

Report *Francis Andrews*

16 Trust Board Mortality Report November 2020 v.2.pdf (13 pages)

11:20 - 11:30
10 min

17. Learning from Deaths Report

Report *Francis Andrews*

17. BoD learning from deaths report.pdf (7 pages)

11:30 - 11:40
10 min

18. Refresh of 2019 - 24 strategy

Report *Sharon Martin*

18. Strategy review 2020.pdf (21 pages)

11:40 - 11:50
10 min

19. Audit Committee Chair Report

Alan Stuttard

19 Audit Committee Chair Reports - BoD - Nov 2020.pdf (7 pages)

11:50 - 12:00
10 min

20. Standing Orders and Matter Reserved

Esther Steel

20. Standing Orders November 2020.pdf (53 pages)

12:00 - 12:00
0 min

21. Standing Financial Instructions and Scheme of Delegation

Annette Walker

12. Updated SFIs and SoD-2.pdf (81 pages)

12:00 - 12:10
10 min

22. Infection Prevention and Control Annual Report

Marie Forshaw

22 Annual Infection Control Report 2019-20 (2).pdf (32 pages)

12:10 - 12:20
10 min

23. Revalidation Annual Report

Francis Andrews

23 Medical Appraisal and Revalidation Board Report 2020 v1.2.pdf (26 pages)

12:20 - 12:25
5 min

24. Any Other Business

Verbal *Donna Hall*

Bolton NHS Foundation Trust – Board Meeting 26 November 2020

Location: WebEx **Time: 09.00 – 13.00**

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09.00	1.	Welcome and Introductions	Chair	Verbal	
		Bolton – a poem by Ibby Ismail	I Ismail	Verbal	To receive
09.05	2.	Patient Story	DoN	Verbal	To note
09.20	3.	Apologies for Absence	DCG	Verbal	Apologies noted
	4.	Declarations of Interest	Chair	Verbal	To note any new declarations of interest or declarations in relation to items on the agenda
	5.	Minutes of meeting held 24 September 2020	Chair	Minutes	To approve the previous minutes
	6.	Action sheet	Chair	Action log	To note progress on agreed actions
	7.	Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
Safety Quality and Effectiveness					
09.25	8.	CEO Report	CEO	Report	To receive
09:35	9.	COVID Update and Reset	COO/ DS&T	Presentation	For assurance
	9.1	Covid Health and Wellbeing	DoP	Report	To receive for assurance
10.00	10.	Flu Vaccination update	DoN	Report	To receive for assurance
10:05	11	Integrated Performance Report	COO	Report	To receive
10.20	12.	Quality Assurance Committee Chair Report – 21 October and 18 November 2020	QA Chair	Report	To provide assurance on work delegated to the sub committee.

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
10.30	13.	Finance and Investment Committee Chair Report – October and November	F&I Chair	Report	To provide assurance on work delegated to the sub committee.
10.40	14.	People Committee Chair Report – October and November	PC Chair	Report	To provide assurance on work delegated to the sub committee.

10.50 Coffee break

11.00	15	Safeguarding Annual Report	DoN	Report	To receive for assurance
11.10	16	Mortality update	MD	Report/presentation	To receive for assurance
11.20	17	Learning from deaths report	MD	Report	To receive for assurance
Strategy					
11.30	18	Strategy Review 2020	D S&T	Presentation	To approve
Governance					
11.40	19	Audit Committee Chair Report 24 November 2020	Audit Chair	Report	To approve
11.50	20	Standing Orders and Matters Reserved	DCG	Report	To approve
12.00	21	Standing Financial Instructions and Scheme of Delegation	DoF	Report	To approve
12.10	22	Infection Prevention and Control Annual Report	DoN	Report	To receive for assurance
12.20	23	Revalidation Annual Report	Report	MD	To receive for assurance
12.25	24	Any other business			

Questions from Members of the Public		
	25	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		
12.30	26	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted

Meeting:	**Board of Directors**
Date:	**Thursday 24th September 2020**
Time:	**09:00**
Venue:	**Via Webex**

NHS Bolton NHS Foundation Trust

Present:

Donna Hall	Chair	DH
Fiona Noden	Chief Executive	FN
Andy Ennis	Chief Operating Officer	AE
Francis Andrews	Medical Director	FA
Annette Walker	Director of Finance	AW
James Mawrey	Director of People	JM
Sharon Martin	Director of Strategic Transformation	SM
Andrew Thornton	Non Executive Director	AT
Malcolm Brown	Non Executive Director	MB
Rebecca Ganz	Non Executive Director	RG
Jackie Njoroge	Non Executive Director	JN
Martin North	Non Executive Director	MN
Alan Stuttard	Non Executive Director	AS
Bilkis Ismail	Non Executive Director	BI

Apologies:

Marie Forshaw	Director of Nursing	MF

In Attendance:

Esther Steel	Director of Corporate Governance	ES
Linda Denham	Deputy Director of Nursing	LD
Michaela Toms	Divisional Nurse Director	MT
Ibrahim Ismail	Aspirant Non Executive	II

Minutes:

Kimberley Güzel	Personal Assistant	KG

Observers: Chris Gee (Bolton News), Public Governors, Members of the Public

Meeting:	**Board of Directors**
Date:	**Thursday 24th September 2020**
Time:	**09:00**
Venue:	**Via Webex**

NHS Bolton NHS Foundation Trust

1. Welcome and Introductions

The Chair welcomed everyone to the meeting together with all observers. The Chair also reminded observers they were unable to make contributions to the meeting.

2. Patient Story

The Chair reminded everyone the patient story should remain confidential.

Mrs P (who has worked for the Trust for 30 years) presented the story of her father-in-law who very sadly passed away in Royal Bolton Hospital after contracting Covid-19 following his admittance.

Mrs P detailed a number of issues including lack of interpreters, lack of communication with the family by hospital staff and food being brought in for the patient that was not presented to him.

Mrs P suggested liaison officers and interpreting services might be support mechanisms that could be looked at in the future together with frequent communications with relatives.

Mrs P went on to thank Board members for listening to her story.

The Chair thanked Mrs P for delivering her story and also offered apologies on behalf of the Trust for the family's experience.

The Chief Executive also thanked Mrs P for relaying her story.

Resolved: Board members discussed the concerns raised by Mrs P and considered telephone/video calls with relatives being facilitated and also food deliveries to support patients. A Task & Finish group chaired by the Assistant Director of AHPs is rapidly producing guidance on communication with patients and relatives.

Actions:

FT/20/27 update on actions taken in response to patient story (Covid/communication/BAME patients)

3. Declarations of Interest

None.

4. Minutes of the previous meeting on 30th July 2020

The minutes of 30th July 2020 were approved as a true and accurate reflection of the meeting.

5. Action Sheet

Updated to reflect progress made to discharge the agreed actions. The outstanding action was for the Chief Operating Officer to present a verbal update on national benchmarking comparisons.

6. Matters Arising

There were no matters arising.

7. CEO Report

The Chief Executive presented the CEO report providing a summary of reportable incidents, awards, recognition and media interest. Board members discussed the Board Assurance Framework and it was advised that although some organisations ceased this work during the pandemic the Executives felt it was too important strategically to pause. The framework also assists the Board to understand its risks.

Resolved: Report noted.

8. COVID and Reset Update

The Chief Operating Officer presented a 13 slide presentation. Headlines:

- Covid cases are rising again.
- Equipping a fifth room for endoscopy.
- Same day emergency care - an additional 19 trolley facility will be available from January 2021 from a £2m investment.

- Biggest challenge is supporting our workforce.
- Developing Attend Anywhere hubs to maximum virtual appointments.
- Risk assessing staff and redeploying as required.
- Testing capacity and PPE stocks will be included in daily Sitrep.
- Communications open with GM on current position and potential assistance.

Resolved: Report noted. Board assured.

Brexit - The issue of supply of drugs and equipment following Brexit has been raised with GM. Stocks of PPE have largely been replenished following the first wave. We are at the same stage of readiness for Brexit as we were prior to covid.
Attend Anywhere - There is no maximum number of appointments. Some specialities will still need to see patients but where a call or virtual appointment is appropriate we can undertake as many as necessary but it is very dependent on specific specialities.
Flu - Vaccination programme is ready for roll-out to all staff.
Regular Covid updates to the Board - Will be provided on a weekly basis.
Social Care - A lot of work with nursing homes has been undertaken along with testing of key workers to ensure social care staff remain in place.

9. Integrated Performance Report

IPM only occurred yesterday so there is no update to the Board. There has been a truncated performance review with divisions as we are conscious of the pressures they are under. The data is heavily impacted by Covid. We need to work on how we help the Board to be clear on what are the key issues as although we would like to deal with everything, there are areas where we must accept some slippage. Work on this will be undertaken and brought back to Board for assurance we are focusing on the correct areas that keep our patients and staff safe.

Resolved: Report noted.

It was suggested that information being submitted to the Board should be as simple and concise as possible to avoid duplicating information that may well be provided to the Board in the weekly updates and focus on what we need assurance on.

Diabetic podiatry service wait times - As far as we know there are no particular delays in access to podiatry services. Clinics were stood down due to Covid and people were seen in their own homes instead. We are almost back to full clinic capacity but feedback and reassurance will be provided at the next meeting.

Mortality update - Pneumonia is improving and we are now classified as similar to other organisations in the UK. AQuA are currently doing some quality improvement work with respiratory and acute medicine. We are also looking at acute bronchitis as this appears to be going up. Our SHMI is higher than expected but we have agreement with the CCG that going forward from April 2021 we will be including ambulatory care in our figures as everywhere else does. Recording of specialist palliative care and co-morbidities will increase our SHMI.

Communication - More comms from the Board of Directors will be looked at in terms of recognition of the hard work staff are doing. Videos from BoD could be considered.

Actions:

FT/20/29	MT to revert with feedback on diabetic podiatry to Bilkis Ismail.
FT/20/30	proposal on dashboard changes for discussion within development session
FT/20/31	JM to provide update on staff recommending Trust for treatment
FT/20/32	update on waiting times for diagnostic tests and recovery plan for diagnostics

10. Quality Assurance Committee Chair Report

A summary of the report (slide 69 of the pack) was delivered. It was a productive meeting. Committee members noted the continued broad positive performance, robust attendance and engagement during the difficult and challenging climate. No risks escalated.

Resolved: Report noted. Board assured.

Actions

FT/20/33 End of life report to Bilkis - quarterly updates on EOL care and bereavement support added to QAC workplan

11. Finance & Investment Committee Chair Report

A summary of the report (slides 70 - 73 of the pack) was delivered. It was highlighted that the upgrade to the ledger system will take place in early October 2020. The patient level costing system is on track to meet the submission date of 5th November 2020. The sustainability development management plan is due to be in place by around March 2021. No risks escalated.

Resolved: Report noted. Board assured.

Since the F&IC meeting, confirmation has been received that we will get the ICU funding. This will go to Board along with urgent and elective care capital. We will also potentially receive funding for a new oxygen VIE cylinder. The Board were assured of the financial grip and control within the Trust. We are being strong in understanding the additional funding is not going to last. This is underlined by the work divisions have undertaken in continuing to focus on cost improvement and value for money. On iFM and transfer pricing, Deloitte have been asked to prepare an advisory piece on governance around how iFM and the Trust are working together to provide a wider context in relation to transfer pricing and being arms length.

12. People Committee Chair Report

A summary of the report (slides 74 - 77 of the pack) was delivered. The Committee asked for focus to be given on the triangulation of data from the Go Engage findings, FTSU report, HEE Reports and Employee Relations data to support in identifying any 'hotspot issues'. BoD are asked to note the Committee asked for a full report regarding maternity and the cultural improvement programme. No risks escalated.

Resolved: Report noted. Board assured.

The Board were assured that inclusion is definitely being considered in all areas in the Trust. We have a dashboard that measures performance on key metrics. The reason for it not being included in the chair's report is due to the fact it will be covered under the next agenda item, WRES and WDES. The point was made that inclusion should be covered very strongly through Board papers. A revised cover sheet is being meaningfully considered to ensure it is much more than a tick box exercise. This will be picked up with the BAME forum. The Board were assured on medical appraisal. Many Trusts have completely stopped medical appraisals. We took a different approach and completed them where possible. We also have mechanisms for complaints against doctors and there is a low risk of adverse consequences.

13. WRES and WDES 2020

A summary of the paper (slides 78 - 91 of the pack) was delivered. Our commitment to ensuring Equality Diversity and Inclusion within our workforce is essential to ensure we deliver safe, caring and excellent services in line with our Trust values. Implementing the Workforce Race Equality Standard and the Workforce Disability Equality Standard is part of our commitment to meeting the Equality Delivery Standards, which are both a required component of the standard NHS contract. The paper sets out there has been some improvement in the last twelve months surrounding this important agenda though more focused work is required. The Board's

attention was drawn to the plethora of actions undertaken during 2019/2020 and the remaining outstanding actions. Thanks was noted to Jane Seddon and Rahila Ahmed for their hard work. BI thanked JM for driving this work forward. Success for the Trust will be when BAME and Equality forums are no longer required. BI will be consulted on the Terms of Reference for the Strategic Leadership Group.

Resolved: Report noted.

iFM - Are not currently producing stats as they are not yet in a position to do so, due to their maturity. However the Board is assured there is a zero tolerance approach to discrimination.

BAME - This is a very broad term and a request was made to drill down to avoid disparity and to cover all communities.

Actions:

FT/20/34 drill down BAME data to cover all communities - report back through people committee

14. Gender Pay Gap Report

A summary of the paper (slides 92 - 103 of the pack) was delivered. The purpose of this report is to update the Board of Directors on the findings of the Gender Pay Gap (GPG) analysis which all organisations (with over 250 employees) are required to undertake and publish by the end of March 2021. The gender pay gap reporting is important to help us to better understand our own position and the broader factors which contribute to pay disparity. The paper sets out there has been some improvement in the last twelve months surrounding this important agenda though more focused work is required. Board members will recall that in July 2020 we had a specific focus on inclusion and the measures to be taken within the Trust. We are required to report the GPG for the reporting period 19/20 no later than March 2021. This work has

been conducted earlier to align with other inclusion reports being presented to the Board of Directors.

Resolved: Report noted.

15. Board of Directors Inclusion Policy

A summary of the paper (slides 104 - 108 of the pack) was delivered. This policy provides a framework to ensure that we avoid bias, prejudice or discrimination and attract, motivate and retain the best talent from diverse backgrounds to the Board of Directors of Bolton NHS FT. All appointments to the BoD will be made on merit against objective criteria, in the context of the overall balance of skills and backgrounds that the BoD need to maintain in order to remain effective. This policy applies specifically to the BoD; separate policies cover diversity and inclusion across our wider workforce.

Resolved: Report noted. Board approved.

The role of Associate Non Executive Director could be progressed. This might be best addressed in one of our development days. Journey sharing from existing NEDs should be considered.

16. Annual Complaints Report 2019/2020

A summary of the paper (slides 109 - 111 of the pack) was delivered. This paper is to provide the Trust Board with an overview of the discussions that took place at Quality Assurance Committee when receiving the 2019/2020 Annual Complaints Report.

Resolved: Report noted.

Comments:

The Board welcomes more patient stories, such as the story presented earlier, in order for the Trust to learn from these experiences.

17. Fit & Proper Personal Declaration 2020

A summary of the paper (slides 112 - 118 of the pack) was delivered. In accordance with the Fit and Proper Persons requirement, all Board members are required to complete an annual self-declaration in relation to their personal position against the standards set out in the Trust's Fit and Proper Person Policy. The purpose of this policy is to ensure that the Trust complies with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 5: Fit and Proper Persons Requirement. The self-assessments for all individuals have been completed and a hard copy will be retained on the individual's personal file. No issues have been identified that impact on the individual's ability to perform their duties as a member of the Board.

Resolved: Report noted. Board assured.

18. Board Champions and Nominated Leads

A summary of the paper (slides 119 - 128 of the pack) was delivered. there has been an increasing focus on the designation of Board Champions and nominated leads designed to engender board level commitment and focus around key areas of service development or delivery. There is a summary within the paper of the statutory and other guidance setting out a requirement for a Champion or Board lead. The list has been reviewed and updated to reflect changes to Board membership. Proposed changes:

- The addition of a "well-being guardian" which the People Plan 2020 suggests should be a Non-Executive; and
- The requirement to have a NED lead for procurement to be removed - this was linked to a document produced in 2013 procurement is overseen by the Finance and Investment Committee.

Resolved: Report noted. Board approved.

19. Any Other Business

Future Board Meetings - Propose to move to bi-monthly formal public board meetings and in the intervening months there will be some form of Board development.

Resolved: Proposal noted. Board approved.

20. Questions from Members of the Public

No questions.

21. Resolution to Exclude the Press and Public

To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

22. Date and Time of Next Meeting

Thursday 26th November 2020 @ 09:00.

September 2020 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/20/28	24/09/2020	Covid update	resume weekly Covid updates to NEDs	ES	Sep-20	complete
FT/20/29	24/09/2020	performance report	Michaela Toms to respond to BI comment on diabetic podiatry	MT	Sep-20	complete
FT/20/33	24/09/2020	QA Chair report	End of life report to Bilkis - quarterly updates on EOL care and bereavement support added to QAC workplan	ES	Sep-20	complete
FT/20/31	24/09/2020	performance report	JM to provide update on staff recommending Trust for treatment	JM	Oct-20	Discussed at People Committee with further work commissioned to be reported through the people committee chair report when complete - close
FT/20/32	24/09/2020	performance report	update on waiting times for diagnostic tests and recovery plan for diagnostics	AE	Oct-20	included within performance report - complete
FT/20/10	27/02/2020	AHP update	update on AHP workforce to be added to Workforce Assurance Committee workplan	JM	Nov-20	report to October People Committee - complete
FT/20/34	24/09/2020	WRES	drill down BAME data to cover all communities - report back through people committee	JM	Nov-20	agenda item November People Committee - complete
FT/20/30	24/09/2020	performance report	proposal on dashboard changes for discussion within development session	AE	Oct-20	verbal update
FT/19/84	19/12/2019	patient story	report back on the offer for children with special needs	MF	Nov-20	verbal update
FT/20/02	30/01/2020	patient story	AE to follow up with JN potential for student involvement in environmental/sustainability developments	AE	Nov-20	verbal update
FT/20/27	24/09/2020	patient story	update on actions taken in response to patient story (Covid/communication/BAME patients)	DoN	Nov-20	verbal update
FT/20/12	27/02/2020	Operational Plan and contract changes	update for Board on Primary Care Networks	SM	Nov-20	to be included within ICP update in November
FT/20/09	27/02/2020	Seven Day services	Further discussion on implications of guidance through Execs	FA/JM	Jan-21	deferred nationally due to Covid-19 pressures
FT/20/17	30/04/2020	performance report	Repeat SPC education session		Jan-21	Defer for incorporation in 21/22 development plan
FT/20/35	24/09/2020	inclusion	continue development of policy and implementation of policy through further debate in development session	ES	Jan-21	
FT/20/36	24/09/2020	inclusion	review cover page to include inclusivity impact review	ES	Mar-21	
FT/19/82	28/11/2019	iFM business plan	Carbon Neutral strategy and update on the work of the sustainability group	AE	Sep-21	

Key

complete	agenda item	due	overdue	not due

Agenda Item

Title:	Chief Executive Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	
Exec Sponsor	Fiona Noden		Decision	
Summary:	The Chief Executive report: • Provides an overview of the current climate in which we are operating. • Includes a summary of key issues including risks, incidents and achievements. • Includes any key updates from stakeholders and regulatory bodies which the Board of Directors need to be aware.			
Previously considered by:	Prepared in consultation with the Executive Team			
Proposed Resolution	To note the update.			

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Fiona Noden Lindsay Dunn	**Presented by:**	Fiona Noden Chief Executive

1. Context

Since the last meeting of the Board we have experienced a significant rise in COVID-19 cases across Greater Manchester, which has led to an increase in both our internal COVID-19 escalation status and that across Greater Manchester. We are also notably in a national lockdown. Whilst we are currently happily able to report a slight decrease in COVID-19 patients, this is a very recent shift, and there is no denying there have been significant pressures on our services and our staff. Unfortunately, as a result of this we have had to once again pause our elective activity, and visiting is still restricted at Royal Bolton Hospital.

Supporting staff with their health and wellbeing continues to be a priority, and through initiatives such as World Kindness Day and Anti Bullying Week we have made sure that our staff know what support is available to them as they continue to work through the extraordinary challenges that the pandemic is bringing. Further information on the support we are providing for our staff can be found in the report on Covid Health and Well-being within this month's papers.

We are in the process of establishing the twice weekly staff testing programme, to help prevent the transmission of COVID-19 between staff who may be asymptomatic and positive, and to reduce staff absence during the busy winter months. This project was developed and delivery begun at short notice with the concerted efforts of many of our teams.

2. This month's Board Papers

This month's Board papers continue to reflect the ongoing balance of operational challenges and our business as usual calendar of reports that contribute to our governance arrangements. The Standing Orders and Standing Financial Instructions and their supporting documents set the overall framework by which we are governed.

The Board will also be asked to receive a number of routine annual and quarterly reports, these are key to assuring the Board that despite the ongoing challenge of COVID 19 we continue to monitor the environment in which we are working.

3. Awards & Recognition

We have had success in a number of national awards:

Dementia Care Awards - Best Dementia Care Practitioner, Kerry Lyons
HSJ Awards - shortlisted for AI work in Radiology
HSJ Patient Safety Awards - Highly commended for the Homeless Nursing Team
HTN – Health Tech to Shout About award – AI project
Nursing Times Awards – shortlisted in two categories for Admiral Nursing Service

FABB Awards

Since our last Board the following areas have been presented with our 'For a Better Bolton awards:

- Clinical Psychology
  - For the support given to patients and staff throughout the pandemic.
- COVID Deployment Team
  - For their work in creating, and managing the deployment service to assist all areas of the Trust.
- Health Improvement Practitioner Service

  - For their continued support to the testing services, commitment to primary care patients by supporting 10,000 shielding patients when they needed food, medicine or a conversation and their support in conducting nearly 200 BAME staff health assessments.
- Home First
  - For getting patients back home where-ever possible and keeping patients safe.
- Hospital at Night Team
  - For continuing to keep patient's safe.
- iFM Security & Receptionists
  - For maintaining a safe environment for patients, visitors and staff.
- Research Team
  - For delivering and supporting our clinical teams in the urgent PHE COVID 19 trials across the Trust, providing support to staff and patients, giving training and guidance and enabling our patients access to potentially lifesaving treatments as part of the RECOVERY trial. They have worked together and supported each other as a team through this difficult time and have shown real strength and compassion.
- Volunteering Team
  - For their support to patients, staff and overall services.

4.0 Reportable Issues Log

Issues occurring between 17/09/20 to current:

4.1 Serious Incidents & Never Events

In the period since our last Board meeting we reported three serious incidents:

4.2 Red Complaints

There has been one Red complaint since the last report.

4.3 Regulation 28 Reports

There have been no coroner's letters or regulation 28 reports.

4.4 Health & Safety

Seven incidents have been RIDDOR reported to the HSE since 1st September to 15th November 2020. Four relate to a slip, trip or fall resulting in injury. One relates to an accident in the workplace which resulted in injury to the leg. Two incidents relate to violent patients. One incident relates to PPE; a member of staff having a reaction to wearing a surgical mask.

4.5 Maternity Incidents

During September and October, we had 4 still births and 2 early neonatal deaths. ENS is currently suspended due to COVID.

4.6 Whistleblowing & Freedom to Speak Up

The FTSU Guardian continues to meet with myself, Director of People and a Non-Executive Director on a monthly basis. Our Freedom to Speak up cases continue to rise which is really positive as this demonstrates an open, honest culture and that staff have confidence in the process. Focused work in the Maternity Unit is taking

place and their cultural improvement journey is being monitored by the People Committee.

4.7 Media coverage

This month's focus has been largely centred on the continued challenges of COVID and how we are managing this within the organisation, alongside continued positive staff stories and recognition. The communications team worked with partners at Bolton Council, Bolton CCG, GMHSCP and colleagues within NHS England and Improvement to ensure that patients and the public understood the impact on our services and were reassured about where to go for care when needed.

Key media activity since the last meeting includes:

- British Empire Medal awarded to HCA Andrea Greenall for services during the pandemic.
- Dr Moulinath Banerjee awarded Diabetes UK Clinical Champion role.
- Miss Gemma Faulkner announced as Regional Director for Royal College of Surgeons.
- An in depth piece with Huffington Post and members of frontline staff discussing the impact Wave 2 is having on our staff.
- Similar coverage on Channel 4 and ITV discussing high infection rates and reinforcing public health messaging from the perspective of staff treating COVID-19.
- Profile pieces featuring staff from across the organisation talking about their role as part of the 'for a better Bolton' series. A number of these have been picked up and shared by the national NHS team.
- Profiles of staff for use on national NHS channels during National Pathology Week, highlighting this often hidden, but vital role within the Trust.
- The arrival of Panther – a new testing system to allow us to double our COVID testing capacity.
- Awareness raising of our staff and their support for colleagues and patients during key awareness months – Black History Month and Breast Cancer Awareness Months, including patient case studies in the Bolton News.
- Announcements about charitable funding from NHS Charities Together.
- Launch of new communication and language pathway for early years.
- Letters of thanks from a local school were shared with staff and a video shared on social media; at the time of writing this had received over 1,000 hits.

5 Board Assurance Framework Summary

The Board Assurance Framework (BAF) Summary is attached. This shows the key risks to the achievement of our strategic ambitions, the actions required to reduce or mitigate these risks and the governance in place to provide the required oversight.

Our most significant strategic risk relates to the impact that Covid is having on ambition 1, to provide safe, high quality and compassionate care to every person, every time.

Ambition	Lead	I	L		Key Risks/issues	Key actions	Oversight
To provide safe, high quality and compassionate care to every person, every time **1)Reducing deaths in hospital**	FA	4	4	16	Prompt identification and escalation of ill patients Increase in HSMR/RAMI Phase 3 requirements	Work with AQUA and NHS Northwest on pneumonia Root cause analysis of avoidable cardiac arrests Delivery of MRG Workstream Audit of cases and coding to understand cause	QA committee Mortality Reduction Group Learning from Deaths
To provide safe, high quality and compassionate care to every person, every time **2)Delivery of Operational Performance**	AE	4	5	20	Capacity – physical and staffing exacerbated by COVID 19 infection control requirements Patient confidence to use services following COVID 19 Impact of COVID 19 on pathways, including risks associated with overcrowding Back log of work as a result of the cessation of activity during initial outbreak	Redesign of pathways for COVID compliance Urgent Care programme plan to ensure best practice, e.g. SAFER Enhanced pathways as part of the new streaming model Cancer and RTT Patient treatment list management Review of OPD and Theatre capacity and transformation Detailed capacity and demand management Joint working with GM on cancer pathways	Urgent care programme board Covid Reset Group Contract and Performance GM Cancer Board
To be a great place to work, where all staff feel valued and can reach their full potential	JM	4	4	16	Sickness rates Increase of stress related issues as a result of Covid Staff experience (particular focus required maternity)	Health and Wellbeing plan in place and positive impact, on-going monitoring in place Recruitment work plan in place, on-going Staff experience plan in place and positive impact, on-going Maternity cultural improvement plan, implementation on-going	IPM People committee
To continue to use our resources wisely so that we can invest and improve our services	AW	4	3	12	Delivery of required level of savings Financial regime changes due to Covid System level financial envelopes and funding streams In year cost pressures Lack of capital funding for equipment	Strategic financial modelling / run rate analysis including impact of Covid, Sep 20 System Financial Reset Work, Sep 20 Review of costs and income (patient level costing) Sep 20 Agree financial recovery trajectory with GM and NHSI, once BAU returns Capital prioritisation process in place for BAU capital	F&I committee IPM Contract and Performance Group
Our estate will be sustainable and developed in a way that supports staff and community health and wellbeing	AW	4	4	16	Availability of capital funding and changes to capital regime. Lack of revenue to support capital Technical accounting rules (IFRS 16) consequences Planning considerations – traffic and car parking constraints Controllability of non FT estate in community Backlog maintenance	Fully costed estates strategy over 5 years, Dec 20 6 Facet survey rolling programme, Sep 20 Demolition and disposal strategy, Dec 20 Agile working policy, Sep 20 Environmental sustainability strategy, Dec 20 Community estates strategy, Dec 20 Implementation of Premises Assurance Model April 21	Strategic Estates Board Strategic Estates Group Finance Committee
To integrate care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton	SM	4	3	12	Failure to Deliver Integrated Care Partnership	Appointment of ICP Chair – now complete Communication and Engagement Plan across all providers in place - complete Development of an OD Framework to support cultural change, Dec 20	Strategy / Transformation Board QA

						Develop Alliance Agreement to support the governance of the partnership, April 20 Embed ICP Community Focused Transformation Programme (including Public Sector Reform) within the ICP, on-going	
To develop partnerships that will improve services and support education, research and innovation	SM	4	**4**	**16**	The ISC and Healthier together programmes have been put on hold for the next 12 months to release capacity to deliver COVID. GM partnership work has been strengthened to respond to the COVID Incident.	Continued Involvement of executives at a GM level, on-going Assessment of the changes required for COVID delivery on the Healthier together plan, on-going Assessment of the changes to ISC programme on the Healthier Together Plan, on-going	Strategy Transformation QA F and I

Agenda Item:

Title:	COVID-19 Staff Wellness Programme Update			
Meeting:	Board of Directors	**Purpose:**	Assurance	
Date:	26th November 2020		Discussion	✓
Exec Sponsor:	James Mawrey		Decision	

Summary:	This report updates the Board of Directors on the Trust's COVID-19 Staff Wellness Programme and enabling actions that will ensure that our staff are supported during wave two. The report also outlines our approach to creating a sustainable culture of staff wellness. A plethora of wellness support is in place to help our staff to cope more effectively with increased operational pressures, the psychological impact of the pandemic and manage their home commitments. Although we have the lowest sickness absence rate in Greater Manchester and one of the lowest in the North West, we know from staff feedback that some colleagues are feeling fatigued, anxious and suffering from moral injury which is impacting on their psychological wellbeing. We are therefore continuing to focus on the staff wellness agenda to help increase employee engagement and wellbeing which in turn will improve patient care and employee attendance. The Staff Health and Wellbeing Steering Group (with escalation reports to the People Committee) monitors the delivery of our Staff Wellness Programme.

Previously considered by:	The People Committee and COVID-19 Command Groups have been sighted on, and approved key actions where necessary, relating to the Trust's Staff Wellness Programme.

Proposed Resolution:	For discussion and noting.

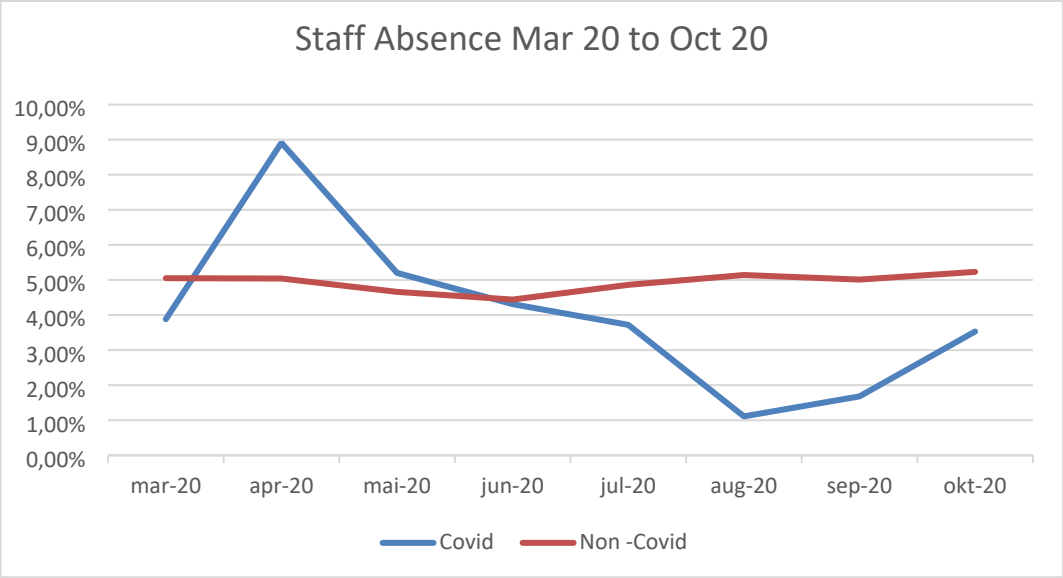
This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Lisa Gammack, Associate Director - OD	**Presented by:**	James Mawrey, Director of People

1. Introduction

1.1 People working across health and social care have come together and stepped up in ways never seen before, changing the way they work, making significant personal sacrifices and working harder and longer hours. In response to this the Trust has accelerated its' staff wellness agenda by putting in place a plethora of support to help our employees to cope more effectively with increased operational pressures, the psychological impact of the pandemic and manage their home commitments.

1.2 The Board is aware that our overall sickness absence level has significantly increased due to the pandemic. The graph below shows the overall COVID and non-COVID related sickness absence levels from March to October 2020. In October 2020 our overall sickness absence rate was 8.76%.



1.3 On a positive note, Bolton FT has the lowest sickness absence levels in Greater Manchester and one of the lowest in the North West. Our impressive sickness management performance is testament to the approach taken by the Divisions and the Workforce & OD Directorate alongside swift decision making by our COVID command structure.

1.4 We are continuing to find new ways to show our employees that we care for them, through acts of kindness and continuing to enhance our staff wellness offer. Both with the strategic aim of rewarding and supporting our amazing workforce and providing safe high quality patient care.

2. Current Position

2.1 The Board received an update on our COVID-19 Staff Wellness Programme in May 2020. Since then the following support has continued to be provided and/or been introduced:

- Mental health telephone support/counselling delivered by Wellbeing Partners – 312 employees have accessed this support since 1st April 2020;
- Employee Assistance Programme – 24/7 telephone counselling and advice line, telephone number 03303 800658. 237 employees have accessed the service during the period from 1st April to 30th September 2020;
- PTSD fast track support delivered by Vivup – so far no employees have been referred for fast track support. Individuals have presented themselves to OH feeling they may be suffering with PTSD and appropriate support has been put in place;

- Bereavement support provided by our in-house Bereavement Service;
- Caring for Yourself Programme – 104 employees attended a one-day face to face session during August to November 2020 plus 85 staff accessed the Caring for Yourself/Teams webinars;
- Set up lavender rooms across the RBH site and in community buildings – these provide safe and quiet space for staff to take time out and access wellbeing resources;
- Free access to mental health apps including Shinymind, Headspace, Sleepio, Daylight, etc. – to date 615 staff have accessed the Shinymind App;
- Vivup, an online wellbeing portal – to date 2036 staff have signed up to use the portal;
- Neyber, an online financial wellbeing portal;
- Financial wellbeing webinars;
- Chaplaincy and spiritual support;
- Online physical fitness classes delivered by our gym instructors – to date 687 places have been delivered;
- RBH onsite gym – 604 attendances to date since it re-opened on 27th July 2020.
- Accessible staff wellness tools, information and guidance;
- Free staff car parking has been extended to 31st March 2021;
- Additional changing facilities on the RBH site;
- Continuation of the additional 25% staff discount in the RBH Elior restaurant;
- Re-launched the leadership and management development offer which includes the new BAME Development Programme, coaching skills and the 'lead inspire and care' sessions.

2.2 We still intend to convert the old Sports and Social Club on the RBH site into a Staff Wellness Centre. However, plans have been put on hold because the space is currently being used as staff changing facilities.

2.3 We are providing regular communications to our workforce that normalises ongoing distress at this stage of the pandemic and continuing to signpost staff to the wellness support in place. The Chief Executive continually encourages staff to seek support and look after themselves via her weekly blogs and November's Team Brief was themed around staff wellness.

2.4 This year's Staff Flu Immunisation Programme has got off to an amazing start. 50% of our workforce had been immunised as at 13th November 2020 which is 10% above the same point in last year's programme. The Director of Nursing & Midwifery is leading a task group focusing on this important programme with strong divisional input, and we continue to aspire to achieving a 100% success rate.

3. Sustainable Positive Change

3.1 Fighting the pandemic is a marathon not a sprint and so we understand that there is more to do enhance our long term approach to fostering a strong culture of staff wellness. Patient care will always come first but individuals cannot deliver safe high quality care if they are not mentally and physically well.

3.2 We know from our analysis that staff generally access wellness support at the point when they feel distressed or go off sick. We are therefore working collaboratively with divisions to develop new approaches to help staff take greater responsibility for their own health and wellbeing. We want our staff to understand that it is 'OK not to be OK' and prioritise caring for themselves. We have included a section on staff health and wellbeing in the new staff induction sessions to ensure that all new staff are aware of the support available to them and the important of self-care.

3.3 Changing culture will require very different thinking and solutions. If we do what we have always done, then we will get what we have always got. We have articulated through the new VOICE Behaviour Framework that we need everyone to 'Be Kind' and 'Be Bold' which encompasses self-care and trying new approaches. We will continue to work with divisions to find innovative ways to change hearts and minds and help our staff to lead healthier lifestyles.

4. Immediate Priorities

4.1 The OD Service is continuing to focus on the following priorities with the aim of enhancing the support we provide to our amazing staff:

- Working with our occupational health provider, Wellbeing Partners, to enhance their service provision to ensure that it meets current and future demand.
- Helping line managers to increase their skills, knowledge and confidence to have impactful wellbeing conversations using the new 'For a Better Bolton Conversation Toolkit' which was launched on 13th November 2020.
- Exploring the feasibility of establishing a Staff Health Psychology Service which builds on the clinics provided by our Clinical Health Psychology Team during the peak of the pandemic. A business case will be shared with the COVID-19 Command Groups.
- Finalising plans to introduce Schwartz rounds across the organisation including identifying a clinical lead and a pool of suitable people to be trained as Schwartz round facilitators.
- Establishing a task group to prepare a business case seeking approval to implement trauma risk management (TRiM) which is a method of secondary PTSD prevention used by emergency services and some other organisations.
- Increasing the number of lavender rooms (also referred to as wobble rooms) across workplaces.
- Advancing plans to increase and improve the provision of staff rest facilities on the RBH site. iFM have been asked to assess the provision and standard of current rest facilities to help identify where charitable funding is required to enhance facilities. So far funding has been requested to improve facilities in the Maternity Department, it has been agreed that the Boardroom will be used as a temporary rest facility and space is being freed up on the main hospital spine to be converted into a safe space for staff to rest and recuperate.
- Refreshing our Staff Health and Wellbeing Strategy to reflect the current and emerging priorities.
- Establishing a Staff Wellness Champions Network to work with the Staff Experience Team to develop and implement new ways to enhance staff wellness and morale and cascade important staff wellness information to colleagues.

5. Next Steps

5.1 The Board of Directors will continue to receive regular updates on the progress of this agenda from the Executive Director of People and Associate Director of OD.

6. Conclusion

6.1 The COVID-19 pandemic has acted as a springboard, bringing about an incredible scale and pace of transformation. We must build on this momentum and continue to transform – keeping our staff at the heart of everything we do.

6.2 We must continue to look after our incredibly hard working staff by taking robust actions to keep them safe, healthy and well, both physically and psychologically. This will require radical approaches and support and commitment from managers at all levels within the Trust.

7. Recommendation

7.1 The Board of Directors is asked to consider and note the approach that we are taking on this critical agenda.

Agenda Item

Title:	Healthcare Worker Flu Vaccination Best Practice Checklist

Meeting:	Trust Board	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	
Exec Sponsor	Director of Nursing		Decision	

Summary:	This paper articulates the Trust position in relation to the NHS England best practice checklist.

Previously considered by:	Infection Prevention and Control Committee

Proposed Resolution	Continued surveillance

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*		*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*		*To develop **partnerships** that will improve services and support education, research and innovation*	

Prepared by:	Richard Catlin, Assistant Director IPC	**Presented by:**	Marie Forshaw, Director of Nursing

Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December 2020

		Trust self-assessment
A	**Committed leadership**	
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Compliant
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Compliant
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Compliant
A4	Agree on a board champion for flu campaign	Compliant
A5	All board members receive flu vaccination and publicise this	Compliant
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Compliant
A7	Flu team to meet regularly from September 2020	Compliant
B	**Communication plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Compliant
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Compliant
B3	Board and senior managers having their vaccinations to be publicised	Compliant
B4	Flu vaccination programme and access to vaccination on induction programmes	Compliant
B5	Programme to be publicised on screensavers, posters and social media	Compliant
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Compliant
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Compliant
C2	Schedule for easy access drop in clinics agreed	Compliant
C3	Schedule for 24 hour mobile vaccinations to be agreed	Compliant
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Compliant
D2	Success to be celebrated weekly	Compliant

Agenda Item
11

	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	26th November 2020		Discussion	x
Exec Sponsor	Esther Steel		Decision	

Summary:	The attached performance report is provided to support the Board's oversight of performance and progress towards strategic goals and to ensure responsiveness and clear line of sight from ward to Board. COVID-19 has resulted in significant operational challenges that have impacted significantly on many of the metrics included in this report

Previously considered by:	The Executive and operational management teams

Proposed Resolution	The Board are asked to consider the key metrics noting the impact of COVID-19 and consider if any further scrutiny is required through one of the Board Committees

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	BI team	**Presented by:**	Andy Ennis Chief Operating Officer

Bolton NHS Foundation Trust

Integrated Performance Report

October 2020

Guide to Statistical Process Control

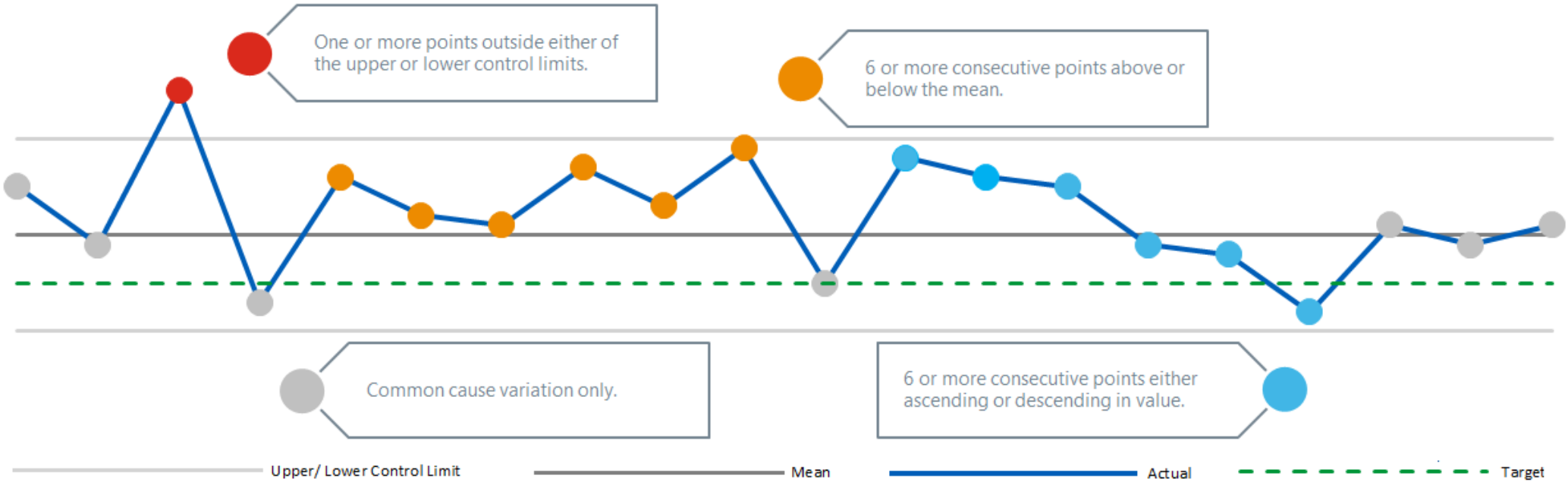
NHS Bolton NHS Foundation Trust

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **http://www.improvement.nhs.uk/resources/making-data-count**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre reference line **(dark grey)** is the mean, and the two light grey lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.



Executive Summary

Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
	Common cause	H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	13	1	1	1	0	1	2	13
Infection Prevention and Control	7	0	1	0	0	0	0	8
Mortality	4	0	0	0	0	0	0	4
Patient Experience	13	1	0	0	2	5	0	11
Maternity	8	0	1	0	1	1	0	9
Operational Performance								
Access	5	0	1	4	1	1	6	4
Productivity	7	0	3	0	1	1	1	9
Cancer	5	2	0	0	0	2	0	5
Community	4	0	0	0	0	2	0	2
Workforce								
Sickness, Vacancy and Turnover	1	0	0	2	0	0	1	2
Organisational Development	2	1	0	0	1	1	0	3
Agency	2	0	0	1	0	0	0	0
Finance								
Finance	0	1	1	0	2	1	1	2
Appendices								
Heat Maps								

Variation

Common cause	Common cause variation.
H	Indicates that special cause variation has occurred that is a cause for concern due to higher values in relation to the target.
L	Indicates that special cause variation has occurred that is a cause for concern due to lower values in relation to the target.
H	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to higher values.
L	Indicates that special cause variation has occurred that constitutes an improvement in relation to the target due to lower values.

Assurance

P	Indicates that we are consistently meeting the target for the indicator in question.
F	Indicates that we are consistently falling short of the target for the indicator in question.
?	Indicates that we will not consistently meet the target for this indicator as the target is within the range of common cause variation.

Quality and Safety

Harm Free Care

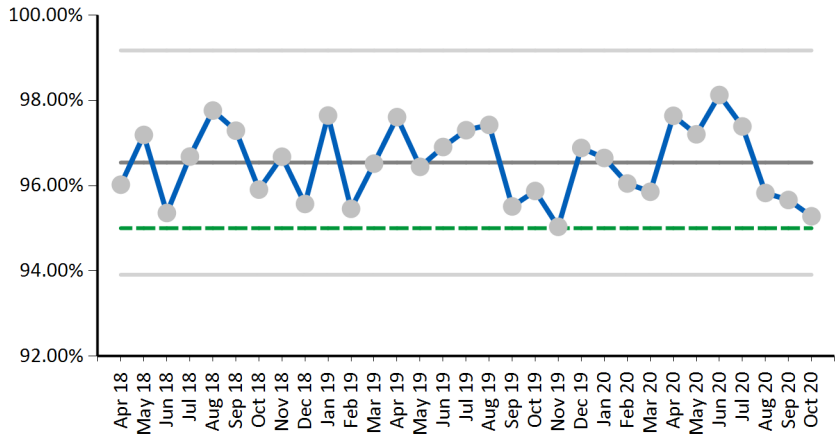
Pressure Ulcers
The number of pressure ulcers in the hospital and community has reduced this month in comparison to the previous month, with the number of category 2 pressure ulcers in hospital below trajectory and no category 3 or 4 pressure ulcers developing in month. In the community, the number of category 2 and category 3 pressure ulcers was also below trajectory, and there were no category 4 pressure ulcers.

Falls
Inpatient falls have reduced significantly in October despite the increase in bed occupancy and the second wave of COVID – 19. We are now below the national benchmark of 6.6 falls per 1000 bed days.

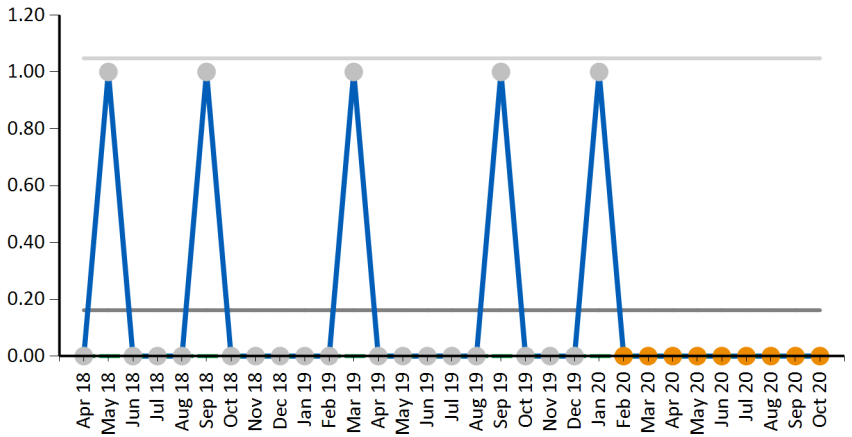
		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	Medium	>= 95%	95.3%	Oct-20		>= 95%	95.7%	Sep-20	>= 95%	96.6%	
9 - Never Events	High	= 0	0	Oct-20	L	= 0	0	Sep-20	= 0	0	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	Low	<= 5.30	6.33	Oct-20	H	<= 5.30	9.44	Sep-20	<= 5.30	7.42	
14 - Inpatient falls resulting in Harm (Moderate +)	High	<= 1.6	2	Oct-20		<= 1.6	3	Sep-20	<= 11.2	11	
15 - Acute Inpatients acquiring pressure damage (category 2)	Low	<= 6.0	4.0	Oct-20		<= 6.0	6.0	Sep-20	<= 42.0	33.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	Medium	<= 0.5	0.0	Oct-20		<= 0.5	0.0	Sep-20	<= 3.5	4.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	High	= 0.0	0.0	Oct-20		= 0.0	0.0	Sep-20	= 0.0	0.0	
18 - Community patients acquiring pressure damage (category 2)	Low	<= 7.0	7.0	Oct-20		<= 7.0	11.0	Sep-20	<= 49.0	77.0	

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
19 - Community patients acquiring pressure damage (category 3)	Medium	<= 4.0	3.0	Oct-20		<= 4.0	5.0	Sep-20	<= 28.0	31.0	
20 - Community patients acquiring pressure damage (category 4)	High	<= 1.0	0.0	Oct-20		<= 1.0	0.0	Sep-20	<= 7.0	1.0	
21 - Total Pressure Damage due to lapses in care	Medium	<= 6	3	Oct-20		<= 6	3	Sep-20	<= 39	17	
28 - Emergency patients screened for Sepsis (quarterly)	High	>= 90%	82.0%	Q2 2020/21		>= 90%	83.3%	Q4 2019/20	>= 90%	82.0%	
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	High	>= 90%	100.0%	Q2 2020/21		>= 90%	33.3%	Q4 2019/20	>= 90%	100.0%	
30 - Clinical Correspondence - Inpatients %<1 working day		>= 95%	85.1%	Oct-20	H	>= 95%	84.7%	Sep-20	>= 95%	82.4%	F
31 - Clinical Correspondence - Outpatients %<5 working days		>= 95.0%	70.8%	Oct-20		>= 95.0%	81.4%	Sep-20	>= 95.0%	79.0%	F
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	Low	= 100%	100.0%	Oct-20		= 100%	100.0%	Sep-20	= 100%	90.8%	
88 - Nursing KPI Audits	Low	>= 85%	91.4%	Oct-20		>= 85%	90.9%	Sep-20	>= 85%	91.4%	P
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days		= 100%	0.0%	Oct-20		= 100%	0.0%	Jul-20	= 100%		

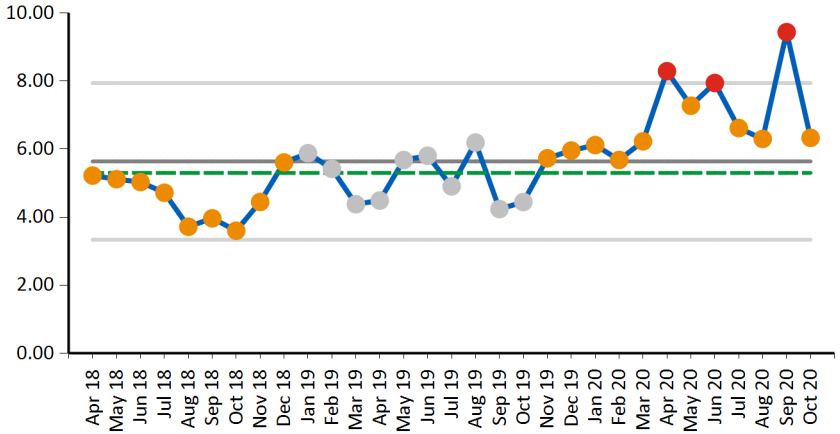
6 - Compliance with preventative measure for VTE



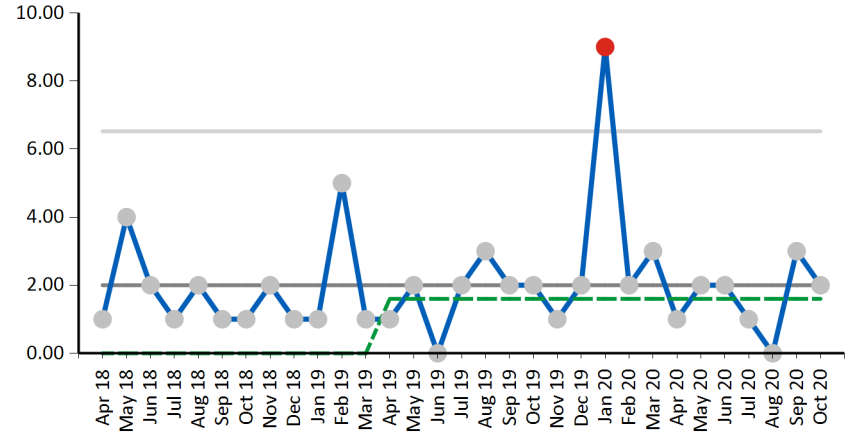
9 - Never Events



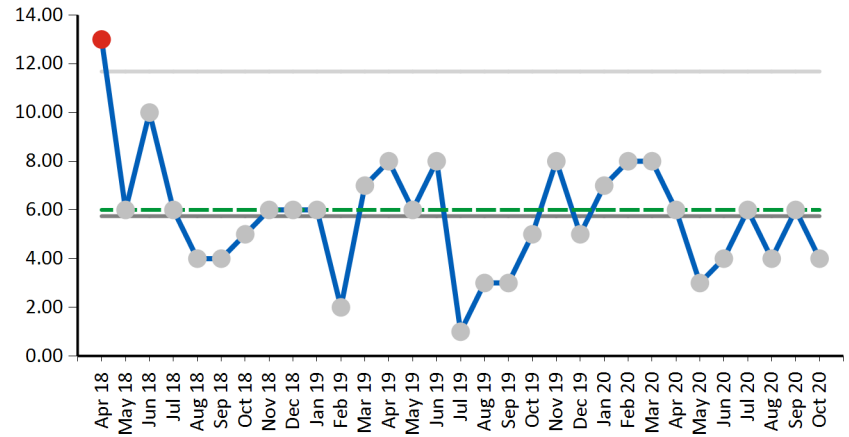
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



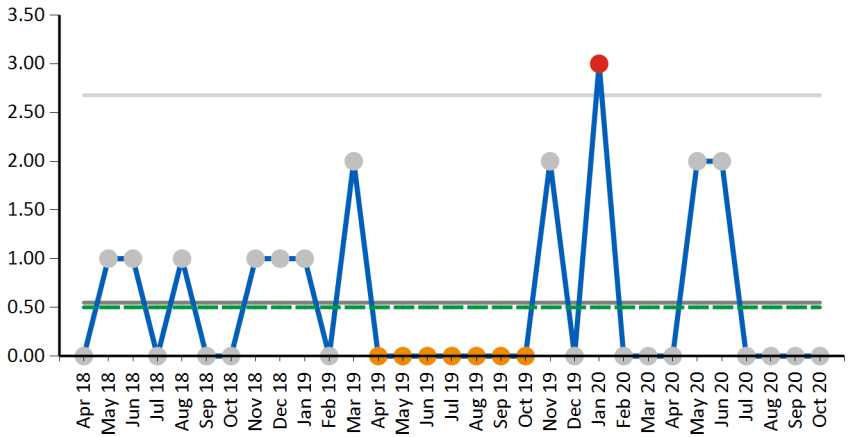
14 - Inpatient falls resulting in Harm (Moderate +)



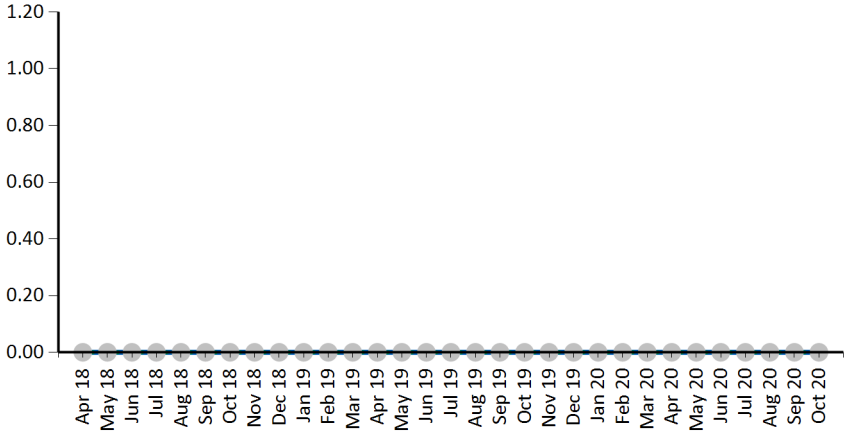
15 - Acute Inpatients acquiring pressure damage (category 2)



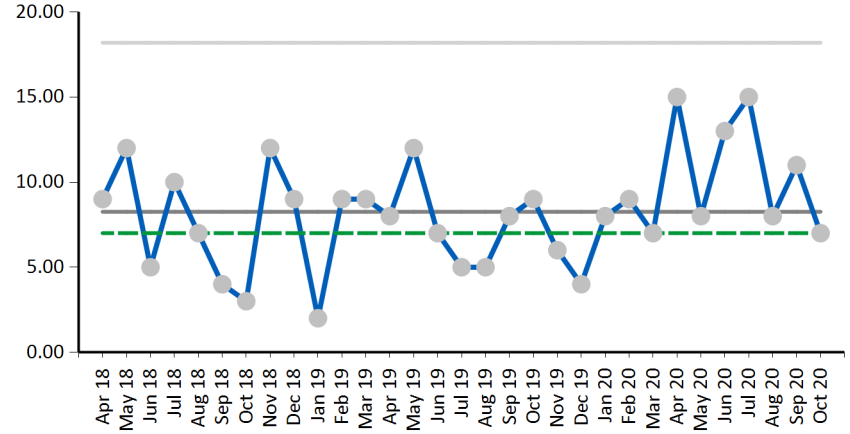
16 - Acute Inpatients acquiring pressure damage (category 3)



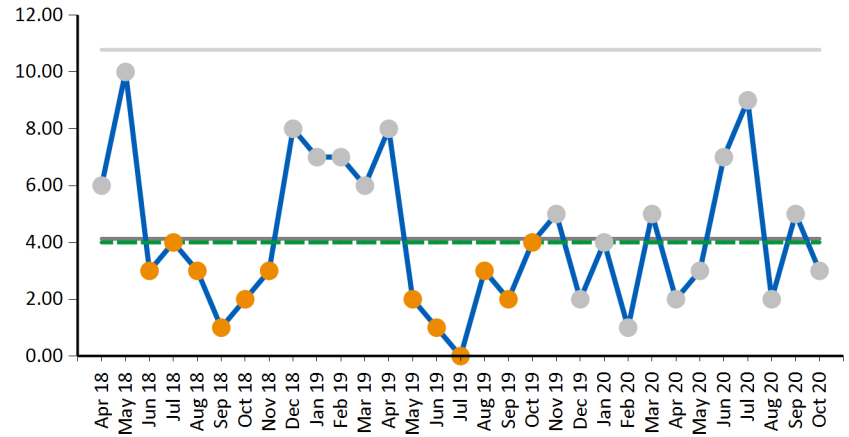
17 - Acute Inpatients acquiring pressure damage (category 4)



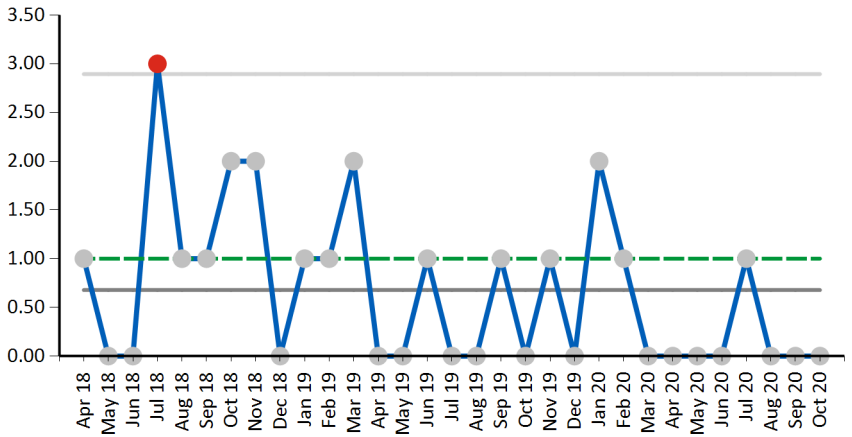
18 - Community patients acquiring pressure damage (category 2)



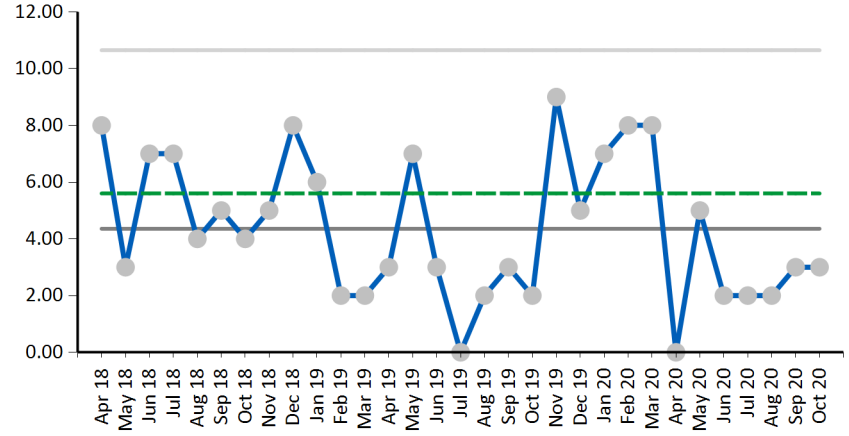
19 - Community patients acquiring pressure damage (category 3)



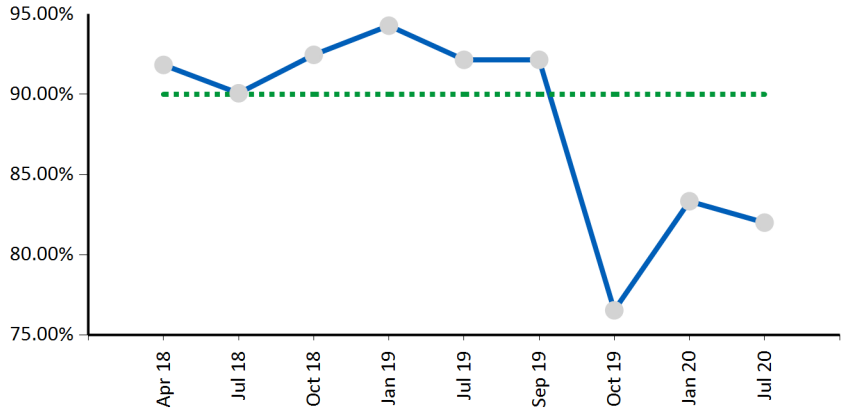
20 - Community patients acquiring pressure damage (category 4)



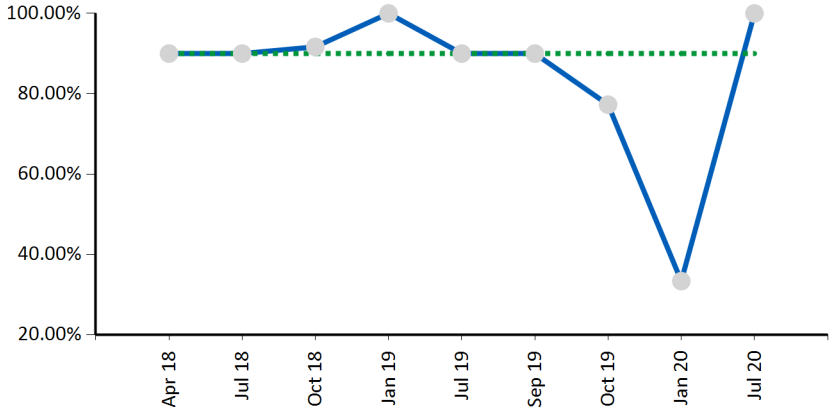
21 - Total Pressure Damage due to lapses in care



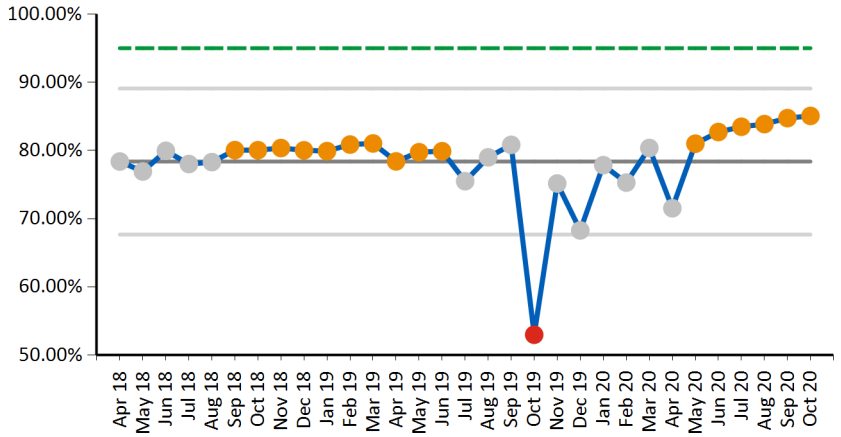
28 - Emergency patients screened for Sepsis (quarterly) - SPC data available after 20 data points



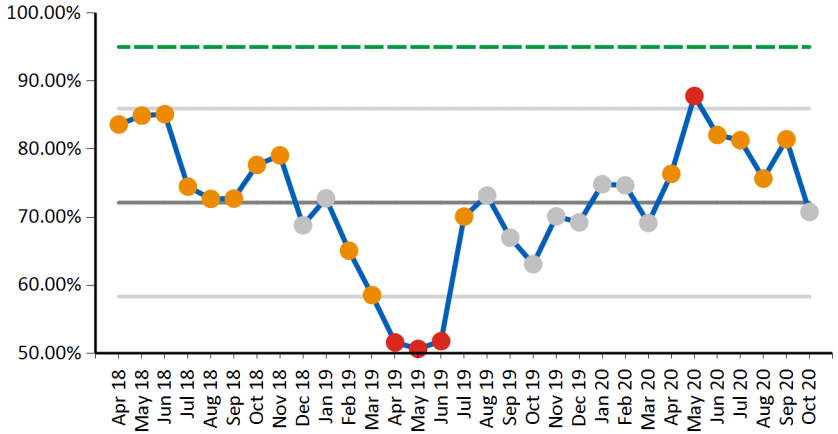
29 - Emergency patients who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



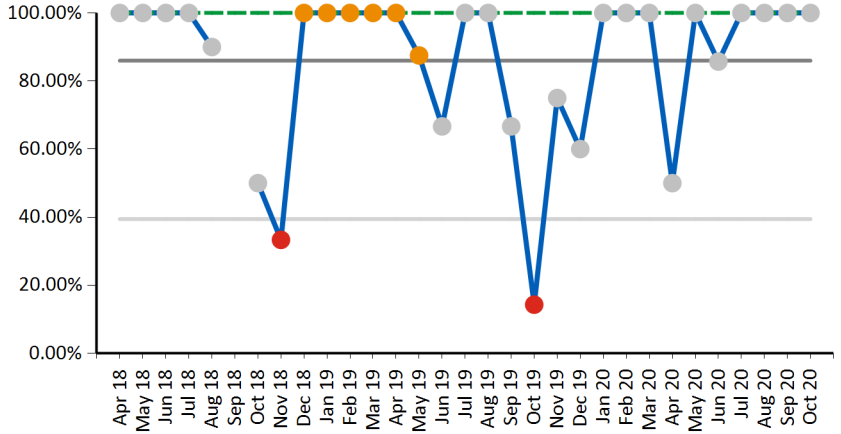
30 - Clinical Correspondence - Inpatients %<1 working day



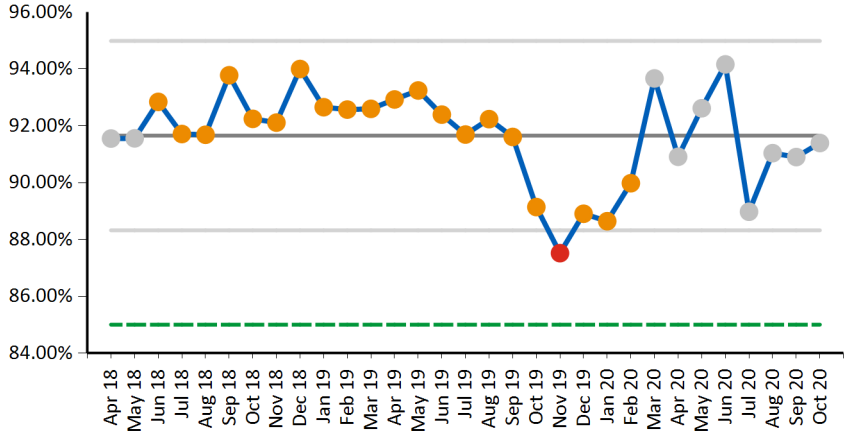
31 - Clinical Correspondence - Outpatients %<5 working days



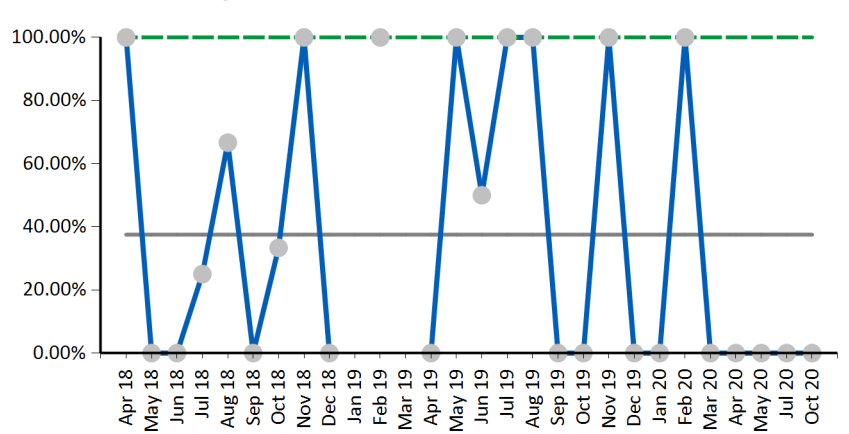
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



88 - Nursing KPI Audits



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

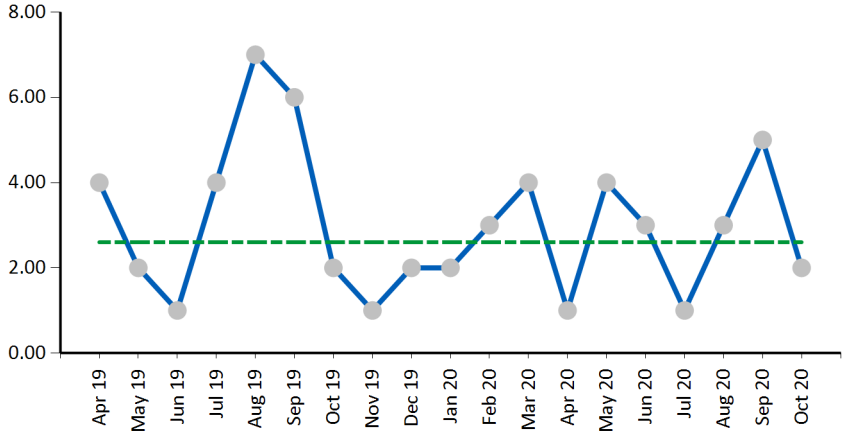


Infection Prevention and Control

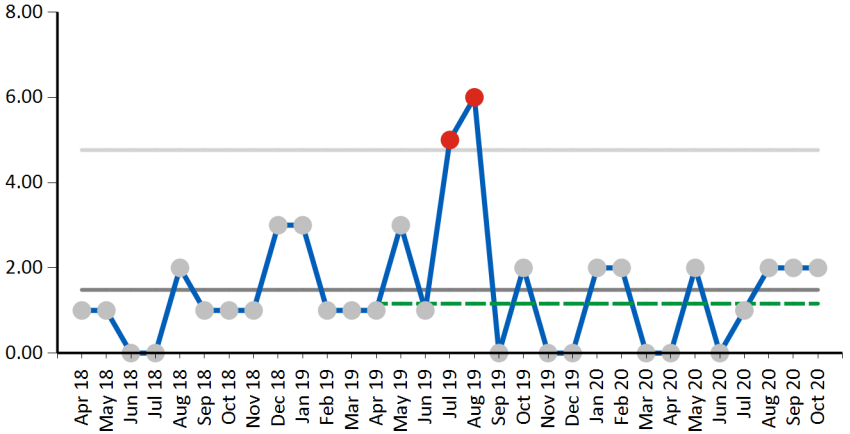
There has been a general reduction in HCAI in October. There has been a significant surge of COVID-19 cases across the region and the upturn in community cases has led to an inevitable increase in nosocomial cases. Additional control measures are in place and the all cases are now decreasing whilst nosocomial cases have plateaued but it is expected that they will decrease in line with all cases.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections	High	<= 3	2	Oct-20		<= 3	5	Sep-20	<= 18	19	
346 - Total Community Onset Hospital Associated C.diff infections	High	<= 1	2	Oct-20		<= 1	2	Sep-20	<= 8	9	
347 - Total C.diff infections contributing to objective	High	<= 3	4	Oct-20		<= 3	7	Sep-20	<= 18	28	
217 - Total Hospital-Onset MRSA BSIs	High	= 0	0	Oct-20		= 0	0	Sep-20	= 0	2	
218 - Total Trust apportioned E. coli BSI	High	<= 3	1	Oct-20		<= 3	4	Sep-20	<= 21	11	
219 - Blood Culture Contaminants (rate)	High	<= 3%	4.1%	Oct-20		<= 3%	4.8%	Sep-20	<= 3%	4.5%	
199 - Compliance with antibiotic prescribing standards		>= 95%	71.0%	Q3 2019/20		>= 95%	87.0%	Q2 2019/20	>= 95%		
304 - Total Trust apportioned MSSA BSIs	High	<= 1.3	0.0	Oct-20		<= 1.3	3.0	Sep-20	<= 9.1	9.0	
305 - Total Trust apportioned Klebsiella spp. BSIs	High	<= 1	1	Oct-20		<= 1	0	Sep-20	<= 8	4	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs	High	= 0	0	Oct-20		= 0	0	Sep-20	= 0	3	
491 - Nosocomial COVID-19 cases			3	Oct-20			11	Sep-20		131	

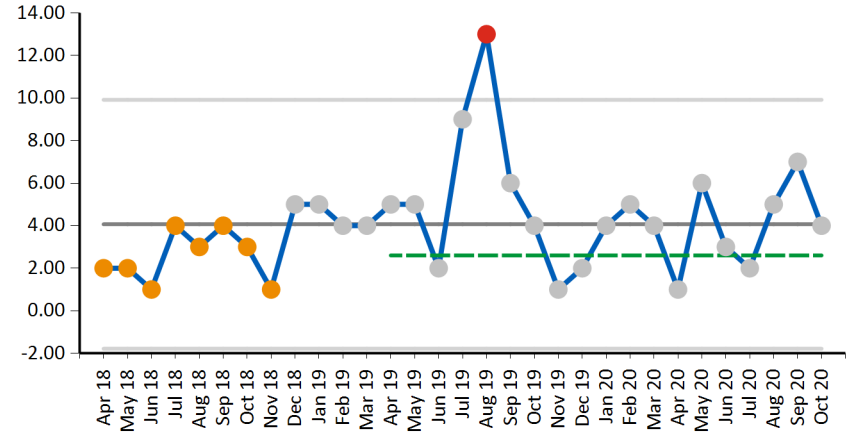
215 - Total Hospital Onset C.diff infections



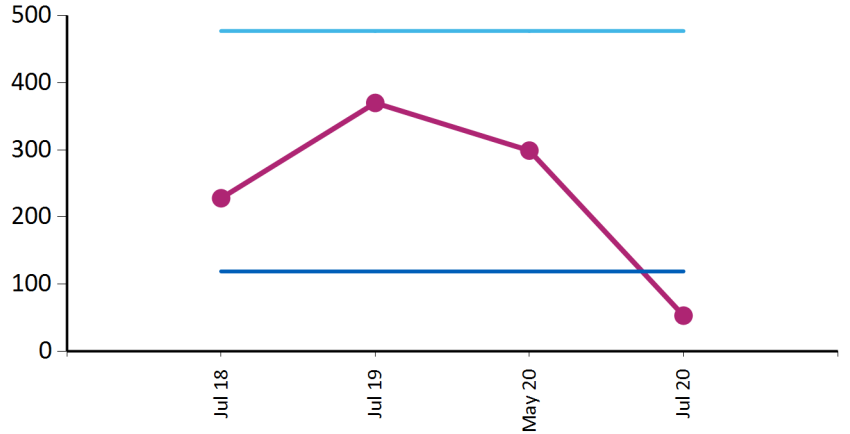
346 - Total Community Onset Hospital Associated C.diff infections



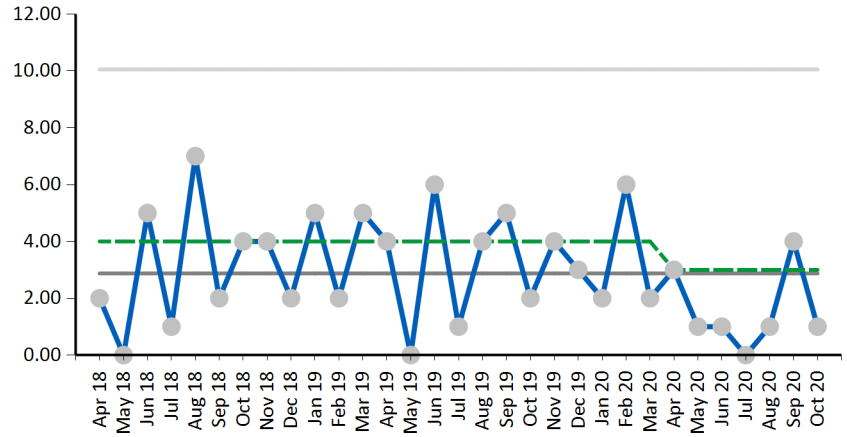
347 - Total C.diff infections contributing to objective



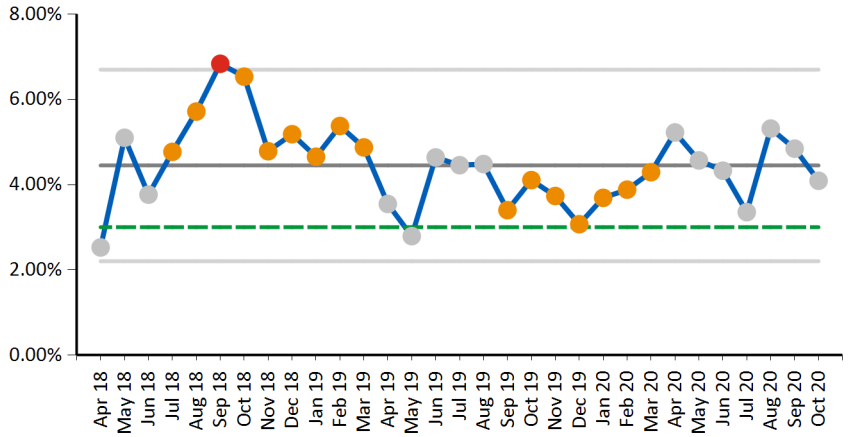
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



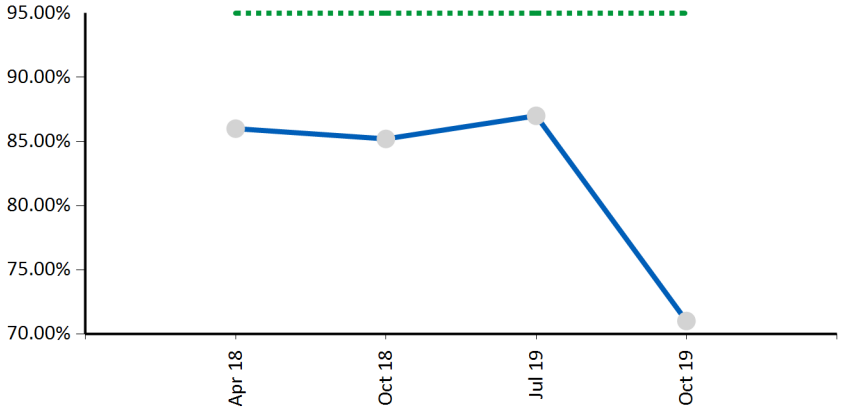
218 - Total Trust apportioned E. coli BSI



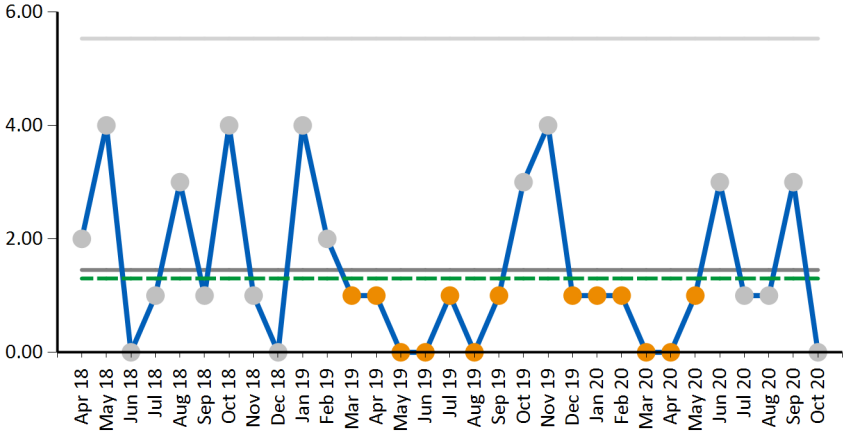
219 - Blood Culture Contaminants (rate)



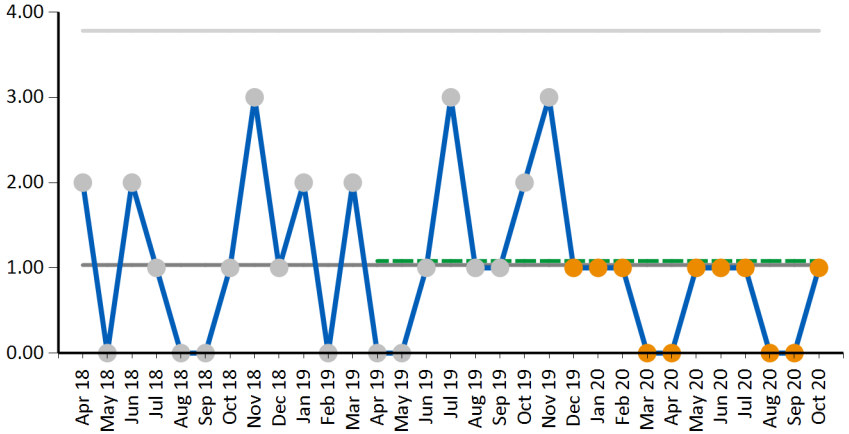
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



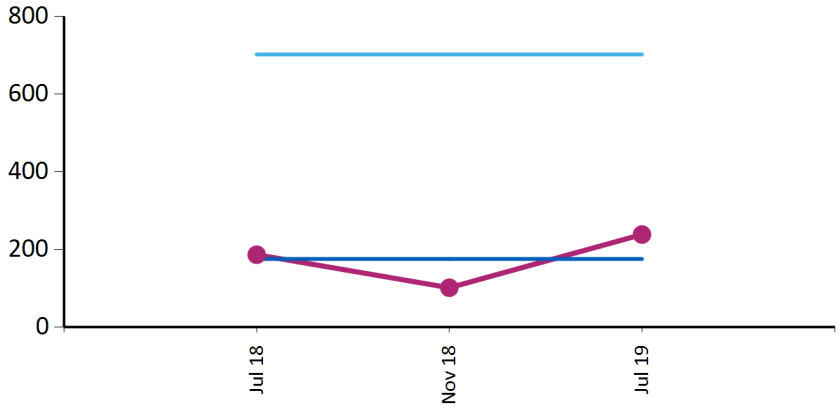
304 - Total Trust apportioned MSSA BSIs



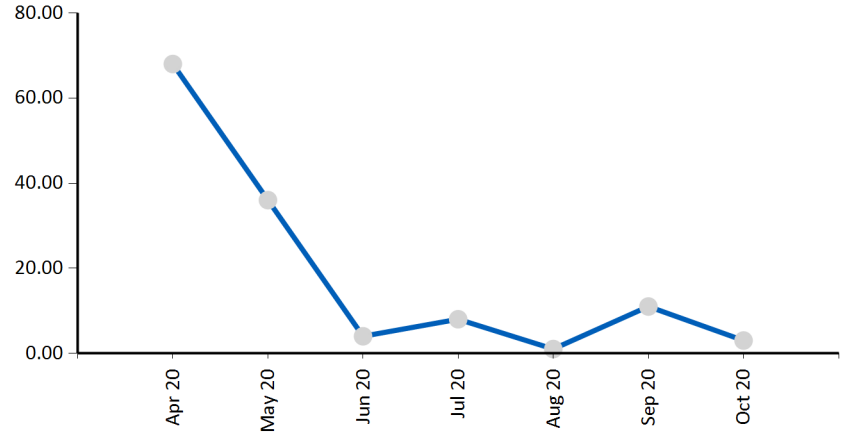
305 - Total Trust apportioned Klebsiella spp. BSIs



306 - Total Trust apportioned Pseudomonas aeruginosa BSIs - G Chart (Days Between Cases)



491 - Nosocomial COVID-19 cases - SPC data available after 20 data points



Mortality

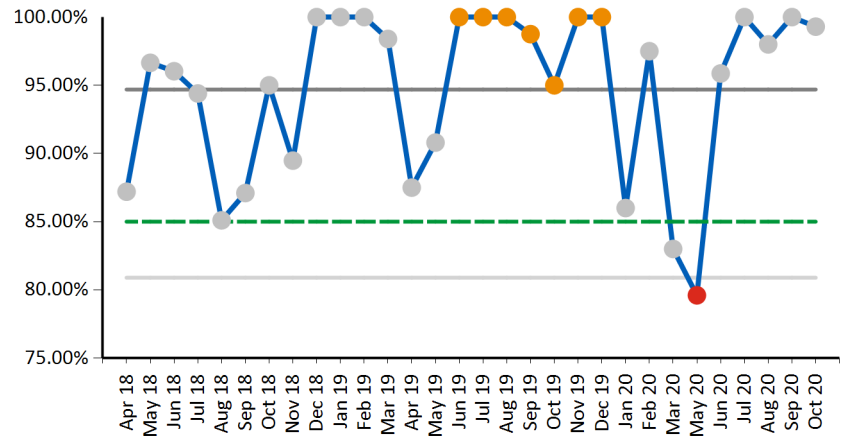
Crude – The rise can be attributed to the beginning of the second wave of the pandemic – the crude rate is not adjusted for Covid deaths. The number of spells (denominator) was highest in October since before April which will have helped to keep the crude rate within range despite the rising number of deaths.

RAMI – the Index has increased to just below the average for the reported timescale but remains within the confidence limits. RAMI is again not adjusted for Covid death. This indicator has been rebased but the new indicator figures were not available for the Board deadline so these will be adjusted for the next report.

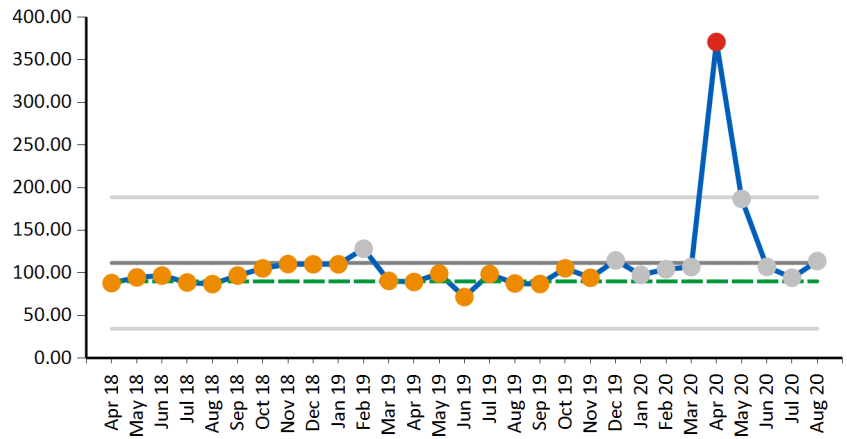
SHMI – The Index has been higher than the average for the reportable period from March to May (SHMI has a five month time lag as deaths within 30 days of discharge are included). SHMI has been adjusted for Covid by removing deaths where ICD10 codes for confirmed or suspected Covid are recorded. Despite this the in-month SHMI for May is the highest recorded since May the previous year. There is continuing work with clinicians to ensure recording is complete. The 12 month rolling average for SHMI to May 2020 is 117.6, this remains significantly higher than the England average, however, the diagnosis group for pneumonia is within expected levels.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	High	>= 85%	99.3%	Oct-20		>= 85%	100.0%	Sep-20	>= 85%	95.5%	
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)	Low	<= 90	113.8	Aug-20		<= 90	94.2	Jul-20	<= 90	113.8	
11 - Standardised Hospital Mortality (ratio)	Low	<= 100.00	135.50	May-20		<= 100.00	127.40	Apr-20	<= 100.00	135.50	
12 - Crude Mortality %		<= 2.9%	2.8%	Oct-20		<= 2.9%	2.2%	Sep-20	<= 2.9%	3.2%	

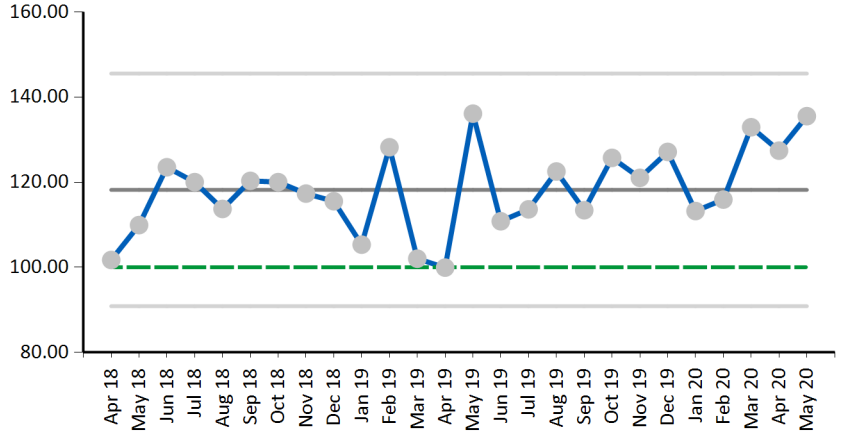
3 - National Early Warning Scores to Gold standard



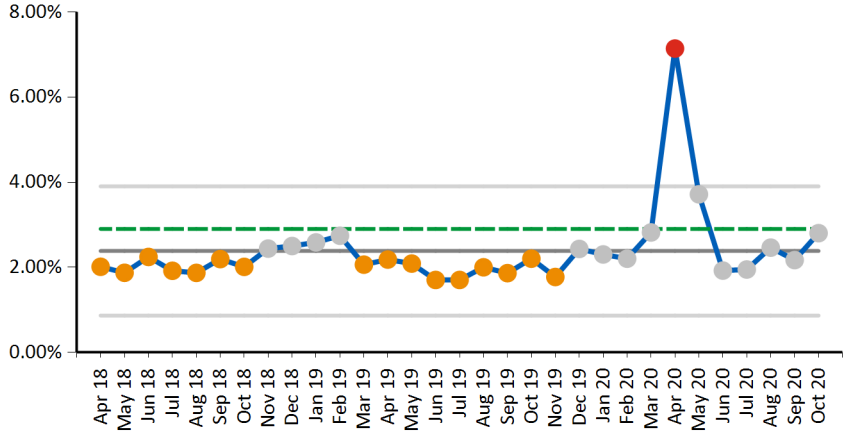
10 - Risk adjusted Mortality (ratio) (2 mths in arrears)



11 - Standardised Hospital Mortality (ratio)



12 - Crude Mortality %



Patient Experience

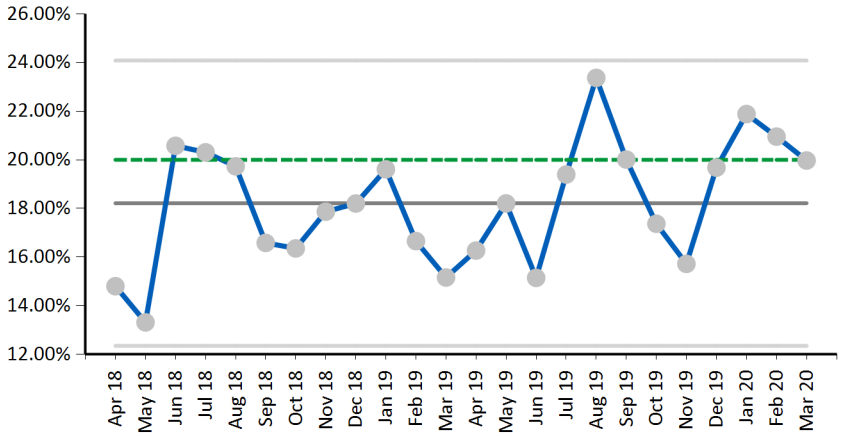
FFT
The Trust continued to collect FFT during October and received the NHSE announcement that they expect us to collect from December, report in January and they will publish in February. In light of the second wave of the CVID-19 pandemic, the latest guidance is to make every effort to collect safely and to focus on the comments and recommendations rather than response rates (The Trust response rate in October was 20%). The Patient Experience Manager is currently working on a plan to support colleagues in achieving this using electronic methods.

Complaints
The 100% target for acknowledging complaints within 3 working days was achieved in October 2020. The Trust also achieved above the Trajectory of 95% by providing 100% of complainants with a response to their complaint within 35 working days during October 2020.

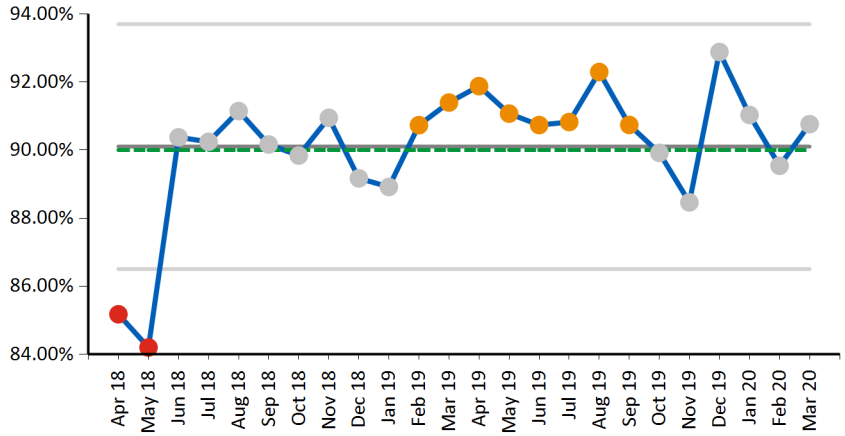
		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	Low	>= 20%	20.0%	Mar-20		>= 20%	21.0%	Feb-20	>= 20%		
294 - A&E Friends and Family Satisfaction Rates %	Low	>= 90%	90.8%	Mar-20		>= 90%	89.5%	Feb-20	>= 90%		
80 - Inpatient Friends and Family Response Rate	Low	>= 30%	24.4%	Mar-20		>= 30%	26.6%	Feb-20	>= 30%		
240 - Friends and Family Test (Inpatients) - Satisfaction %	Low	>= 90%	97.9%	Mar-20		>= 90%	96.9%	Feb-20	>= 90%		
81 - Maternity Friends and Family Response Rate	Low	>= 15%	12.4%	Mar-20		>= 15%	22.9%	Feb-20	>= 15%		
241 - Maternity Friends and Family Test - Satisfaction %	Low	>= 90%	94.3%	Mar-20		>= 90%	96.9%	Feb-20	>= 90%		
82 - Antenatal - Friends and Family Response Rate	Low	>= 15%	0.0%	Mar-20		>= 15%	12.3%	Feb-20	>= 15%		
242 - Antenatal Friends and Family Test - Satisfaction %	Low	>= 90%		Mar-20		>= 90%	100.0%	Feb-20	>= 90%		
83 - Birth - Friends and Family Response Rate	Low	>= 15%	26.5%	Mar-20		>= 15%	28.7%	Feb-20	>= 15%		
243 - Birth Friends and Family Test - Satisfaction %	Low	>= 90%	93.1%	Mar-20		>= 90%	93.7%	Feb-20	>= 90%		
84 - Hospital Postnatal - Friends and Family Response Rate	Low	>= 15%	15.8%	Mar-20		>= 15%	33.7%	Feb-20	>= 15%		
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	Low	>= 90%	96.4%	Mar-20		>= 90%	97.7%	Feb-20	>= 90%		

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
85 - Community Postnatal - Friend and Family Response Rate	Low	>= 15%	8.7%	Mar-20	L	>= 15%	19.8%	Feb-20	>= 15%		?
245 - Community Postnatal Friends and Family Test - Satisfaction %	Low	>= 90%	95.1%	Mar-20		>= 90%	98.8%	Feb-20	>= 90%		P
89 - Formal complaints acknowledged within 3 working days	High	= 100%	100.0%	Oct-20	H	= 100%	100.0%	Sep-20	= 100%	100.0%	?
90 - Complaints responded to within the period	High	>= 95%	100.0%	Oct-20		>= 95%	94.7%	Sep-20	>= 95%	88.3%	?

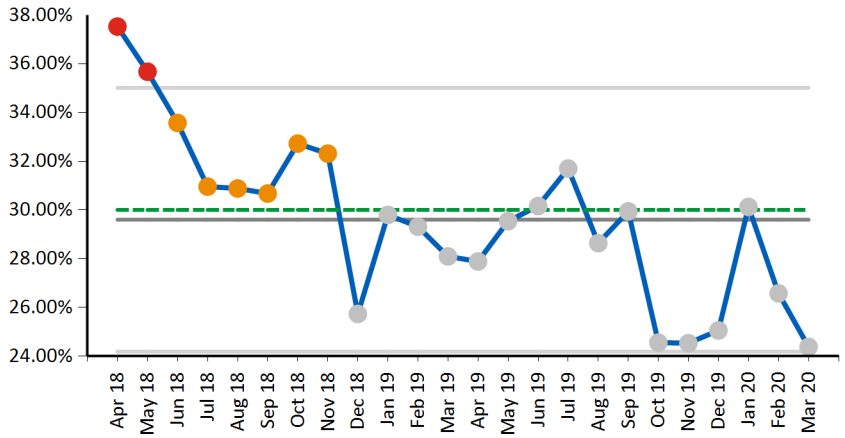
200 - A&E Friends and Family Response Rate



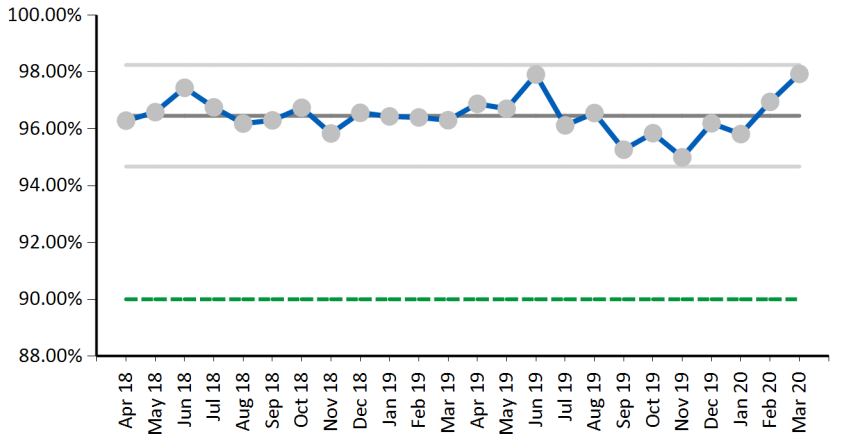
294 - A&E Friends and Family Satisfaction Rates %



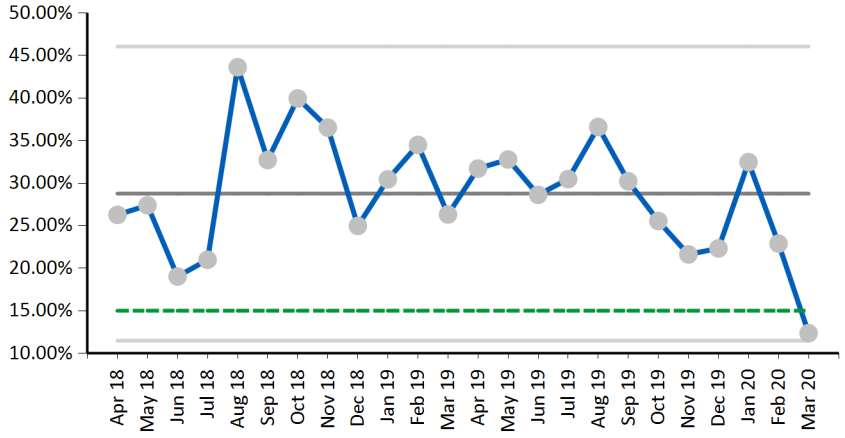
80 - Inpatient Friends and Family Response Rate



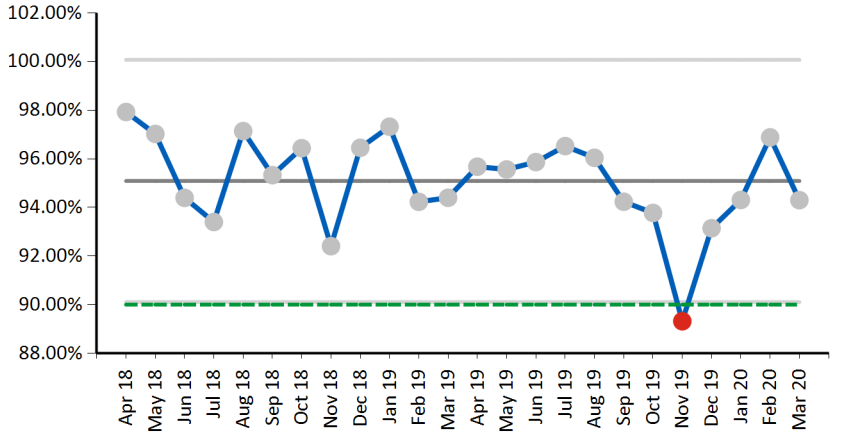
240 - Friends and Family Test (Inpatients) - Satisfaction %



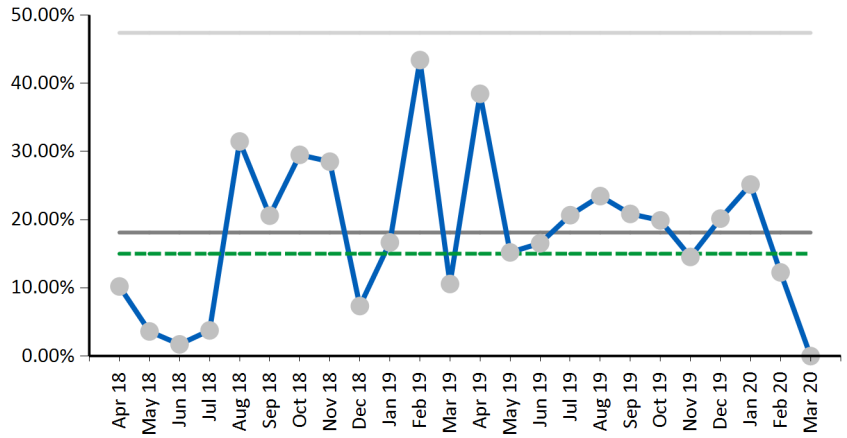
81 - Maternity Friends and Family Response Rate



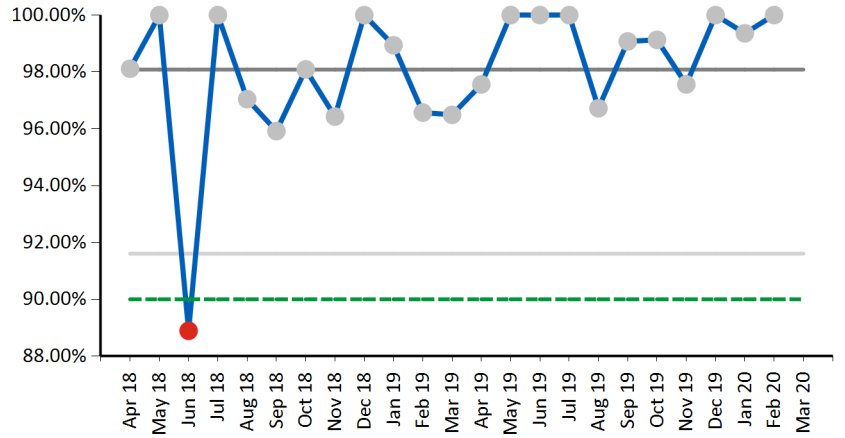
241 - Maternity Friends and Family Test - Satisfaction %



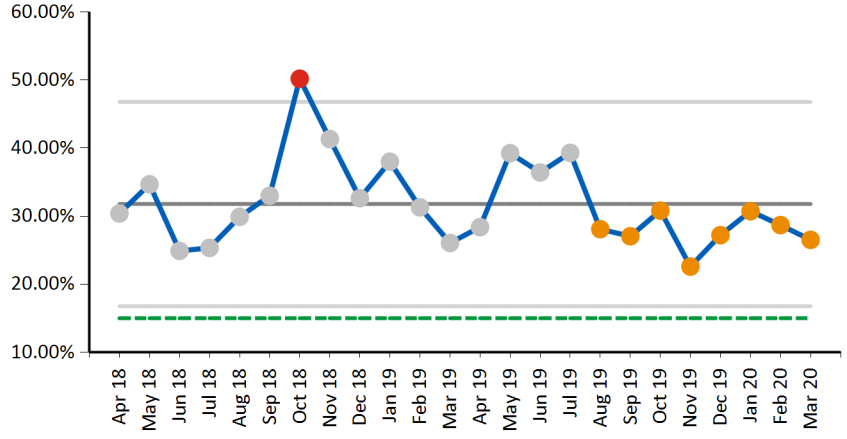
82 - Antenatal - Friends and Family Response Rate



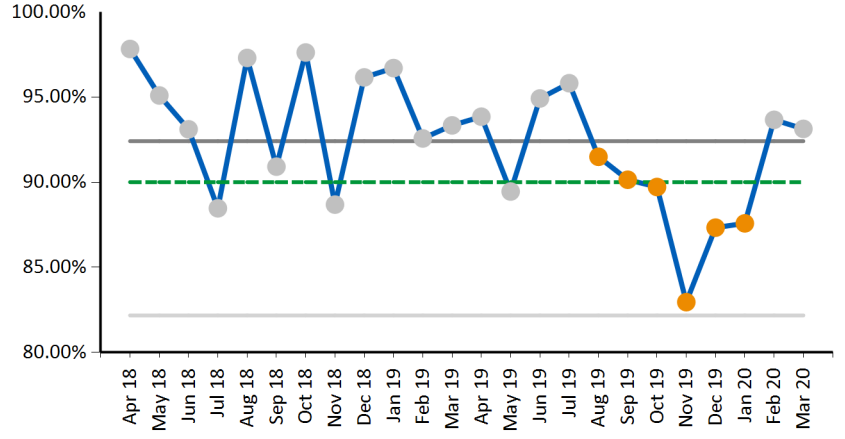
242 - Antenatal Friends and Family Test - Satisfaction %



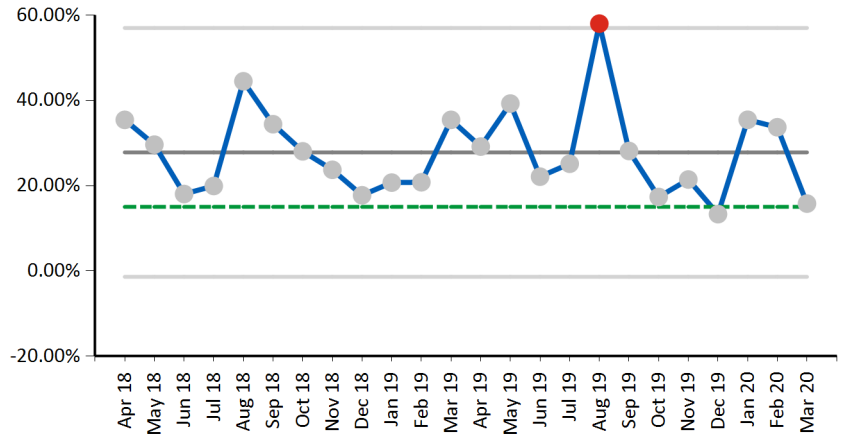
83 - Birth - Friends and Family Response Rate



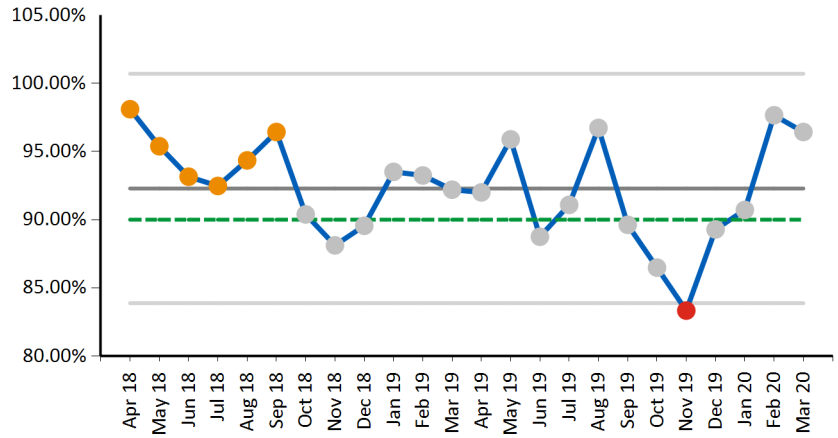
243 - Birth Friends and Family Test - Satisfaction %



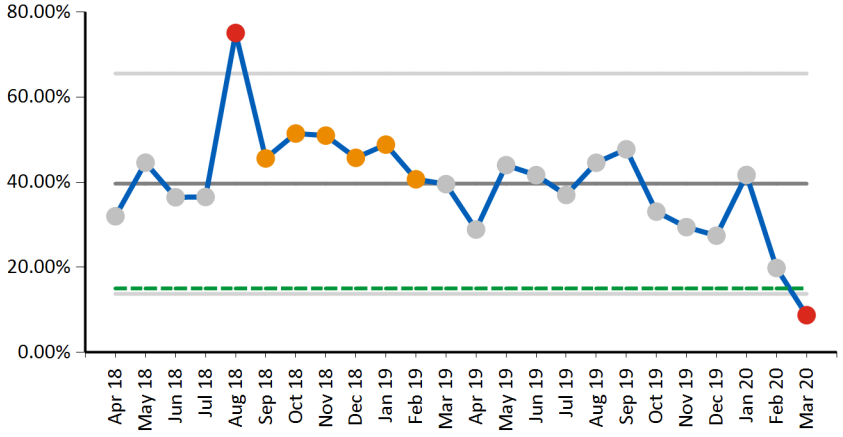
84 - Hospital Postnatal - Friends and Family Response Rate



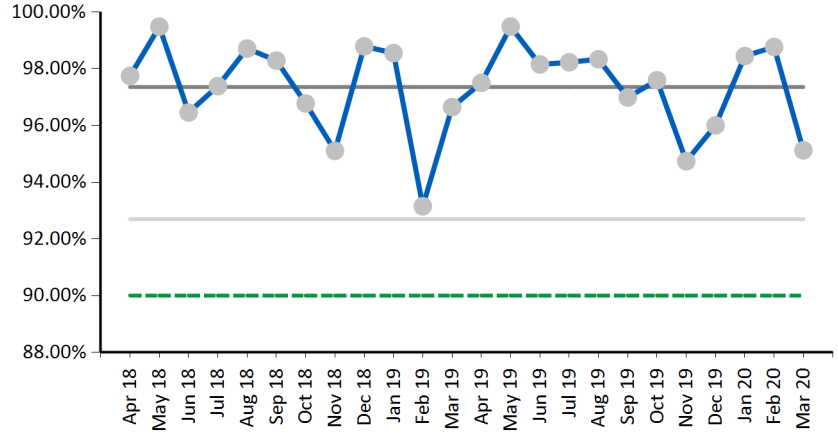
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



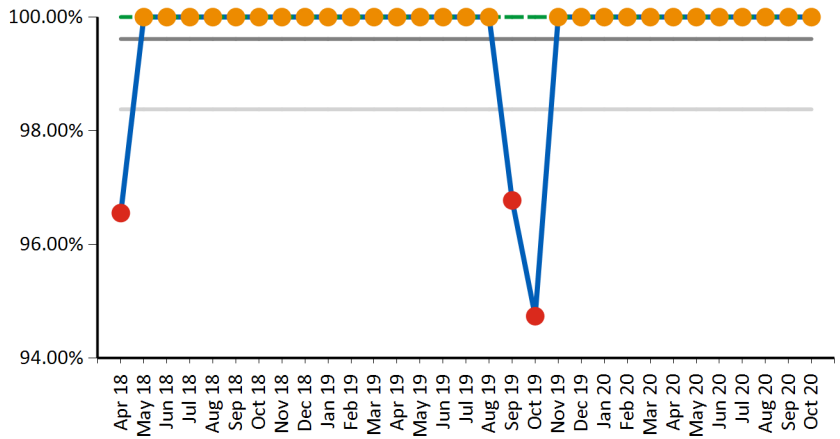
85 - Community Postnatal - Friend and Family Response Rate



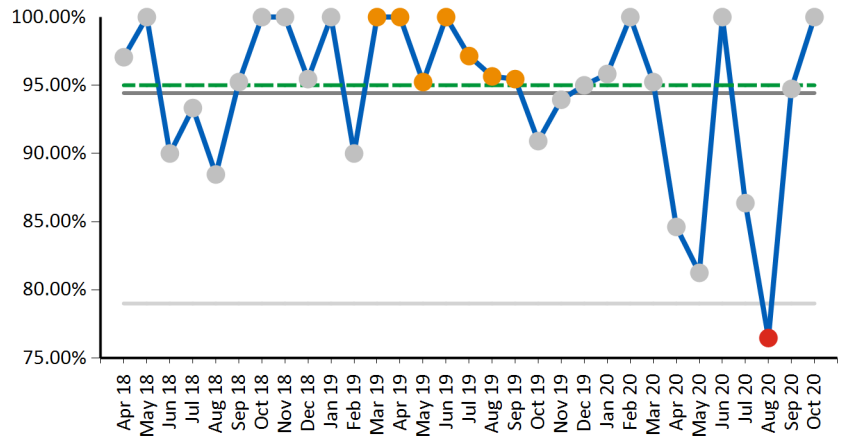
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



Maternity

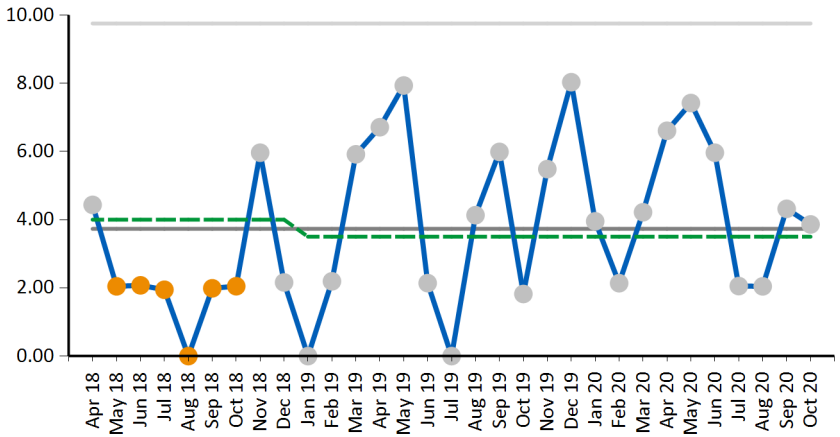
Stillbirth have increased regionally we are performing a quarterly thematic review of all cases. language is a common factor

3rd and 4th degree tears - Lowered slightly from last month, we are reviewing all cases in September to look for common theames.

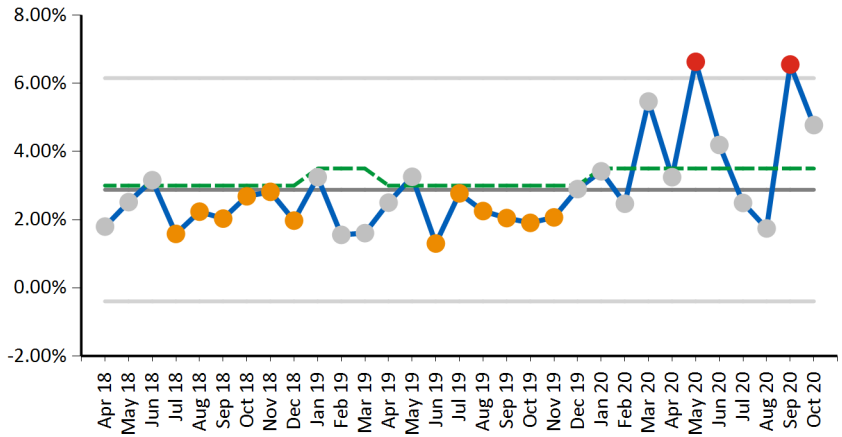
C Section rate has increased across the region not just within the Trust. Our increased induction rate can impact the increased section rate.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	High	<= 3.50	3.86	Oct-20		<= 3.50	4.32	Sep-20	<= 3.50	4.63	
23 - Maternity -3rd/4th degree tears	High	<= 3.5%	4.8%	Oct-20		<= 3.5%	6.6%	Sep-20	<= 3.5%	4.2%	
202 - 1:1 Midwifery care in labour	High	>= 95.0%	96.5%	Oct-20	L	>= 95.0%	96.2%	Sep-20	>= 95.0%	97.7%	P
203 - Booked 12+6	Medium	>= 90.0%	91.1%	Oct-20		>= 90.0%	91.9%	Sep-20	>= 90.0%	91.0%	
204 - Inductions of labour	High	<= 40%	38.4%	Oct-20		<= 40%	38.3%	Sep-20	<= 40%	39.1%	
208 - Total C section	High	<= 33.0%	30.6%	Oct-20		<= 33.0%	36.8%	Sep-20	<= 33.0%	32.1%	
210 - Initiation breast feeding	Medium	>= 65%	68.37%	Oct-20		>= 65%	68.71%	Sep-20	>= 65%	69.02%	
213 - Maternity complaints	Medium	<= 5	4	Oct-20		<= 5	2	Sep-20	<= 35	10	
319 - Maternal deaths (direct)	High	= 0	0	Oct-20	L	= 0	0	Sep-20	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	High	<= 6%	7.5%	Oct-20		<= 6%	7.3%	Sep-20	<= 6%	7.7%	

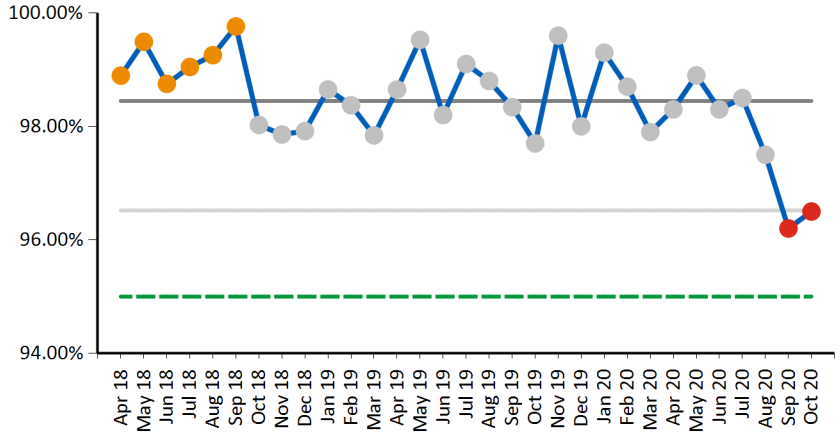
322 - Maternity - Stillbirths per 1000 births



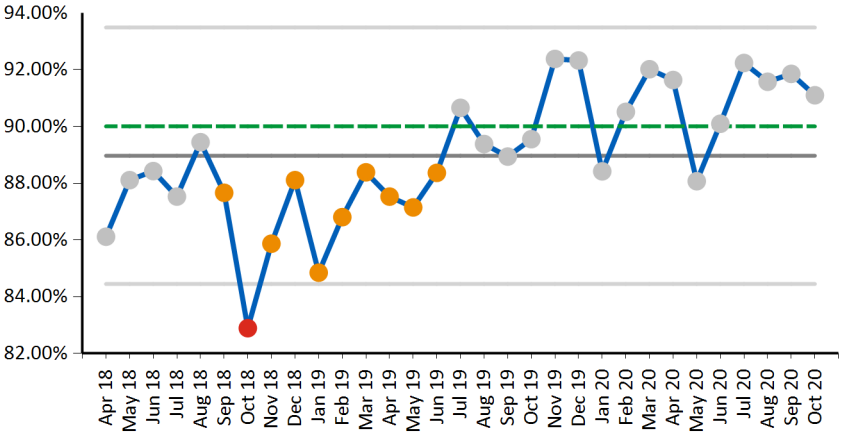
23 - Maternity -3rd/4th degree tears



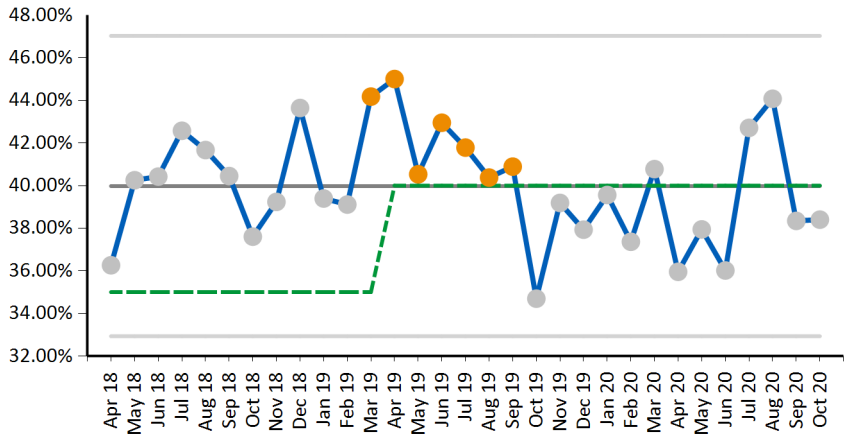
202 - 1:1 Midwifery care in labour



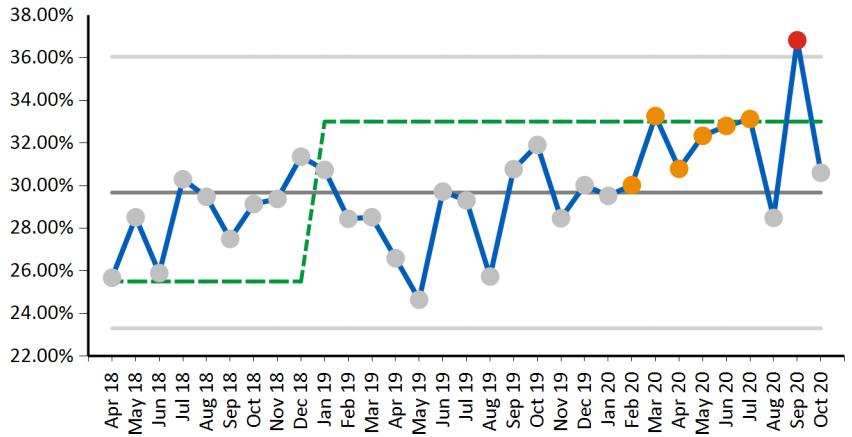
203 - Booked 12+6



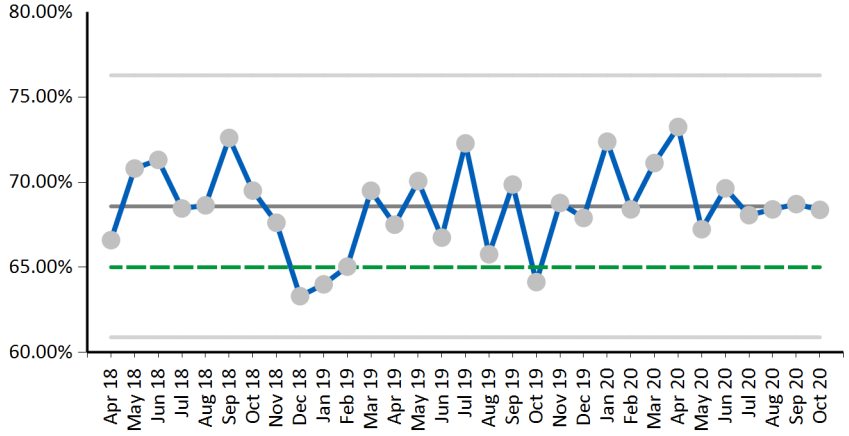
204 - Inductions of labour



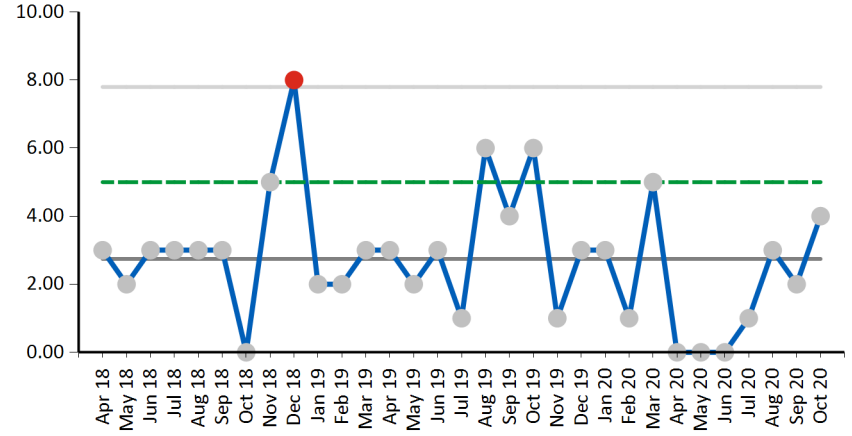
208 - Total C section



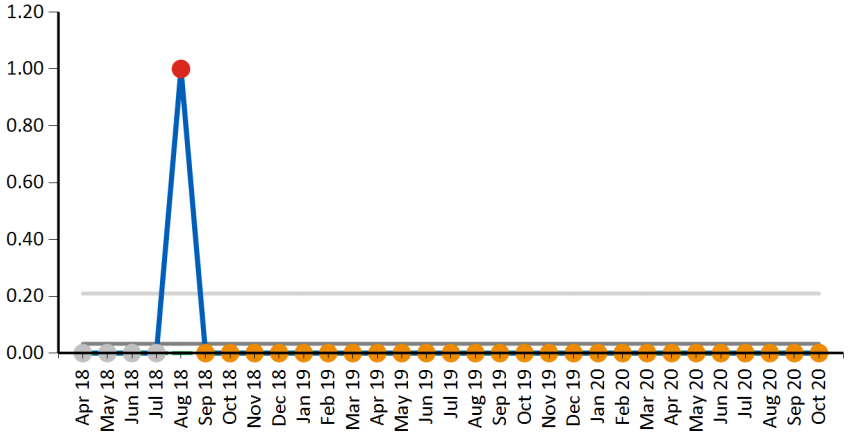
210 - Initiation breast feeding



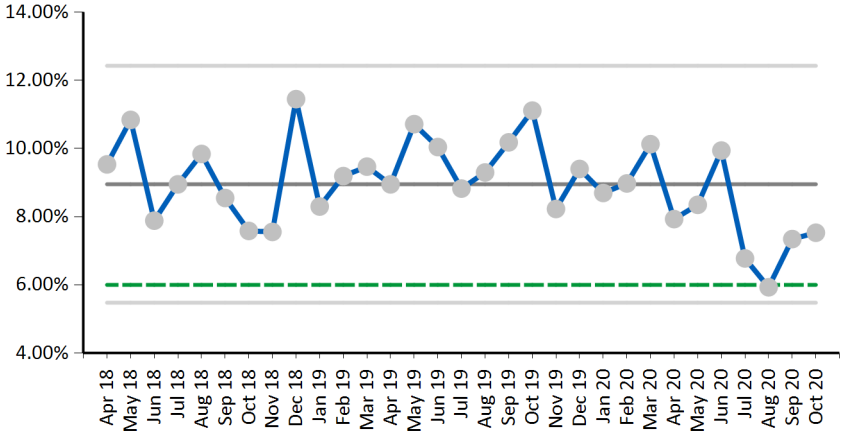
213 - Maternity complaints



319 - Maternal deaths (direct)



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

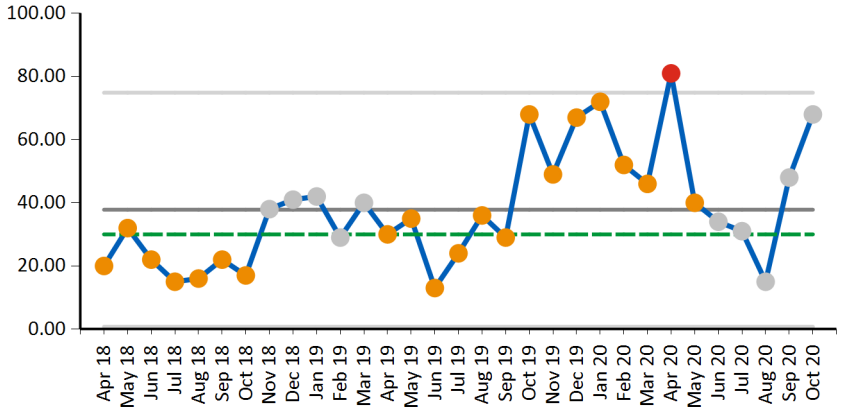


Operational Performance

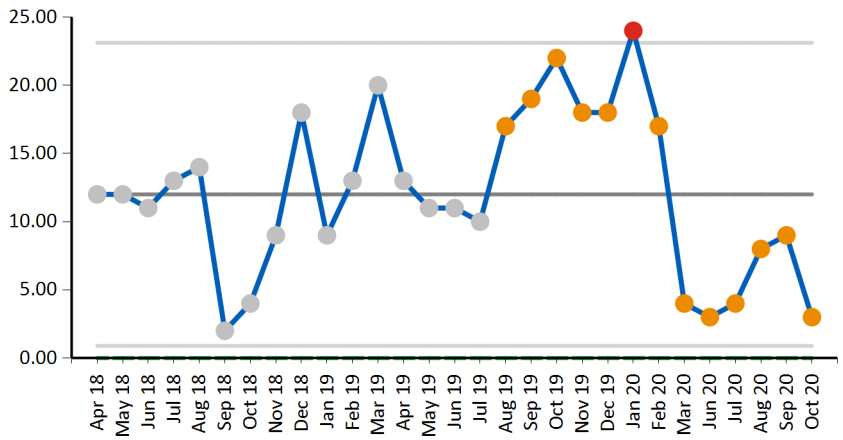
Access

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	Low	<= 30	68	Oct-20		<= 30	48	Sep-20	<= 210	317	?
8 - Same sex accommodation breaches	Medium	= 0	3	Oct-20	L	= 0	9	Sep-20	= 0	27	F
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	High	>= 75%	77.1%	Oct-20		>= 75%	73.9%	Sep-20	>= 75%	77.2%	?
41 - RTT Incomplete pathways within 18 weeks %	Low	>= 92%	58.0%	Oct-20	L	>= 92%	56.6%	Sep-20	>= 92%	54.5%	F
42 - RTT 52 week waits (incomplete pathways)	High	= 0	1,463	Oct-20	H	= 0	1,220	Sep-20	= 0	4,987	F
314 - RTT 18 week waiting list	Low	<= 25,530	24,195	Oct-20		<= 25,530	23,374	Sep-20	<= 25,530	24,195	P
53 - A&E 4 hour target	Medium	>= 95%	76.3%	Oct-20		>= 95%	80.8%	Sep-20	>= 95%	85.0%	F
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	Medium	= 0.0%	15.5%	Oct-20	H	= 0.0%	11.9%	Sep-20	= 0.0%	8.6%	F
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	High	= 0.00%	8.26%	Oct-20	H	= 0.00%	4.31%	Sep-20	= 0.00%	2.47%	?
72 - Diagnostic Waits >6 weeks %	High	<= 1%	44.9%	Oct-20	H	<= 1%	46.1%	Sep-20	<= 1%	51.1%	F
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	High	= 100%	69.2%	Oct-20		= 100%	42.9%	Sep-20	= 100%	71.2%	?

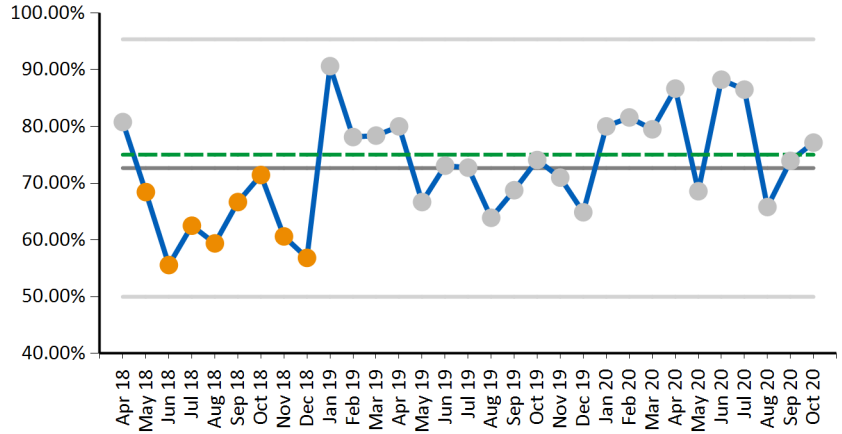
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



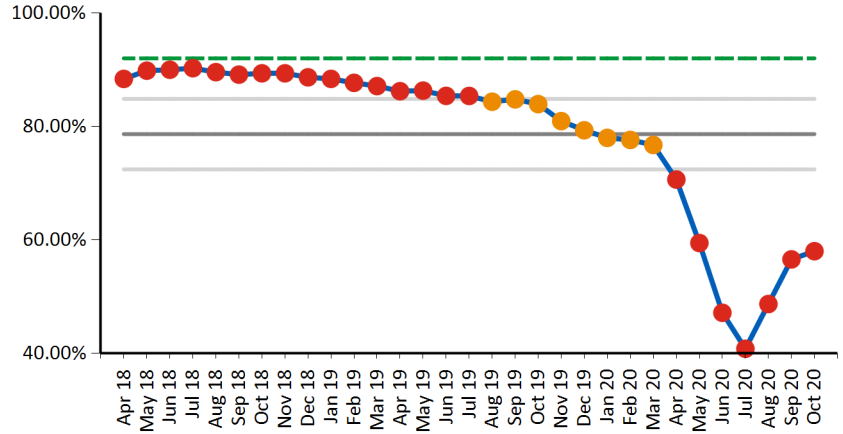
8 - Same sex accommodation breaches



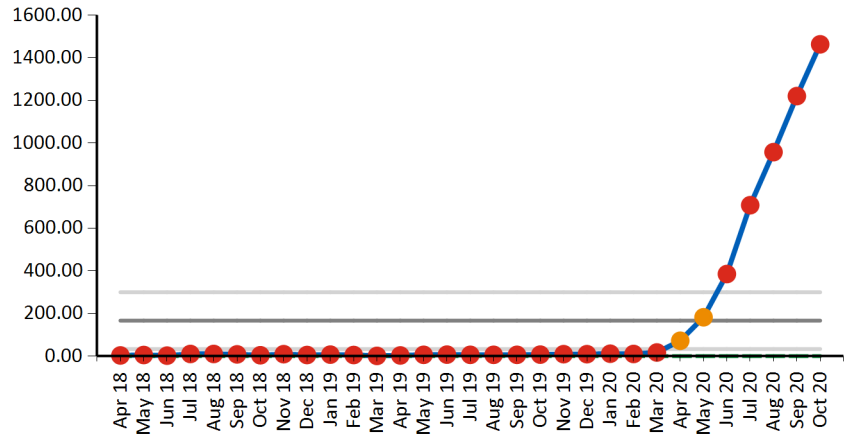
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



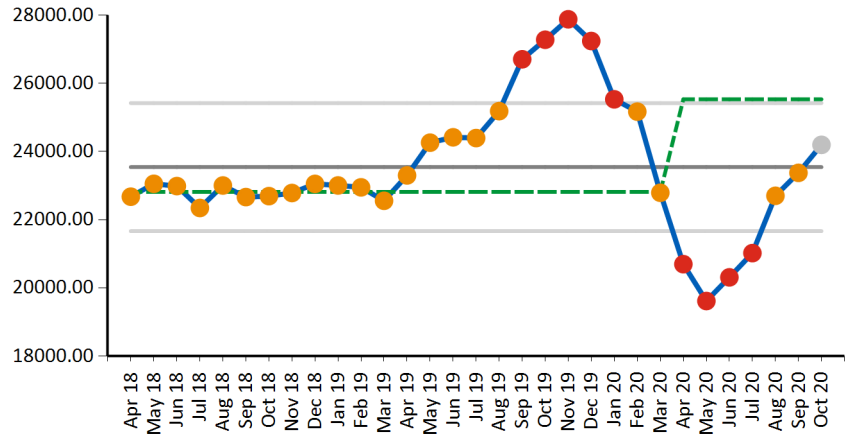
41 - RTT Incomplete pathways within 18 weeks %



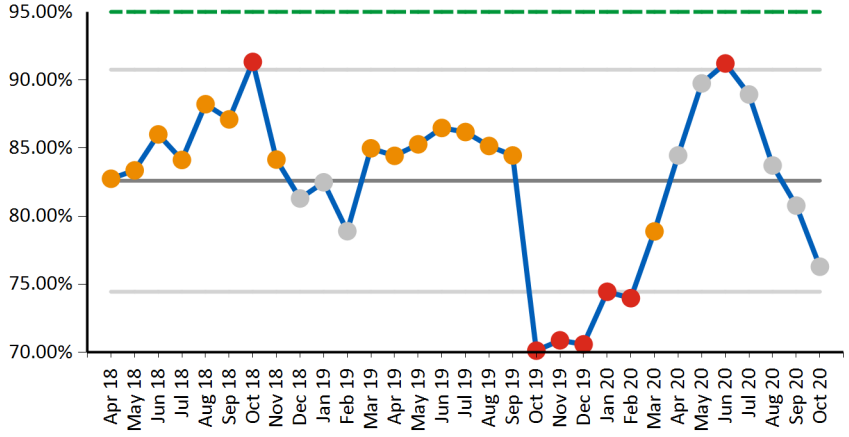
42 - RTT 52 week waits (incomplete pathways)



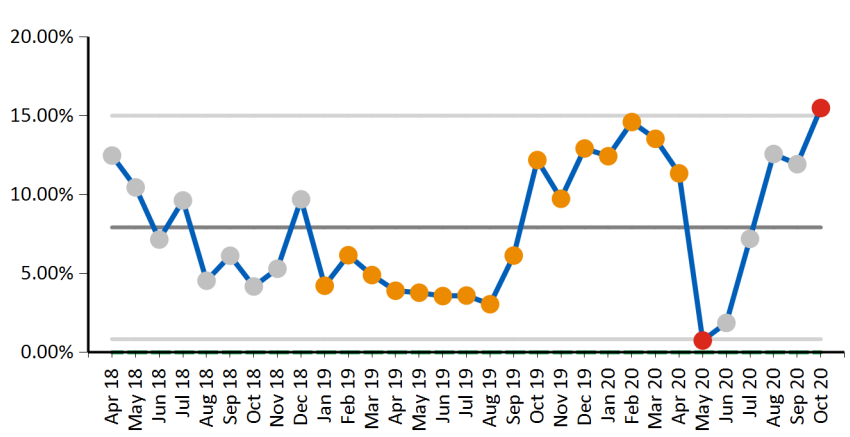
314 - RTT 18 week waiting list



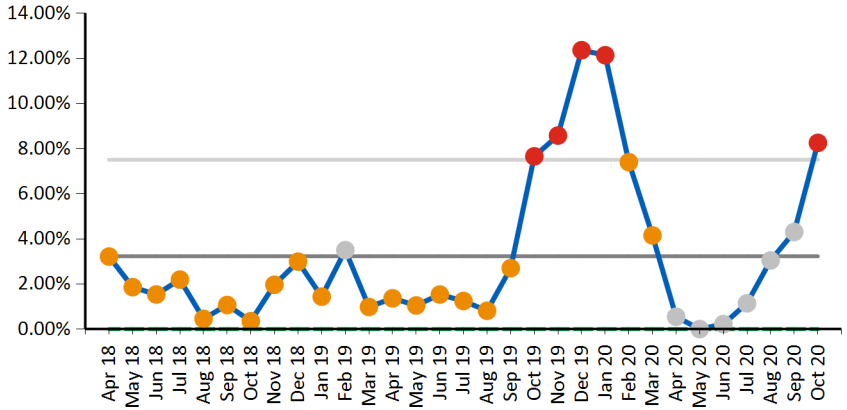
53 - A&E 4 hour target



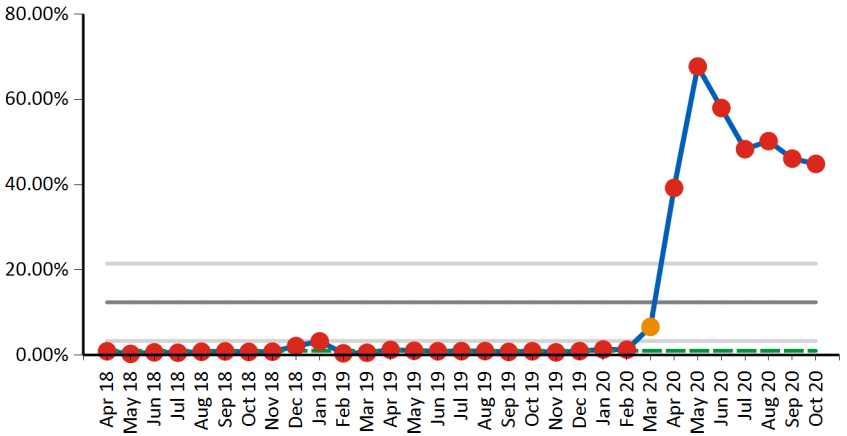
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



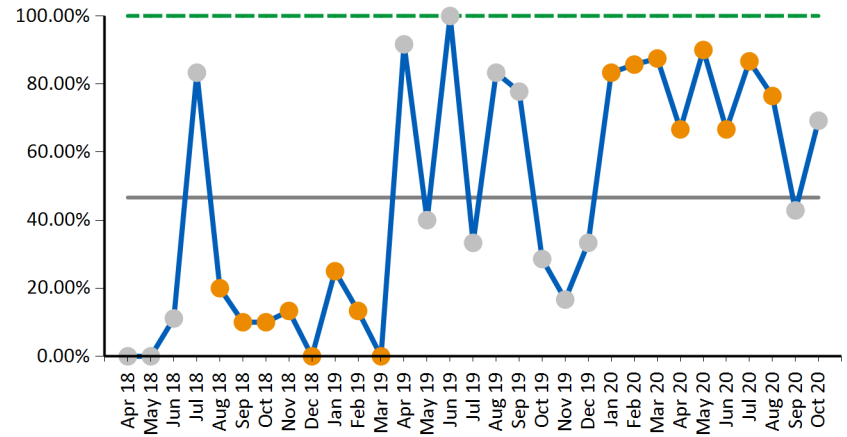
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



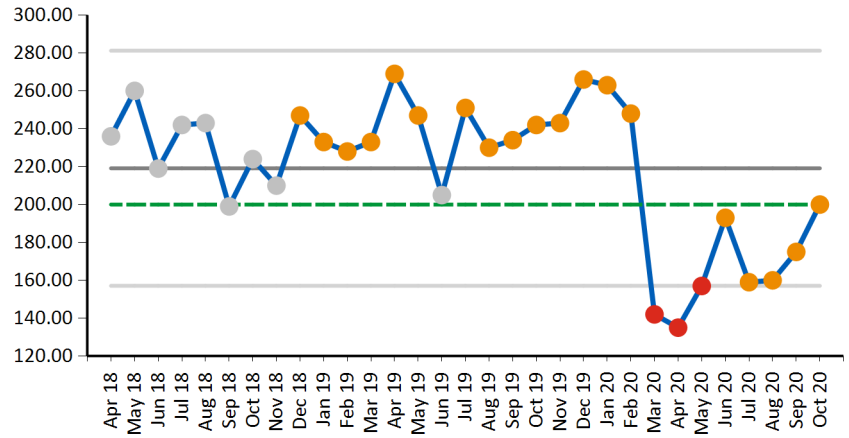
27 - TIA (Transient Ischaemic attack) patients seen <24hrs



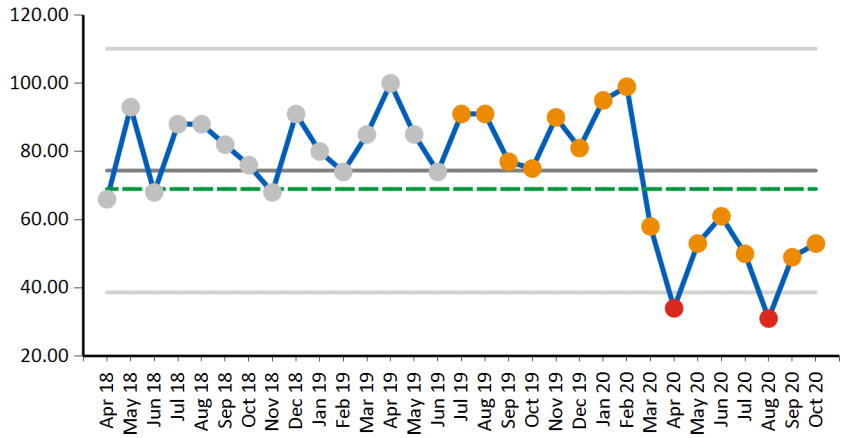
Productivity

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	Low	<= 200	200	Oct-20		<= 200	175	Sep-20	<= 200	200	
307 - Stranded Patients - LOS 21 days and over	Low	<= 69	53	Oct-20		<= 69	49	Sep-20	<= 69	53	
57 - Discharges by Midday	Low	>= 30%	20.4%	Oct-20		>= 30%	22.2%	Sep-20	>= 30%	21.0%	
58 - Discharges by 4pm	Medium	>= 70%	62.2%	Oct-20		>= 70%	59.9%	Sep-20	>= 70%	61.8%	
59 - Re-admission within 30 days of discharge (1 mth in arrears)	High	<= 13.5%	13.0%	Sep-20		<= 13.5%	12.0%	Aug-20	<= 13.5%	12.5%	
489 - Daycase Rates	Low	>= 80%	87.3%	Oct-20		>= 80%	88.2%	Sep-20	>= 80%	87.7%	
61 - Operations cancelled on the day for non-clinical reasons	Low	<= 1%	0.5%	Oct-20		<= 1%	1.4%	Sep-20	<= 1%	1.1%	
62 - Cancelled operations re-booked within 28 days	Low	= 100%	66.7%	Oct-20		= 100%	95.7%	Sep-20	= 100%	41.5%	
318 - Delayed Transfers Of Care (Trust Total)		<= 3.3%	1.8%	Oct-20		<= 3.3%	1.7%	Sep-20	<= 3.3%	1.2%	
65 - Elective Length of Stay (Discharges in month)	Low	<= 2.00	2.59	Oct-20		<= 2.00	1.96	Sep-20	<= 2.00	2.39	
66 - Non Elective Length of Stay (Discharges in month)	Low	<= 3.70	4.69	Oct-20		<= 3.70	4.28	Sep-20	<= 3.70	4.62	
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	High	>= 80%	81.8%	Jul-20		>= 80%	83.3%	Jun-20	>= 80%	77.1%	

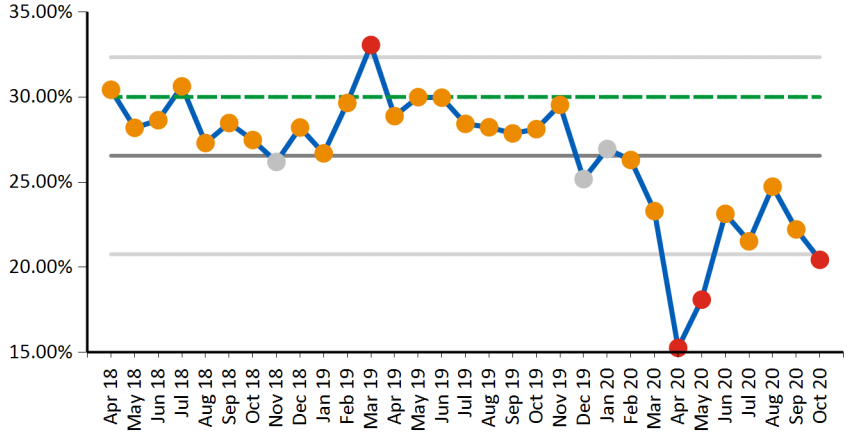
56 - Stranded patients



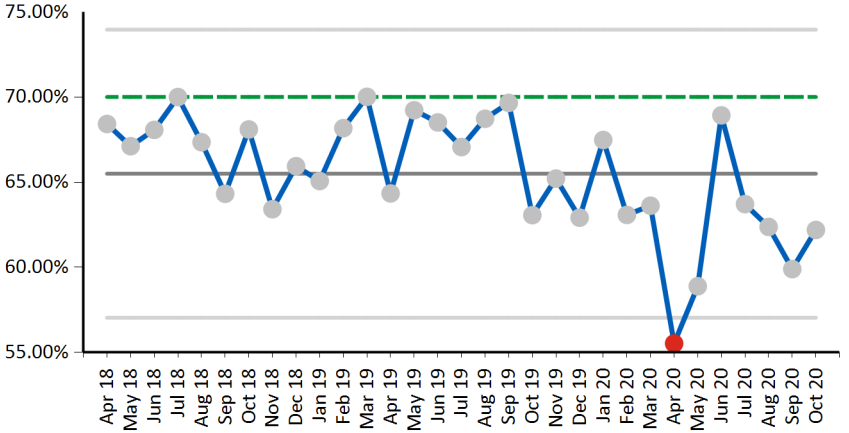
307 - Stranded Patients - LOS 21 days and over



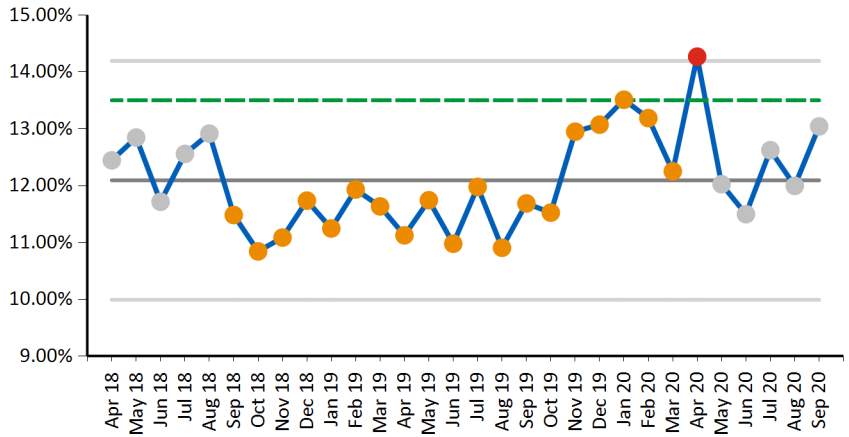
57 - Discharges by Midday



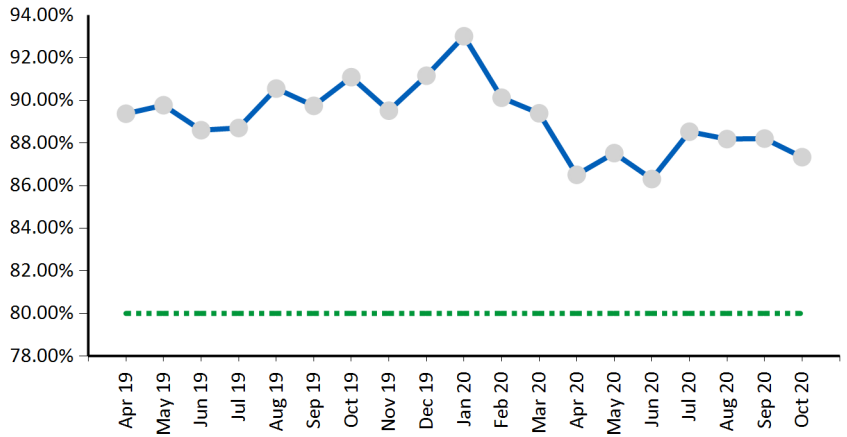
58 - Discharges by 4pm



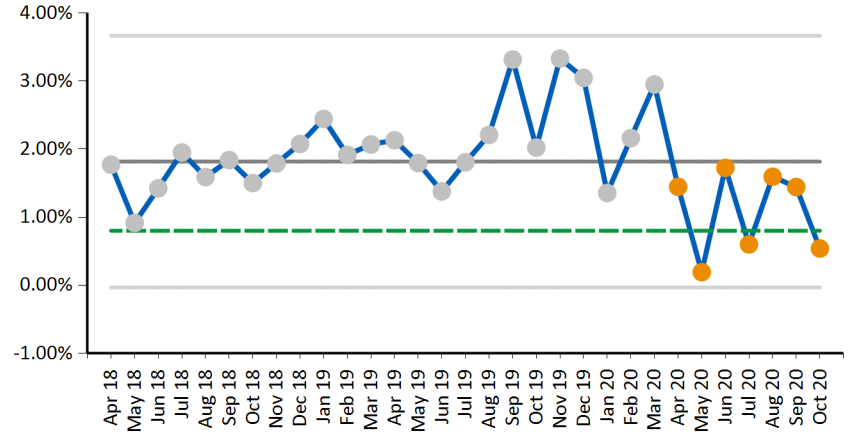
59 - Re-admission within 30 days of discharge (1 mth in arrears)



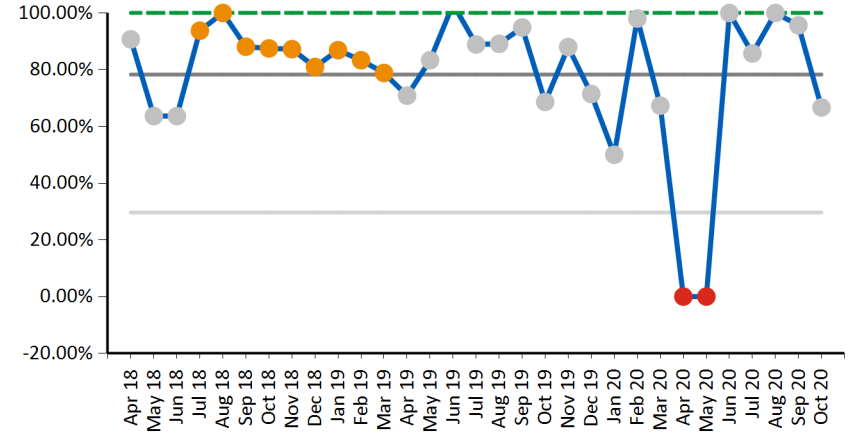
489 - Daycase Rates - SPC data available after 20 data points



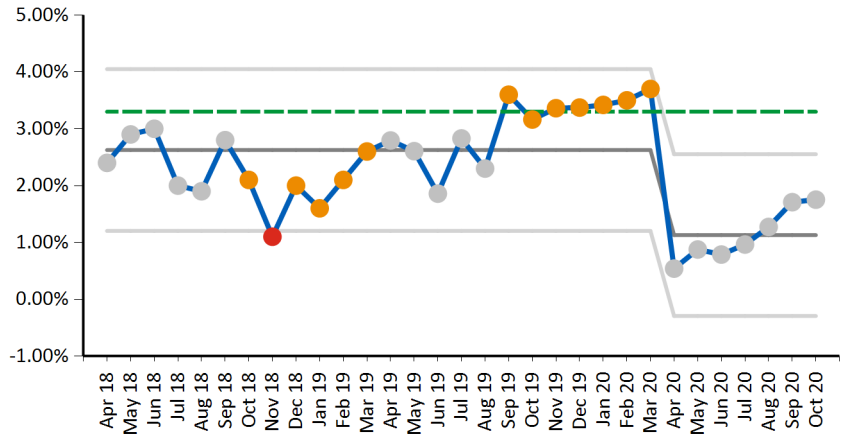
61 - Operations cancelled on the day for non-clinical reasons



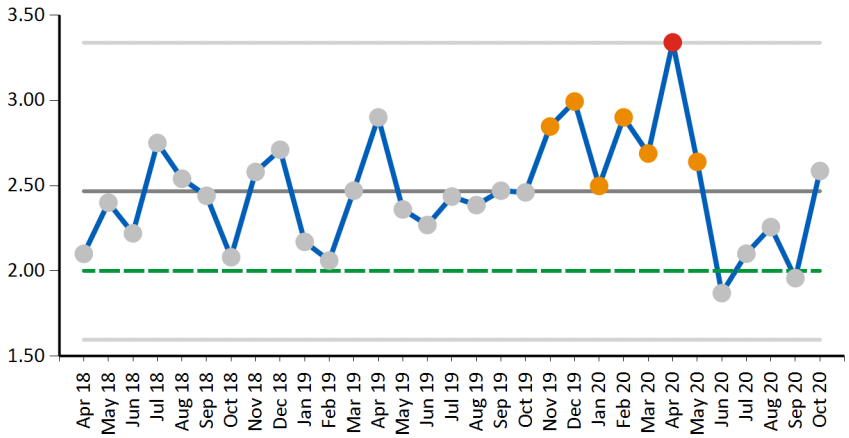
62 - Cancelled operations re-booked within 28 days



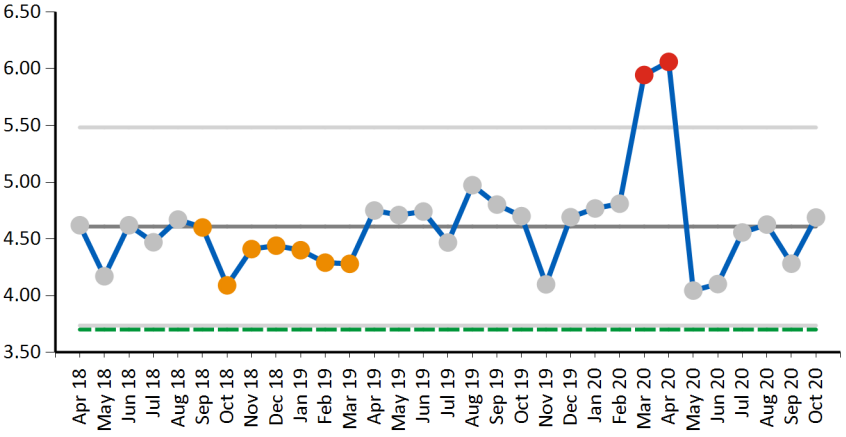
318 - Delayed Transfers Of Care (Trust Total)



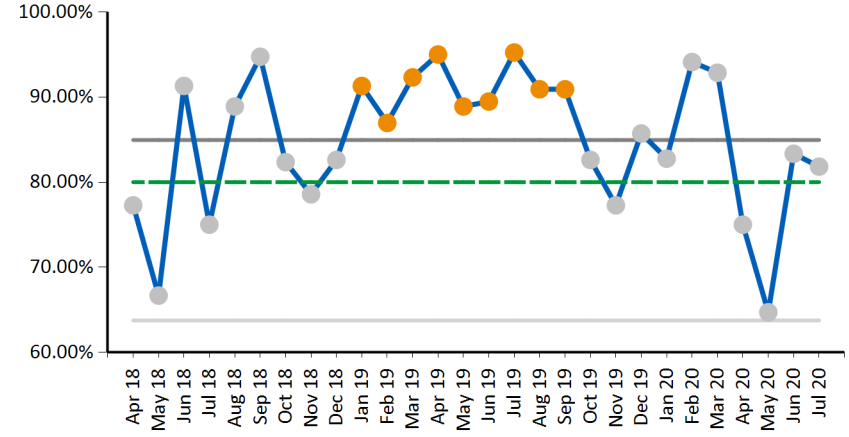
65 - Elective Length of Stay (Discharges in month)



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



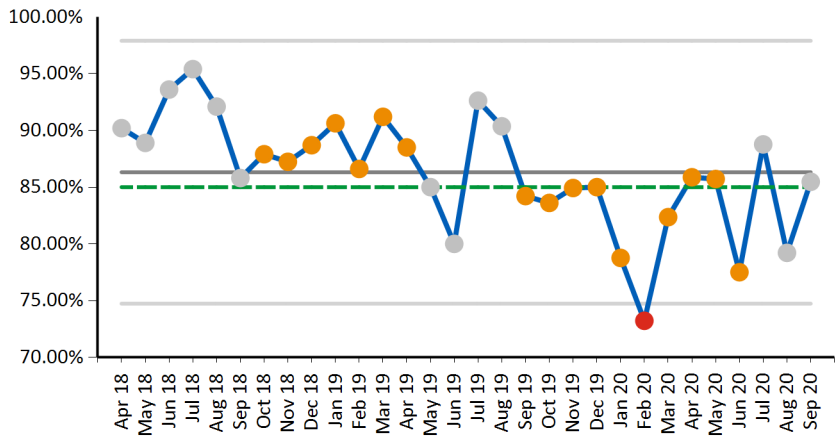
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears



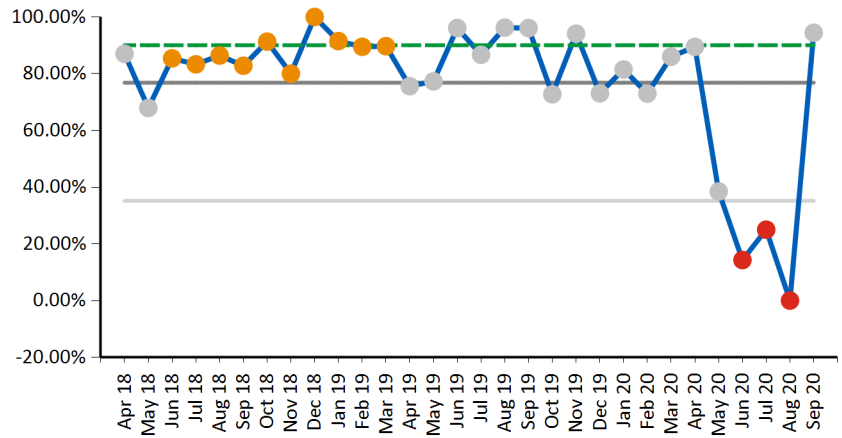
Cancer

Outcome Measure	Focus Level	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
46 - 62 day standard % (1 mth in arrears)	High	>= 85%	85.5%	Sep-20		>= 85%	79.2%	Aug-20	>= 85%	83.8%	
47 - 62 day screening % (1 mth in arrears)	High	>= 90%	94.4%	Sep-20		>= 90%	0.0%	Aug-20	>= 90%	56.6%	
48 - 31 days to first treatment % (1 mth in arrears)	High	>= 96%	100.0%	Sep-20		>= 96%	100.0%	Aug-20	>= 96%	98.1%	
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	High	>= 94%	100.0%	Sep-20		>= 94%	100.0%	Aug-20	>= 94%	100.0%	
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	High	>= 98%	100.0%	Sep-20		>= 98%	100.0%	Aug-20	>= 98%	100.0%	
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	High	>= 93%	96.3%	Sep-20		>= 93%	94.9%	Aug-20	>= 93%	95.9%	
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	High	>= 93%	79.4%	Sep-20		>= 93%	90.2%	Aug-20	>= 93%	90.4%	

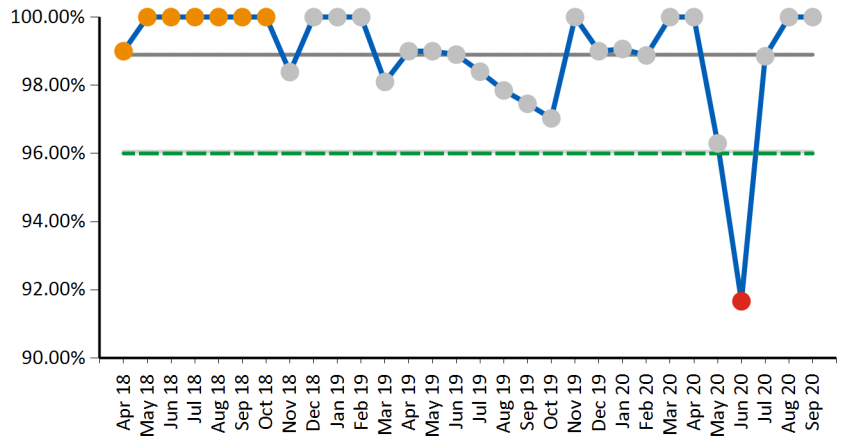
46 - 62 day standard % (1 mth in arrears)



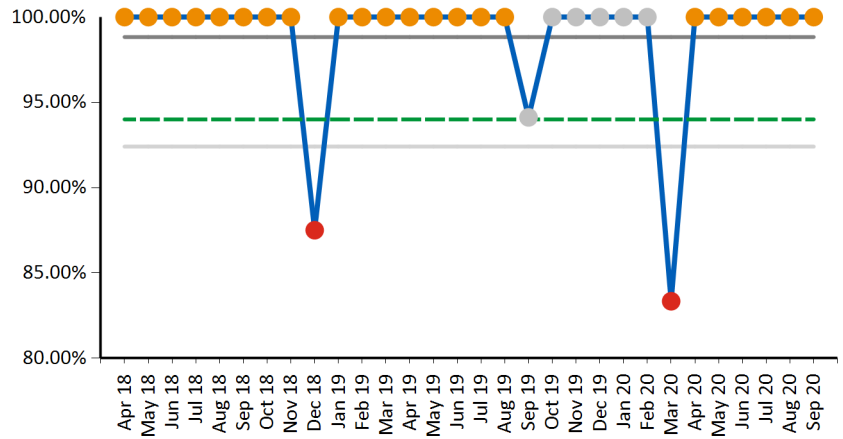
47 - 62 day screening % (1 mth in arrears)



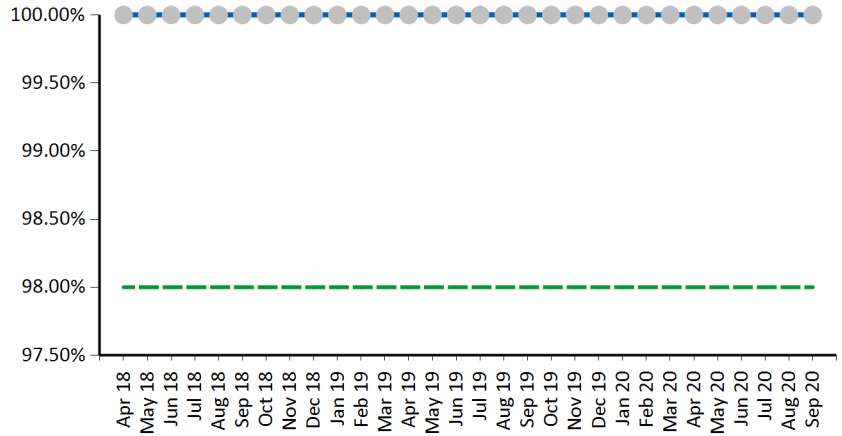
48 - 31 days to first treatment % (1 mth in arrears)



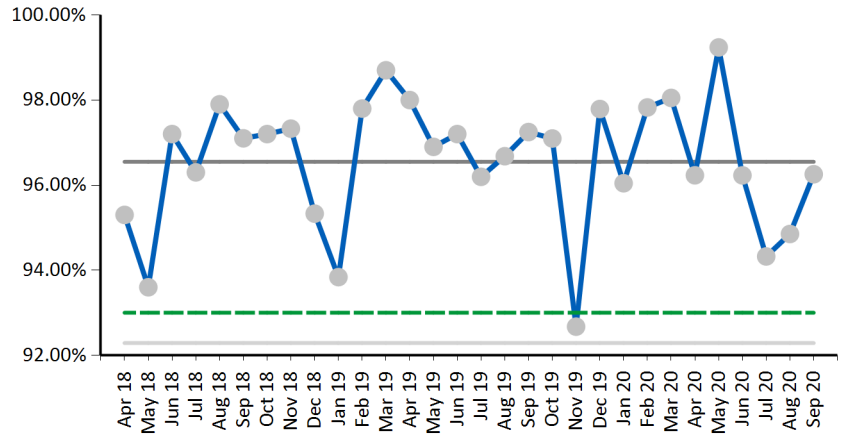
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



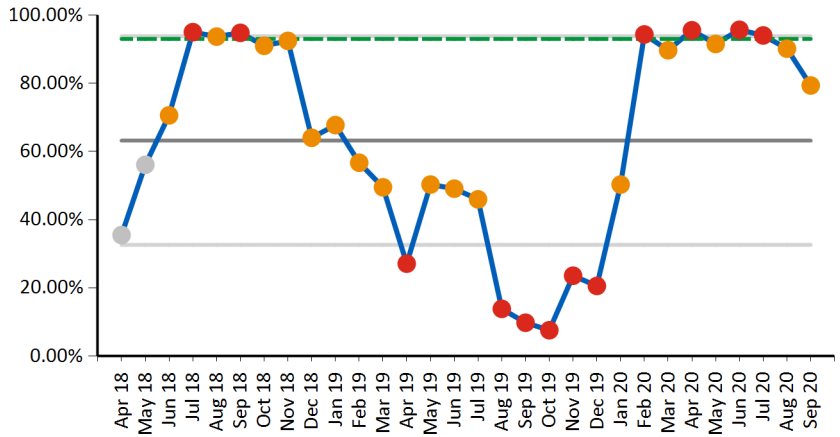
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



51 - Patients 2 week wait (all cancers) % (1 mth in arrears)



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

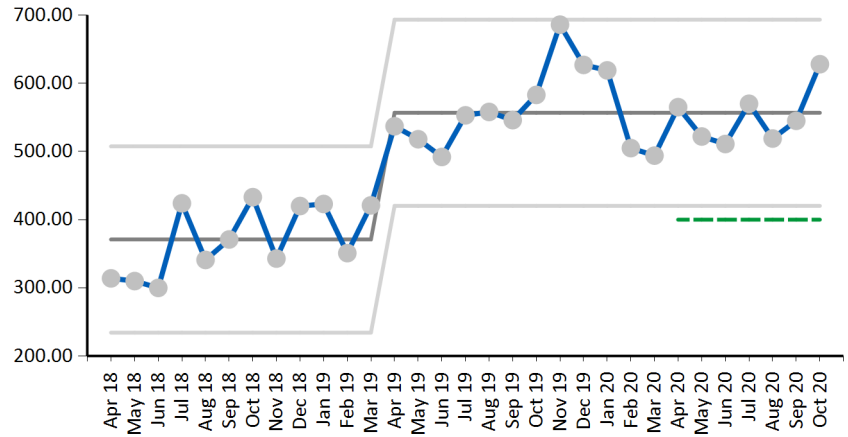


Community

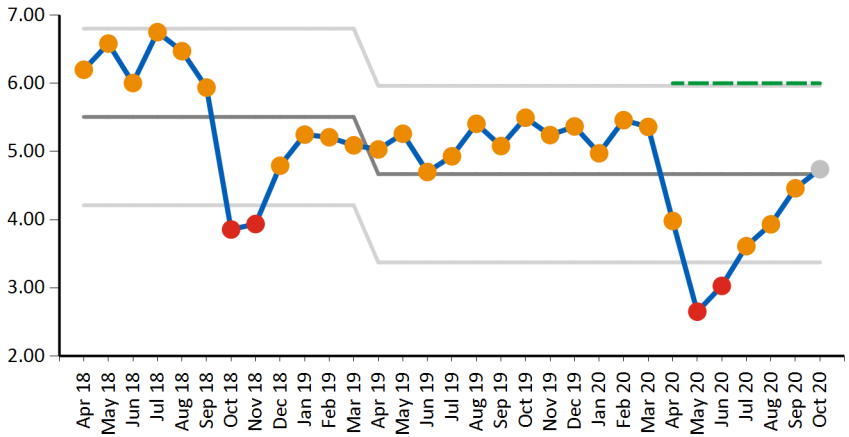
The implementation of the discharge service requirements which were mandated for hospital and community providers in March, continue to have a positive impact by helping people leave hospital in a timely way. The impact of this may be seen in continued low numbers of medically optimised patients and bed days. From November 2020, the Trust will be monitoring and reporting against the new criteria to reside indicator.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED		>= 400	628	Oct-20		>= 400	545	Sep-20	>= 2,800	3,860	
335 - Total Intermediate Tier LOS (weeks)		<= 6.00	4.74	Oct-20		<= 6.00	4.46	Sep-20	<= 6.00	4.74	
230 - Medically Optimised Numbers		<= 50	28	Oct-20		<= 50	11	Sep-20	<= 350	123	
231 - Medically Optimised Days		<= 209	123	Oct-20		<= 209	57	Sep-20	<= 1,463	355	

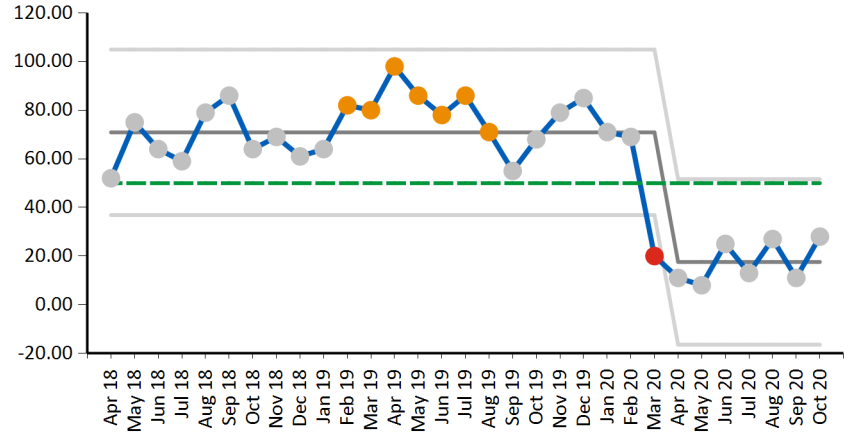
334 - Total Deflections from ED



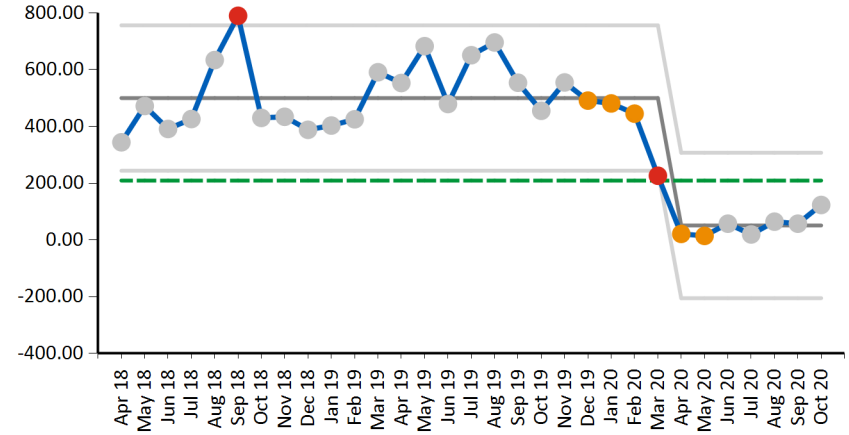
335 - Total Intermediate Tier LOS (weeks)



230 - Medically Optimised Numbers



231 - Medically Optimised Days



Workforce

Sickness, Vacancy and Turnover

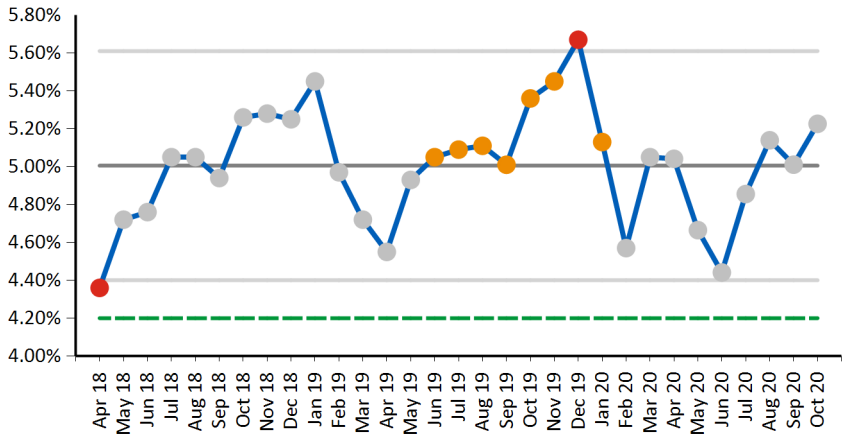
Board members will note that sickness absence has increased this month, however, this is to be expected and Bolton continue to benchmark well across GM Trusts. 'All staff' Covid risk assessments have are now running at 83% and the Trust has also seen the impact of the latest requirement for all clinically extremely vulnerable staff to work from home.

Recruitment metrics remain strong with effective partnership working between the workforce teams and the Divisions. The People Committee receive a monthly Resourcing update which also includes staff testing and flu uptake figures.

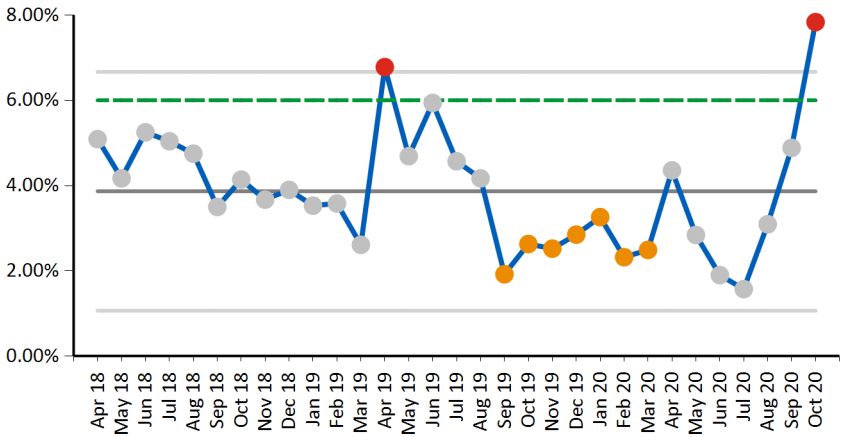
Turnover remains higher than target however, the People Committee were assured that these figures reflected the return of additional staff (including students and retirees) that supported the Trust in the first wave. If these staff are removed turnover reduces to a 'normal' 10.2%.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	High	<= 4.20%	5.23%	Oct-20		<= 4.20%	5.01%	Sep-20	<= 4.20%	4.91%	F
120 - Vacancy level - Trust	High	<= 6%	7.84%	Oct-20	H	<= 6%	4.89%	Sep-20	<= 6%	3.78%	?
121 - Turnover		<= 9.90%	12.59%	Oct-20	H	<= 9.90%	12.69%	Sep-20	<= 9.90%	11.59%	?
366 - Ongoing formal investigation cases over 8 weeks	Medium		4	Oct-20			3	Sep-20		16	

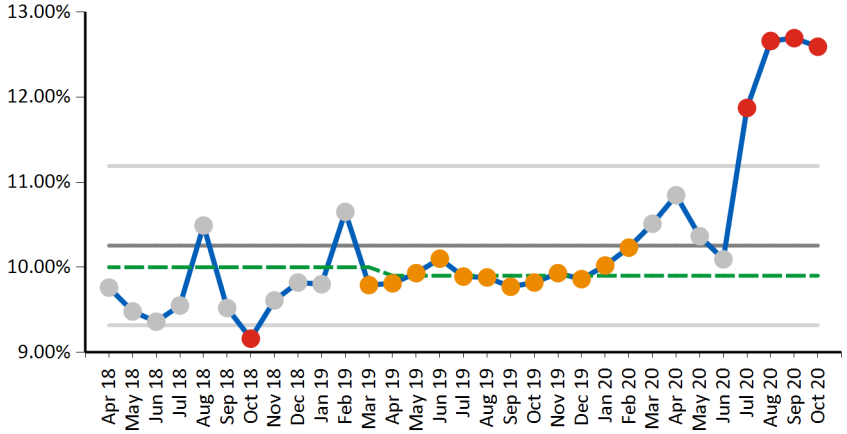
117 - Sickness absence level - Trust



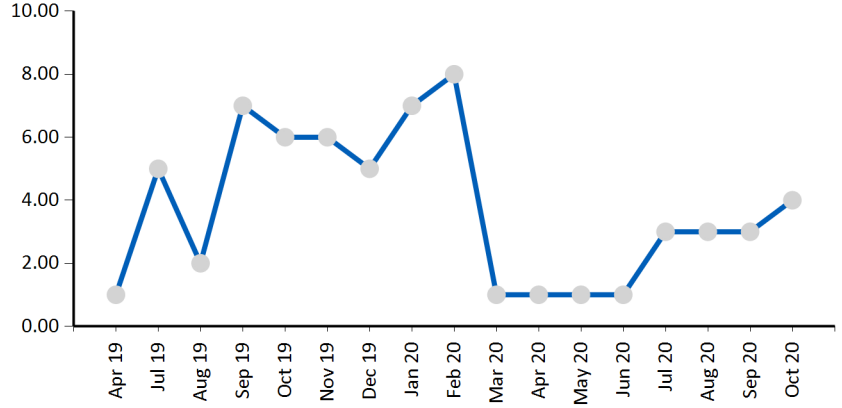
120 - Vacancy level - Trust



121 - Turnover



366 - Ongoing formal investigation cases over 8 weeks - SPC data available after 20 data points

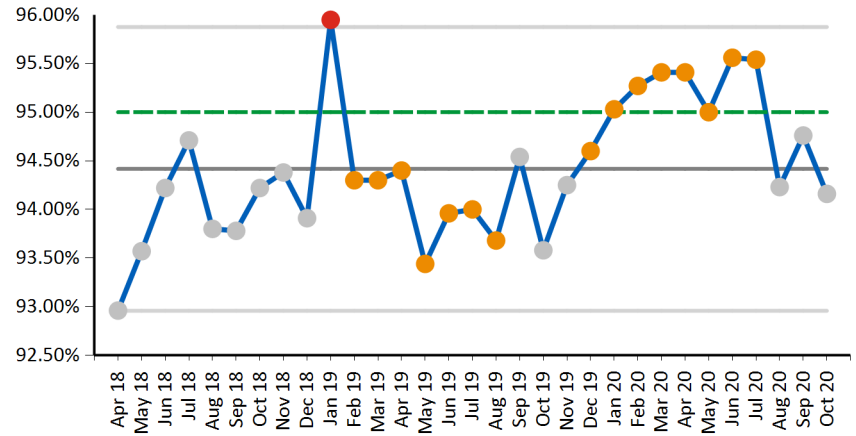


Organisational Development

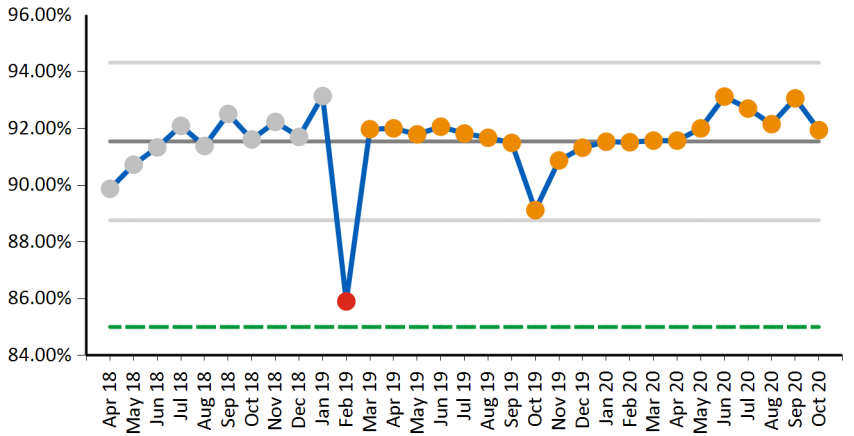
After seeing an increase in September as part of the reset work, the OD indicators each show a slight reduction compared to the previous month, given the pressures on staffing during the second Wave and the maintenance of core services. The options for maintaining training appropriately during this time is being considered by the People Committee.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	High	>= 95%	94.2%	Oct-20		>= 95%	94.8%	Sep-20	>= 95%	95.0%	
38 - Staff completing Mandatory Training	High	>= 85%	91.9%	Oct-20		>= 85%	93.1%	Sep-20	>= 85%	92.4%	
39 - Staff completing Safeguarding Training		>= 95%	96.76%	Oct-20		>= 95%	96.81%	Sep-20	>= 95%	96.48%	
101 - Increased numbers of staff undertaking an appraisal	Medium	>= 85%	79.6%	Oct-20		>= 85%	81.6%	Sep-20	>= 85%	77.8%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	High	>= 66%	70.0%	Q3 2019/20		>= 66%	78.5%	Q2 2019/20	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	High	>= 80%	66.0%	Q3 2019/20		>= 80%	74.9%	Q2 2019/20	>= 80%		

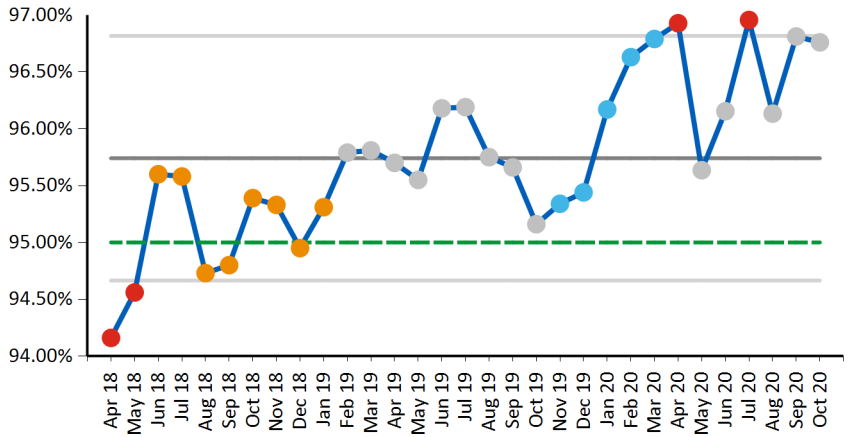
37 - Staff completing Statutory Training



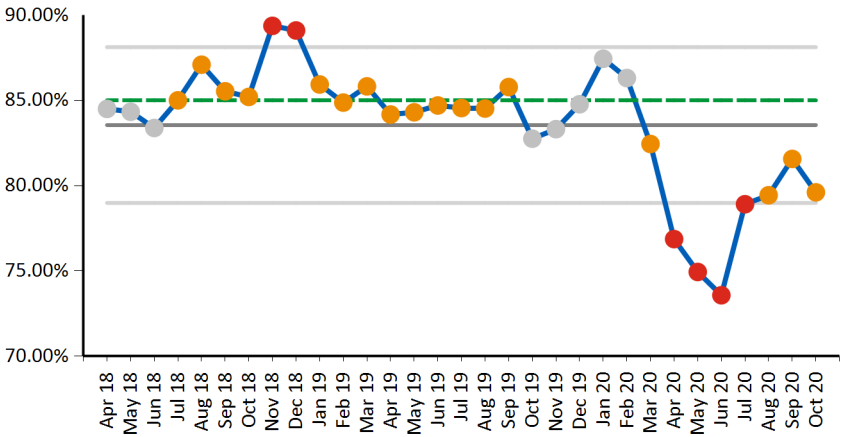
38 - Staff completing Mandatory Training



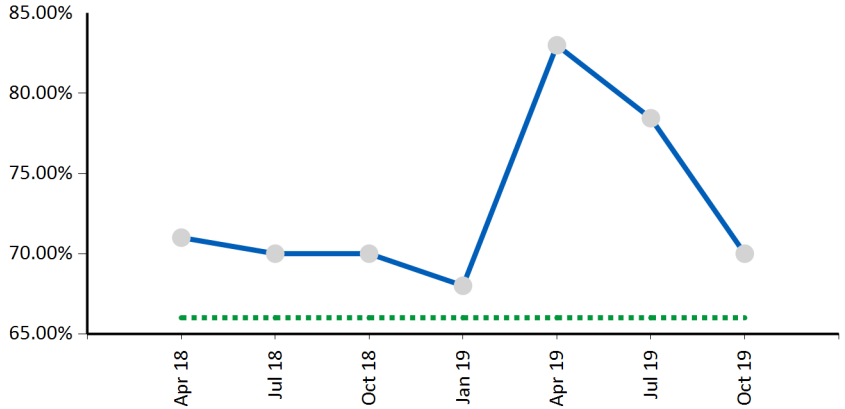
39 - Staff completing Safeguarding Training



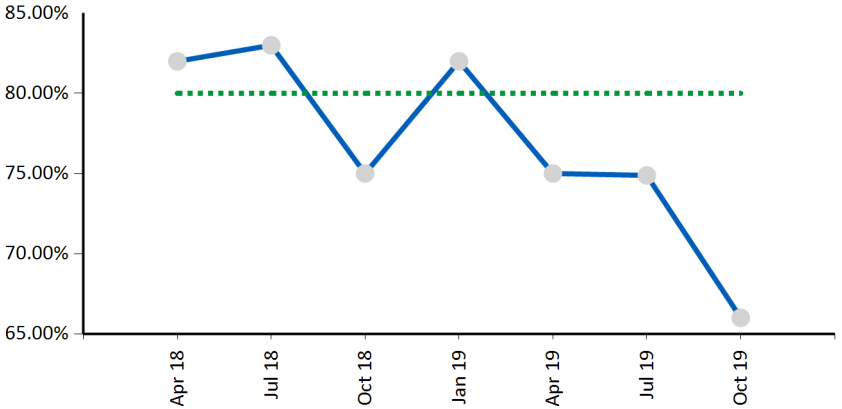
101 - Increased numbers of staff undertaking an appraisal



78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears) - SPC data available after 20 data points



79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears) - SPC data available after 20 data points

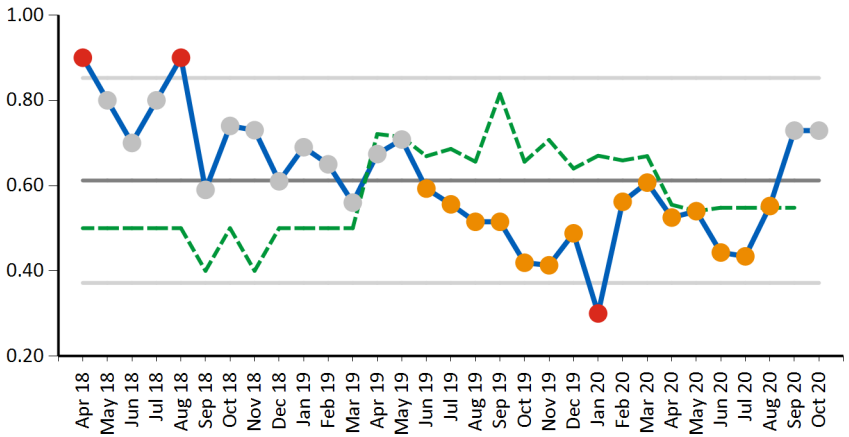


Agency

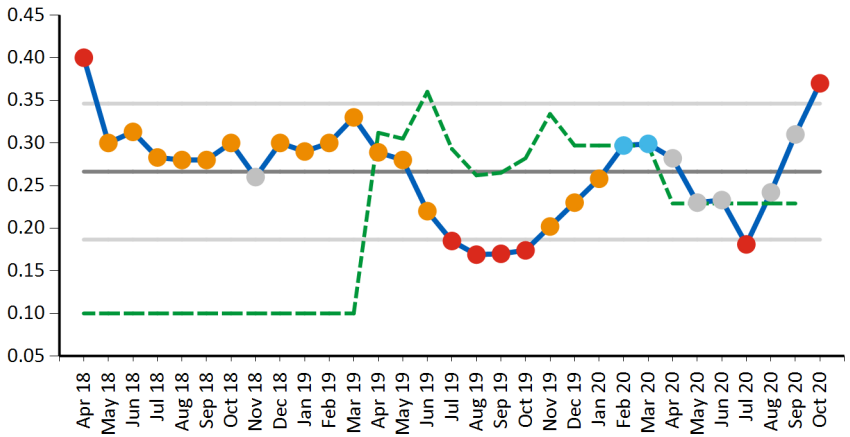
There is continued increase in demand for Bank and Agency staff, October 2020 saw the second highest monthly demand with only March 2020, greater. This is due to capacity pressures, the impact of Covid related absence as well as sickness absence. Whilst appointments have been made to Consultant posts, the positive impact will not be apparent until appointees have started in post. The Trust has agreed enhanced rates for substantive clinical staff to maximise capacity and potentially reduce the demand for agency.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	Medium		0.73	Oct-20		<= 0.55	0.73	Sep-20	<= 3.29	3.95	
111 - Annual ceiling for Nursing Staff agency spend (£m)	Medium		0.37	Oct-20	H	<= 0.23	0.31	Sep-20	<= 1.37	1.85	
112 - Annual ceiling for Medical Staff agency spend (£m)	Medium		0.26	Oct-20		<= 0.25	0.29	Sep-20	<= 1.49	1.44	

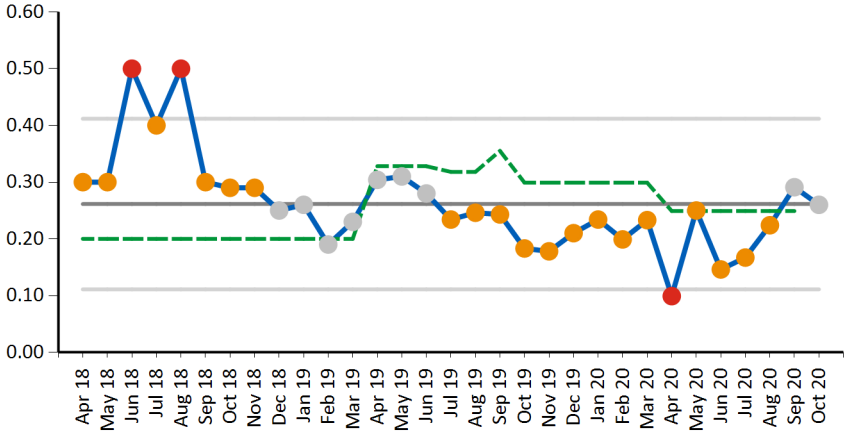
198 - Trust Annual ceiling for agency spend (£m)



111 - Annual ceiling for Nursing Staff agency spend (£m)



112 - Annual ceiling for Medical Staff agency spend (£m)



Finance

Finance

Revenue Performance - The position for the month was a deficit of £235km after accruing £3.6m of top up funds. We spent £1.6m on Covid in the month and had a small income shortfall against plan of £0.2m. Revenue performance is currently rated green due to performance in month 7 being in line with plan.

Forecast Outturn - We are forecasting a £4.8m deficit for M7-12. We have developed forecast scenarios showing a range between a worse case deficit of £13.4m and a best case deficit of £0.3m. The forecast outturn is rated amber until we have more certainty on the scenarios.

Cost Improvement - There is an expectation from NHSI of a minimum level of cost improvement of 1.1% for M7-12. We have set a plan of £2.7m which equates to 1.4%, exceeding the minimum ask. The current trackers indicate that savings of £1.9m has been delivered with a further £1.8m expected to be delivered this year, thus exceeding the plan. Cost improvement is rated green due to the high level of confidence in delivery and expected over achievement.

Variable Pay - We spent £2.1m on variable pay in month 7, slightly more than September. Of this, we spent £340k during the month on Covid. Variable pay is rated amber because agency spend has risen steeply since the Summer due to the impact of Covid and spending levels are slightly above plan.

Capital Spend - Year to date spend is £2.7m of which £1.1m relates to Covid. Our plan for the year has increased to £13.9m including Covid funded schemes. Given the year date send is relatively low compared to the plan and the scale and required speed of a number of projects, Capital has been rated amber.

Cash Position - We had cash of £47.3m at the end of the month. This is much higher than normal due to cash payments from CCGs being made in advance, a healthy year-end balance and additional PSF funds from 2019/20. Cash is rated green as there are no concerns around cash flow this year.

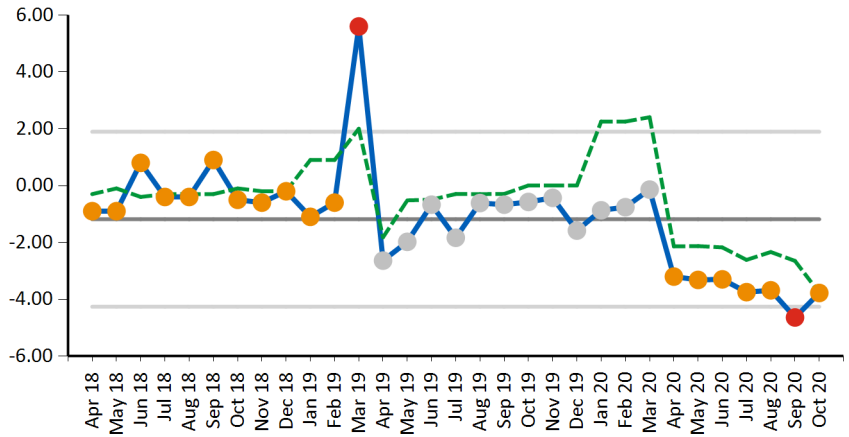
Loans and PDC - We have loans of £43.7m outstanding with a further £3.2m expected to be drawn this year. PDC will be drawn down to cover Covid capital costs and the balance of the LED lighting project. Rated green as there are no concerns in this area.

Better Payment Practices Code - We have paid 91.1% of our invoices within 30 days. This continues to be strong performance but is still below the target of 95%, hence rated amber.

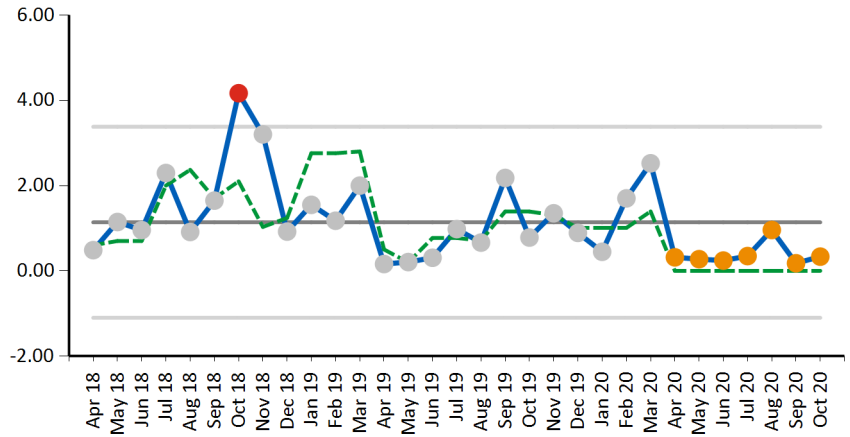
Use of Resources Rating - This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

		Latest				Previous			Year to Date		Target
Outcome Measure	Focus Level	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)		>= -3.8	-3.8	Oct-20		>= -2.7	-4.6	Sep-20	>= -17.8	-25.7	
222 - Capital (£ millions)		= 0.0	0.3	Oct-20		= 0.0	0.2	Sep-20	= 0.0	2.6	
223 - Cash (£ millions)		= 0.0	47.3	Oct-20		= 0.0	53.5	Sep-20	= 0.0	47.3	
224 - Use of Resources		= 0	0	Oct-20		= 0	0	Sep-20	= 0	0	

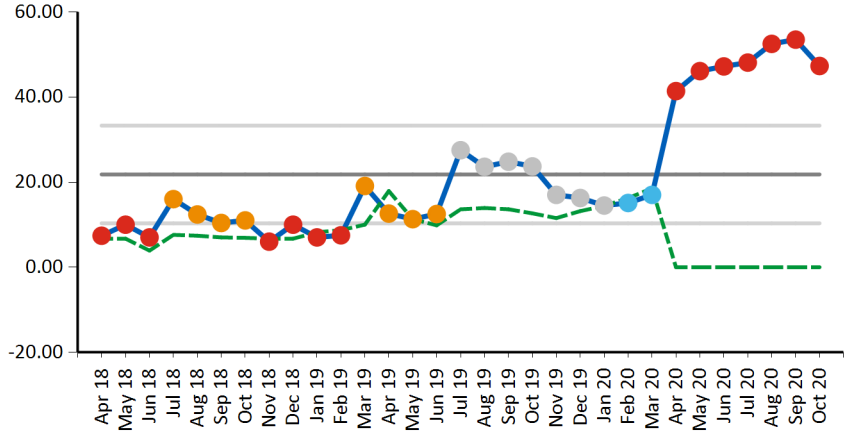
220 - Control Total (£ millions)



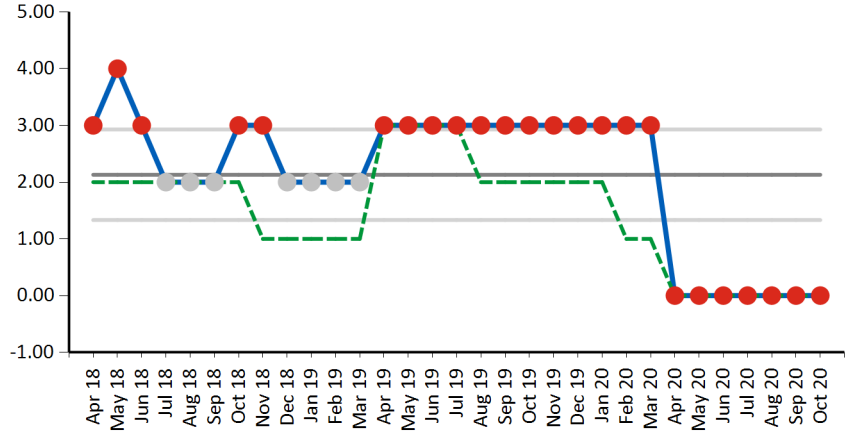
222 - Capital (£ millions)



223 - Cash (£ millions)



224 - Use of Resources



oard Assurance Heat Map - Hospital

	Indicator	Target	ICSD	Acute Division																				Anaesthetics & Surgical Division											Families Division										
			Darley Court	AED-Adults	AED-Paeds	A4	ACU	B1 (Frailty Unit)	B2	B3	B4	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DL	EU (daycare)	H3 (Stroke Unit)	HDU	ICU	E3	E4	F3	F4	G3/TSU	G4/TSU	G5	DCU (daycare)	H2 (daycare)	UU (daycare)	E5 (Paed HDU and Obs)	F5	M2	CDS	M3 (Birth)	Ingleside	M4	M5	M6 & M6 STY	NICU	Overall
	Total Beds	*N/a*	30	0	0	22	10	23	26	21	22	25	26	26	23	10	14	24	22	23	27	12	5	22	10	8	25	25	24	24	24	24	0	25	11	4	38	7	26	15	5	4	22	22	20	38	814
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*		90.0%			100.0%	90.0%	100.0%	95.0%		90.0%	100.0%	90.0%		100.0%		95.0%	100.0%	100.0%	95.0%		100.0%		100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		95.0%	100.0%	100.0%	70.0%	70.0%		95.0%		100.0%	100.0%	100.0%	100.0%	90.0%	97.6%
	IPC Rapid Improvement Tool % (Gen)	*Target = 95%*	94.7%	82.4%	100.0%			95.0%	75.0%	85.0%		100.0%	72.2%	85.0%	85.0%	97.7%	97.7%	84.2%	88.9%	100.0%	95.0%	88.2%	100.0%	94.7%	100.0%	100.0%	100.0%	94.7%	94.7%	94.7%	100.0%	100.0%		100.0%	100.0%	93.3%	94.1%	94.1%	94.4%	95.0%	93.8%	94.1%	94.7%	94.7%	100.0%	75.0%	94.7%
	IPC Rapid Improvement Tool % (Med)	*Target = 95%*	88.0%	100.0%				84.0%		69.6%		78.3%	60.9%	87.5%		95.2%	100.0%	66.7%	87.0%		91.3%	70.8%	100.0%	82.6%		100.0%	91.3%	100.0%	91.3%	91.7%	100.0%				100.0%	94.1%											88.3%
	Mattress Audit Compliance %	*Target = 100%*	100.0%					91.3%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%			100.0%		100.0%										99.7%
	C - Diff	*Target = 0*	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	MSSA BSIs	*Target = 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	0	0	0	0	0	0
	E.Coli BSIs	*Target = 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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	MRSA acquisitions	*Target = 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	0	0	0	0	0	0
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	3	9	0	0	0	3	12	8	1	5	7	8	8	0	4	7	5	2	2	0	1	2	0	0	4	0	1	4	5	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	102
	Harms related to falls (moderate+)	*Target = 1.6*	0	1	0	0	0	0	0	1	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	2
	VTE Assessment Compliance	*Target = 95%*				88.9%	98.4%	10.0%		16.7%	100.0%	100.0%	100.0%	94.5%	25.0%	100.0%	99.6%	99.3%	97.0%	87.5%	91.7%		99.4%	100.0%	100.0%	93.3%	100.0%	99.0%	95.4%	87.1%	88.0%	97.2%		98.8%	99.4%	98.2%			99.6%	90.8%	100.0%	75.5%	88.9%	98.3%	99.8%		95.3%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	4
	Monthly New pressure Ulcers (Grade 3)	*Target = 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	0	0	0	0	0	0	0	0
	Monthly New pressure Ulcers (Grade 4)	*Target = 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	0	0	0	0	0	0	0	0
	PU due to lapses in care	*Target = 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	0	0	1	0	0	0	0	0	0	0	0	0	2
Audit	Monthly KPI Audit %	*Target = 95%*	95.8%	95.1%	98.0%			89.7%	83.6%			79.5%	88.2%	90.1%	84.9%	98.8%	91.2%	76.8%	81.8%	91.5%	82.4%		100.0%	89.0%	100.0%	100.0%	85.3%	97.5%	79.3%	88.9%	94.9%	89.7%		99.1%	98.8%	98.3%	97.1%	97.1%	96.5%	98.7%		100.0%	97.7%	90.7%	95.2%	91.3%	93.3%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*	92.3%	75.3%	75.3%	84.2%		64.2%	58.3%	81.4%		81.6%	75.6%	82.3%	75.8%	84.3%	76.4%	75.1%	83.2%	92.9%	90.2%	71.8%	86.3%	85.7%	92.1%	96.6%	86.8%	81.7%	90.8%	77.7%	90.4%	90.9%	85.3%			88.2%	90.1%	90.1%	91.9%	90.3%	90.4%		71.4%	71.4%	81.3%	90.3%	83.0%
	BoSCA Rating		platinium	silver	silver	silver		bronze	bronze	silver		silver	silver	silver	silver	silver	silver	silver	silver	platinum	gold	bronze	silver	bronze	platinum	platinum	bronze	silver	platinum	silver	platinum	gold	silver			silver	platinum	platinum	platinum	gold	gold		bronze	bronze	silver	gold	Silver
Gover-nance	Serious Incidents in Month	*Target = 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	0	0	0	0	0	0	0	0
	Incidents > 20 days, not yet signed off	*Target = 0*	0	22	2	1	0	1	5	1	3	0	5	8	14	0	2	7	2	4	1	0	5	2	0	0	0	0	1	1	0	0	0	0	0	0	0	0	5	11	0	0	5	8	1	1	118
	Harm related to Incident (Moderate+)	*Target = 0*	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	0	6
Staff Dev-elopment	Appraisals	*Target = 85%*	98.3%	73.6%		85.2%	92.9%	84.2%	86.0%			81.3%	86.7%	79.5%	66.7%	75.9%	87.0%	67.3%	94.6%	93.2%	86.7%	71.4%	86.4%	76.5%	83.0%		81.6%	77.4%	79.0%	80.0%	86.1%	84.8%	52.9%	74.3%	79.6%	88.2%	88.2%		81.5%	70.4%	68.0%	0.0%	100.0%	86.7%		84.1%	79.6%
	Statutory Training	*Target = 95%*	96.52%	93.95%		93.85%	97.45%	87.89%	90.08%			87.93%	90.16%	91.85%	91.25%	93.81%	91.30%	89.58%	93.23%	96.37%	92.56%	97.62%	96.33%	90.53%	96.40%		95.94%	96.37%	94.51%	93.69%	93.96%	91.18%	94.02%	97.88%	96.15%	97.20%	93.5%		86.4%	85.6%	90.3%	100.0%	88.7%	92.4%		95.41%	84.2%
	Mandatory Training	*Target = 85%*	97.8%	94.56%		87.1%	98.0%	83.3%	89.4%			88.6%	91.2%	84.6%	91.6%	93.1%	90.8%	85.8%	90.0%	94.0%	90.2%	95.5%	97.6%	86.3%	96.8%		94.7%	93.6%	94.7%	92.5%	90.9%	89.3%	93.4%	97.6%	92.9%	100.0%	93.7%		80.0%	80.8%	89.0%	75.0%	84.1%	88.8%		92.5%	91.9%
Staffing & Workforce	% Qualified Staff (Day)					2.0%		93.0%				87.0%	71.0%	91.0%	78.0%	100.0%				103.0%	121.0%			89.0%	96.0%	96.0%	92.0%	56.0%		73.0%	75.0%	74.0%					554.0%	554.0%	79.0%	93.0%			88.0%	83.0%			123.8%
	% Qualified Staff (Night)					13.0%		116.0%				100.0%	115.0%	132.0%	102.0%	100.0%				109.0%	115.0%			100.0%	101.0%	101.0%	102.0%	106.0%		138.0%	95.0%	103.0%					1045.0%	1045.0%	100.0%	92.0%			79.0%	96.0%			182.8%
	% un-Qualified Staff (Day)					0.0%		106.0%				117.0%	98.0%	110.0%	119.0%	106.0%				78.0%	99.0%			101.0%	50.0%	50.0%	96.0%	86.0%		123.0%	108.0%	121.0%					60.0%	60.0%	97.0%	89.0%			80.0%	76.0%			88.3%
	% un-Qualified Staff (Night)					8.0%		123.0%				115.0%	103.0%	103.0%	111.0%	123.0%				86.0%	87.0%			124.0%	38.0%	38.0%	108.0%	89.0%		149.0%	102.0%	108.0%					18.0%	18.0%	100.0%	95.0%			69.0%	97.0%			87.5%
	Budgeted Nurse: Bed Ratio (WTE)		12.61	0.88	0.88	-24.05	0.00	2.53	-2.24	0.00	0.00	1.96	-2.56	6.40	-0.99	2.69	-2.02	-3.25	6.31	2.76	-2.95	0.00	13.48	1.40	0.00	-3.43	0.19	9.67	8.73	5.81	6.74	3.45	5.10	1.10	-0.38	1.65	0.37	0.37	-1.03	-9.03	5.22	7.47	-4.12	4.04	3.14	8.28	67.18
	Current Budgeted WTE (Ledger)		50.78	73.28	73.28	0.00		38.03	43.34			33.71	41.23	42.69	40.70	26.93	19.97	50.82	40.30	40.01	39.97		60.93	36.15	0.00	93.60	35.52	35.60	42.40	34.92	44.50	44.49	19.72	32.75	50.92	16.92	33.57	33.57	22.00	86.31	24.64	66.93	26.34	26.34	46.89	105.69	1675.72
	Actual WTE In-Post (Ledger)		38.17	72.40	72.40	24.05		35.50	45.58			31.75	43.79	36.29	41.69	24.24	21.99	54.07	33.99	37.25	42.92		47.45	34.75	0.00	97.03	35.33	25.93	33.67	29.11	37.76	41.04	14.62	31.65	51.30	15.27	33.20	33.20	23.03	95.34	19.42	59.46	30.46	22.30	43.75	97.41	1608.54
	Actual Worked (Ledger)		44.07	81.64	81.64	24.56		45.65	52.56			38.92	47.26	40.53	46.84	23.86	25.19	57.08	42.62	41.10	47.25		48.05	41.12	0.00	94.99	43.18	25.64	38.48	37.45	42.18	47.56	14.82	32.47	51.01	17.18	33.55	33.55	22.68	91.62	19.23	58.52	34.19	24.06	43.22	93.57	1729.09
	Sickness (%)	*Target is < 4.2%*	5.53%	8.74%		11.74%	3.82%	14.31%	10.25%			14.95%	14.08%	9.33%	6.28%	5.85%	6.02%	9.54%	3.03%	2.38%	10.68%	22.02%	10.59%	9.35%	7.92%		8.26%	5.54%	4.22%	12.65%	11.25%	7.29%	10.24%	11.08%	10.29%	3.11%	4.05%		5.20%	4.86%	7.75%	0.00%	6.51%	8.93%		5.27%	5.23%
	Current Budgeted Vacancies		-5.90	-9.25	-9.25	-0.51		-10.15	-6.98	0.00	0.00	-7.17	-3.47	-4.24	-5.15	0.38	-3.20	-3.01	-8.63	-3.85	-4.33	0.00	-0.60		0.00	2.04	-7.85	0.29	-4.81	-8.34	-4.42	-6.52	-0.20	-0.82	0.29	-1.91	-0.35	-0.35	0.35	3.72	0.19	0.94	-3.73	-1.76	0.53	3.84	67.18
	Pending Appointment																																														0.00
	Substantive Staff Turnover	*Target is < 10%*	3.2%	4.4%		24.2%	3.9%	21.4%	10.8%			16.4%	12.1%	9.1%	11.4%	6.7%	4.4%	12.0%	7.6%	13.8%	24.7%	0.0%	8.0%	11.5%	8.8%		2.6%	8.6%	9.9%	15.2%	14.4%	11.5%	11.1%	5.1%	8.7%	10.8%	10.2%		32.2%	9.5%	7.7%	0.0%	5.3%	25.8%		4.2%	12.59%

Data Legend

No data returned	
No Eligible patients	

WTE data is for Nursing staff only. The figures do not include Admin, Therapists or Doctors.

BOSCA Colours - white, bronze, silver, gold, platinum

Board Assurance Heat Map - District Nursing Domiciliary

	Indicator	Target	ICS Division												
			Avondale and Chorley old Road	Breightmet & Little Lever	Crompton with Egerton & Dunscar	Farnworth	Great Lever and Central	Horwich	Pikes Lane (Deane)	Pikes Lane (St Helen's Road)	Waters Meeting	Westhoughton	Evening Service	Treatment Rooms	Overall
Infection Control & Harm Free Care	Hand Washing Compliance %	*Target = 100%*	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		100.0%	100.00%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	1	0	1	0	1	0	1	2	1	0		7
	Monthly New pressure Ulcers (Grade 3)	*Target = 0*	0	0	1	1	0	0	0	0	0	1	0		3
	Monthly New pressure Ulcers (Grade 4)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0		0
	Monthly New pressure Ulcers (Unstageable)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0		0
	PU due to lapses in care	*Target = 0*	0	0	0	0	0	0	0	0	1	0	0		1
Audit	Monthly KPI Audit %	*Target = 95%*	96.99%	98.38%	96.44%	94.94%	91.09%	96.36%		96.31%	96.72%	97.67%	97.73%	98.79%	96.32%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*	92.41%	94.93%	91.10%	94.23%	93.60%	94.33%	97.23%	97.55%	91.74%	97.11%	96.93%	87.10%	94%
	BoSCA Rating		platinum	platinum	gold	gold	platinum	platinum	platinum	gold	platinum	platinum	gold	silver	gold
Staffing & Workforce	Current Budgeted WTE														0.00
	Actual WTE In-Post														0.00
	Actual WTE Worked														0.00
	Pending Appointment														0.00
	Current Budgeted Vacancies (WTE)		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff Development	Sickness (%) (August)	*Target is < 4.2%*	1.1%	3.3%	3.3%	2.7%	8.3%	4.7%	11.1%		4.9%	1.3%	6.5%		7.53%
	Total WTE with 19.81% Headroom (Sickness, Training etc)														
	Substantive Staff Turnover Headcount (rolling average 12 months)	*Target is < 10%*	6.9%	5.9%	0.0%	31.3%	0.0%	13.3%	0.0%		18.8%	0.0%	3.3%	14.3%	3.28%
	12 month Appraisal	*Target = 85%*	85.7%	92.9%	85.0%	79.0%	91.7%	92.9%	81.8%		82.4%	91.7%	92.6%	66.7%	92.59%
	12 month Statutory Training	*Target = 95%*	86.9%	97.4%	93.3%	94.7%	94.4%	96.7%	97.2%		98.0%	97.2%	95.1%	96.0%	95.06%
	12 month Mandatory Training	*Target = 85%*	90.2%	100.0%	92.0%	91.7%	95.7%	100.0%	97.8%		100.0%	100.0%	93.9%	100.0%	93.94%

Data Legend

No data returned	
No Eligible patients	

WTE data is for Nursing staff only. The figures do not include Admin, Therapists, Relief Team or Doctors & so will not marry up with the community performance report.
Home visits on this report excludes Groups so will not marry up with the community performance report.

BOSCA Colours - white, bronze, silver, gold, platinum

Agenda Item

	Quality Assurance Committee Chair's Report

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	26th November 2020		Discussion	x
Exec Sponsor	Esther Steel		Decision	

Summary:	The Quality Assurance Committee has met twice since the last Board of Directors meeting and although there are no risks to escalate there are a number of items to bring to the Boards attention, of particular note was a report on excellence reporting a new innovation running alongside our incident reporting system. The Committee received a monthly update on operational challenges in relation to COVID-19 and quarterly updates on pressure ulcers, falls, quality account objectives and mortality plus regular updates from three of our five clinical divisions these reports provided assurance that despite the current operational challenges the clinical teams are doing all they can to provide safe and effective are to our patients. In accordance with its delegated responsibilities, the Committee approved five final serious investigation reports and on behalf of the Board extended apologies to those affected by these incidents. Further detail provided on the attached meeting reports

Previously considered by:	Quality Assurance Committee

Proposed Resolution	The Board are asked to note the report

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Esther Steel	**Presented by:**	Andrew Thornton

Glossary – definitions for technical terms and acronyms used within this document

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	21 October 2020	Date of next meeting:	18 November 2020
Chair:	A Thornton	Parent Committee:	Board of Directors
Members present/attendees:	F Noden, A Ennis, F Andrews, M Forshaw, J Njoroge, R Ganz, M Brown, E Steel, R Sachs. Representation from the five clinical divisions D Sankey	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
The Quality Assurance Committee met by WebEx on Wednesday 21 October 2020. The meeting was well attended with representation from all clinical divisions			
Patient Story		The Family care division provided a story relating to the care of a small child who underwent treatment of liver disease both before and after a liver transplant which was carried out in Leeds	Noted as a positive story illustrating effective working with a tertiary centre and the impact of Covid on visiting restrictions
Covid update		Update provided on current operational challenges in relation to the increasing incidence of Covid infections	noted
Position Statement Vascular services SLA		Follow up briefing in response to a request from the Committee to provide assurance with regard to specialist provision for vascular patients	The Committee noted the improved arrangements but were advised there are still some concerns with regard to the service provided in respect of diabetic foot patients – this will be monitored by the Committee
Divisional Updates from the Acute Adult Division and the Integrated Care Division		Comprehensive reports received from divisions – commended for candour and detail including the recognition of the impact of Covid on staff	Reports noted

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

Committee/Group Chair's Report

Quality Account Report update diabetes care		The Committee commended the report and the development of the diabetes dashboard and associated initiatives to improve the care for people with diabetes	Discussed the wider implications of diabetes and the need to participate in public health initiatives to reduce the incidence of diabetes.
Quality Account Report update pneumonia		Update provided on actions and progress in relation to the Quality Account priority for pneumonia. Although the Trust is currently subject to a CQC outlier alert for mortality there is assurance that this is not in relation to delivery of care	There is an ongoing programme of work including support from AQUA and MIAA to focus on recording and coding of comorbidities
Excellence Reporting		The Director of Quality Governance presented the first of what will be a new six monthly report summarising excellent recording – this had a soft introduction using the existing incident reporting platform and has been well received by staff (over 300 excellence incidents reported)	QA Committee welcomed the initiative and the report and agreed to continue with the low key approach adopted.
SI 146196		The committee received the final report following a serious incident investigation in relation to interpretation and consent.	Report approved
Health and Safety Committee Chair report		The Health and Safety situation report identified a number of H&S works that have been prioritised including a number of environmental concerns	No risks escalated but concerns noted
Comments			
Risks Escalated –			

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	18th November 2020	Date of next meeting:	16th December 2020
Chair:	Andrew Thornton, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Fiona Noden, Esther Steel, Francis Andrews, Marie Forshaw, Rae Wheatcroft, Richard Sachs, Malcolm Brown, Jackie Njoroge, Bridget Thomas, Carol Sheard, Harni Bharaj, Clare Williams, Angela Volleamere, Ibby Ismail, Michaela Toms, Nadine Caine, Natasha Macdonald, Jackie Smith, Nasha Ellahi.	Quorate (Yes/No):	Yes
		Key Members not present:	Donna Hall, Andy Ennis, George Lipscomb, Vicky Welsby, Paul Settle, Gina Riley, Susan Moss, Diane Sankey.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Clinical Governance and Quality Committee Chairs Report		Director of Nursing	No red issues escalated; a number of amber areas highlighted all of which had actions agreed to address	Report noted
Covid Update		Deputy Chief Operating Officer	Update provided on current position and operational challenges, the trust participated in a national discussion regarding nosocomial outbreaks and daily updates are being provided to NHSI	Report noted
Mortality Update		Medical Director	Comprehensive report provided, some concerns regarding high mortality metrics but no concerns about quality of care provided. Report scheduled for discussion at Board of Directors meeting	Committee overall assured about quality of care but consider mortality reporting an area where further work is required
Family Care Divisional Quarterly Report		Division	Comprehensive report provided – Following national concerns about increase in stillbirths in relation to Covid the Committee requested an update in December on these issues	Committee noted the report and requested update on stillbirths and on the work of the specialist midwife appointed to work with the BAME community
Pressure Ulcer Quarterly Report		Director of Nursing	Quarterly update noted	
Falls Quarterly Report		Director of Nursing	Currently above trajectory but assured that appropriate actions are being taken	

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Committee/Group Chair's Report

Deep Dive of Falls at Darley Court		Divisional Nurse Director	Report noted – Committee noted the temporary closure of Darley Court with capacity transferred to other community beds	
Flu Immunisation Programme		Director of Nursing	Report on actions taken in accordance with NHSI check list -	Report included on Board agenda
Infection Prevention & Control Annual Report		Director of Nursing	Review of annual report prior to escalation to Board	Report included on Board agenda
Serious Incident Reports		Medical Director & Director of Nursing	Four SI reports were scrutinised and approved with apologies expressed on behalf of the Board	Action agreed for the Clinical Governance subcommittee to consider human factors and cultural elements of the incidents
Mortality Committee Chair Report		Deputy Medical Director	The Committee received the report and asked the Committee through the Medical Director to reconsider a decision taken to delay the review of the mortality policy	
Health and Safety Committee Chair Report		Dir of Quality Governance	Report noted	
Comments Meeting held by Web/Ex with good attendance and no connectivity issues				
Risks escalated No risks escalated				

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Agenda Item 13

Title:	Finance & Investment Committee Chair Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	
Exec Sponsor:	Annette Walker		Decision	

Summary:	The attached Chair's reports are from the Finance and Investment Committee meetings held on 21 October and 23 November.

Previously considered by:	Finance & Investment Committee.

Proposed Resolution	The Board are asked to note the chair's reports.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*		*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*		*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Annette Walker	**Presented by:**	Jackie Njoroge

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	21st October 2020	Date of next meeting:	23rd November 2020
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Rebecca Ganz, Fiona Noden, Andy Chilton, Lesley Wallace, Andy Ennis, Annette Walker, Martin North, Sharon Martin, James Mawrey (In attendance: Jackie Njoroge, Esther Steel)	Quorate (Yes/No):	Yes
		Key Members not present:	Bilkis Ismail, Donna Hall

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
GM Financial Envelope		Director of Finance	The Director of Finance gave an update on the revised financial regime that will operate from Months 7 – 12 across GM. AW explained that the final submissions are due to be agreed on 22nd October.	For noting.
Month 6 Finance Report		Deputy Director of Finance	The Deputy Director of Finance (AC) gave an update on the financial position at Month 6. The financial position for Month 6 shows an overall break-even position. This is in line with the new financial regime that has been introduced to help deal with the Covid-19 situation. The current regime will continue until the end of Month 6 and will then be reviewed. The financial position is summarised in the table below: **Month 6 £m** / **YTD £m** Base Income 28.1 / 169.4 NHSI automatic top up 1.3 / 7.6 NHSI top up request 3.4 / 14.3 **Total 32.8 / 191.3** Expenditure 32.8 / 191.3 **Surplus/Deficit 0.00 / 0.00**	For noting.

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Committee/Group Chair's Report

Month 6 Finance Report (continued)			AC advised that in Month 6 the Trust spent £2.3m on Covid related items and year to date total expenditure amounted to £12.2m. Overall the Trust has requested additional top up funding of £14.3m of which £9.9m for Months 1 – 5 has been validated by NHSI and cash received. £1m was held back due to verifying classification and will be paid with M6 top up. It was noted that agency expenditure had increased during August and September. This was mainly due to additional expenditure as a consequence of staff taking accrued leave. Overall agency expenditure remained below previous years. With regard to capital the Trust has a Capital Programme of £7.6m and in addition has received funding for Covid schemes of £6.1m. The Covid schemes relate to: **£m** • Same Day Emergency Care (A&E) 2.6 • Critical Care 2.1 • Endoscopy 0.2 • Equipment 1.2 The Trust has an overall cash position of £53.5m at the end of September which is due to advanced payments for October and additional performance monies from 2019/20, together with the opening cash position of £17.0m. AC advised that the upgrade to the ledger system had been successfully completed.	

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Committee/Group Chair's Report

Month 6 ICIP Update		Deputy Director of Finance	AC presented the ICIP Update as at Month 6. Overall the Trust has delivered FY savings of £2.8m against an original target of £6.8m which represents 0.8% of turnover. However it was noted that the programme has been significantly impacted by Covid. As part of the updated finance regime for Months 7 – 12, Trusts are expected to deliver minimum savings of 1.1% (£2.1m). The Months 1-7 plan has a savings target of £2.7m (1.4%). As a consequence of the savings already delivered by the Trust, this target has nearly been exceeded with further schemes in the pipeline.	For noting.
Use of Model Hospital, Use of Resources and Getting it Right First Time	N/A	Director of Finance	AW presented a report on the Model Hospital statistics, Use of Resources and Getting it Right First Time. The report highlighted that there are a few areas where based on benchmarking information the Trust could make further efficiencies. These included the Estate, Procurement and Corporate Services. However it was noted that some of the benchmarking data was quite old and efficiencies have been made in recent years. The PMO have identified a programme of work to look at opportunities for further efficiencies.	
Analysis of Trust Staffing Levels	N/A	Director of People	JM presented a detailed report on the Trust staffing levels. There were a number of positive areas in particular relating to reducing levels of agency spend, sickness levels (the Trust has the lowest sickness levels in GM and one of the lowest vacancy levels). It was noted that the Covid pandemic is presenting a number of challenges with regard to staffing but the Trust to date is showing a very positive response from staff in dealing with the issues.	For noting.

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Committee/Group Chair's Report

<table>
<tr>
<td>Month 6 iFM Finance Report</td>
<td></td>
<td>iFM Director of Finance</td>
<td>The iFM Director of Finance (LW) presented the iFM financial position for Month 6 and year to date. The overall position is a post tax profit of £304k on turnover of £14.56m. Details are set out in the table below:

<table>
<tr><th></th><th>Month 6</th><th>YTD</th></tr>
<tr><th></th><th>£,000</th><th>£,000</th></tr>
<tr><td>Turnover</td><td>2,403</td><td>14,555</td></tr>
<tr><td>Expenditure</td><td>-2,339</td><td>-14,104</td></tr>
<tr><td>Profit</td><td>64</td><td>450</td></tr>
<tr><td>Tax</td><td>-7</td><td>-146</td></tr>
<tr><td>Profit after tax</td><td>57</td><td>304</td></tr>
</table>

LW advised that iFM had received funding for Covid related items of £1.62m and also good progress was being made with regard to the savings programme.</td>
<td>For noting.</td>
</tr>
<tr>
<td>Procurement Quarterly Update</td>
<td>N/A</td>
<td>iFM Director of Finance</td>
<td>LW presented the quarterly update on procurement matters and highlighted a range of savings that had been achieved by the Procurement team. In addition the Procurement team had taken a lead role in the sourcing and management of PPE in relation to Covid. The Committee expressed their appreciation of the work undertaken by the Procurement team.

Concerns however were expressed regarding the central procurement process in relation to the Towers. It has proved extremely difficult to quantify the savings delivered by the national procurement arrangements.</td>
<td>For noting.</td>
</tr>
</table>

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Committee/Group Chair's Report

GHX Procure @ Bolton	N/A	iFM Director of Finance	LW gave a presentation on the implementation of GHX Procure. This is a materials management system which will greatly enhance the management of consumable products across the Trust. It also has the potential to track all items of medical implants from the initial stock through to the patient and identify which patients had which implants. The Committee expressed their appreciation of the investments in digital technology that had been made to improve the efficiency of the overall Finance function. In addition to the GHX Procure these included the upgrade to the ledger system and the new Patient Level Costing System (PLICS).	For noting.
Chairs' Reports	N/A	Director of Finance	The Director of Finance gave an update on the Chair Reports from CRIG, Contract & Performance Review Group and the Strategic Estates Board.	For noting.
In-house Coronavirus Molecular (PCR) Testing Expansion – Panther Business Case	N/A	Director of Finance	AW presented a Business Case on the purchase of a piece of equipment (Panther) which will substantially increase the Covid testing capability for the Trust and general pathology testing. The total value of the Business Case amounted to £1.27m over 5 years and therefore required the approval of the Finance & Investment Committee within its delegated limits. The Committee approved the Business Case.	For approval.
Risks escalated There are no additional items to escalate to the Board.				

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Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	23rd November 2020	Date of next meeting:	14th December 2020
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Rebecca Ganz, Bilkis Ismail, Fiona Noden, Andy Chilton, Lesley Wallace, Annette Walker, Sharon Martin, James Mawrey, Donna Hall, Mark Costello, Catherine Hulme	Quorate (Yes/No):	Yes
		Key Members not present:	Andy Ennis

Key Agenda Items:	RAG	Lead	Key Points	Action/ decision
Locality System Savings		Chief Financial Officer, Bolton CCG	The Committee received a presentation on locality system savings and noted the work being undertaken by the System Financial Reset Group across the FT, CCG and Local Authority. The financial gap for 2021/22 is currently estimated to be a minimum of £70m. Key areas of focus were noted as Workforce, Estates, prescribing and appraisal of system spend. The next steps will be presented to the Committee in January.	For noting.
Month 7 Finance Report		Deputy Director of Finance	The Committee received an update on the financial position as at Month 7. This showed an in-month deficit of £0.2m after receipt of top-up funds of £3.6m and is in line with the Plan. £1.6m has been spent on Covid related items during the month and lost income of £0.2m was noted. The financial position is summarised in the table below: **Month 7 £m** / **YTD £m** Base Income 28.8 198.2 NHSI top up 0.0 21.9 GM top up 3.6 3.6 **Total 32.3 223.7** Expenditure 32.5 223.8 **Surplus/Deficit (0.20) (0.10)** Probable Forecast out-turn is the planned value of £4.8m deficit with a range of £13.4m deficit to £0.3m deficit.	For noting.

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Committee/Group Chair's Report

Costing – Progress Update Q2/Q3		Deputy Director of Finance	The Committee noted that the 2019/20 Reference Costs were successfully submitted in advance of the deadline. An email from a senior member of the NHSI Costing Team was subsequently received commending the team on the submission and the work undertaken behind the scenes this year. The Team's attention will now turn to BAU Costing and a plan will be put in place and circulated to key stakeholders by the end of November for a soft launch of Costing/PLICS into BAU and the wider organisation. The Committee thanked the team for all the hard work that had gone into the submission and the costing model.	For noting.
Review of Standing Financial Instructions and Scheme of Delegation		Director of Finance	The Committee received for review and comment a revised set of Standing Financial Instructions and Scheme of Delegation. These will also be reviewed by the Audit Committee at its meeting on 24th November, prior to presentation to the Board of Directors. The Committee noted some minor changes which are to be made following circulation of the Committee papers.	Recommended for approval to the Board.
Month 7 iFM Finance Report		iFM Director of Finance	The iFM Director of Finance (LW) presented the iFM financial position for Month 7 and year to date. The overall position is a post tax profit of £339.0k on turnover of £16.69m. Details are set out in the table below: **Month 7 £,000** / **YTD £,000** Turnover 2,131 / 16,686 Expenditure -2,046 / -16,151 Profit 85 / 535 Tax -51 / -197 **Profit after tax 34 / 339** iFM are currently forecasting to remain on Plan.	For noting.

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Committee/Group Chair's Report

Deloitte Transfer Pricing Report		iFM Director of Finance	A transfer pricing exercise has been undertaken by Deloitte to determine if iFM and the Trust are trading on an arm's-length basis. Following a functional analysis of the services provided by iFM and benchmarking exercise of comparable service providers it was identified that the operating profit of 0.68% (FY 19/20), whilst below the inter quartile, was in the range of comparable organisations of 0.3% to 12.1%. It was therefore concluded that iFM is trading on an arm's-length basis. It was agreed that this report would be circulated to the Audit Committee via email for assurance.	For noting.
Insurance Update		iFM Director of Finance	The Committee received an update on the Trust's top-up insurance cover which is arranged through insurance brokers. The Committee asked that cyber insurance be investigated given the reliance placed on current methods of working.	For noting.
Chairs' Reports		Director of Finance	The Committee received and noted updates via the Chairs' Reports from November's CRIG and Strategic Estates Board meetings. The November Contract & Performance Review Group was cancelled due to the pandemic.	For noting.
Risks escalated There are no additional items to escalate to the Board.				

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Agenda Item: 14

Title:	People Committee Chair's Reports (October & November 2020)

Meeting:	Board of Directors	**Purpose:**	Assurance	✓
Date:	26th November 2020		Discussion	✓
Exec Sponsor:	James Mawrey		Decision	

Summary:	The People Committee has met twice since the last Board of Directors meeting and although there are no risks to escalate there are a number of items to bring to the Board's attention. Of particular note is the enhanced Health & Wellbeing focus that has been put in place during the Covid period. The actions appear to be working as absence rates remain lower than GM and North West peer organisations, albeit the Committee heard our staff are understandably tired and it was noted this may have an impact on our staff survey results (survey closes on 27th November). In accordance with its delegated responsibilities, the Committee approved the quarterly Freedom to Speak Up report and Guardian of Safe Working report. Further details are provided in the attached meeting reports.

Previously considered by:	People Committee.

Proposed Resolution:	The Board are asked to note the reports.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	James Mawrey Director of Workforce	**Presented by:**	Malcolm Brown Chair of People Committee

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	October, 2020	Date of next meeting:	November, 2020
Chair:	M Brown	Parent Committee:	Trust Board
Members present/attendees:	J Mawrey, A Ennis. S Martin, M Forshaw, F Andrews, E Steele, A Chilton, P Henshaw, L Gammack and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
Covid resourcing Update		• It was noted that 100% of our High risk staff have received a Risk Assessment and 83% of all staff. • Recruitment event was held on 19th September for Student Nurses (23 offers of employment). • Staff Swabbing service saw 840 staff tested. • Attendance figures whilst spiked remain best in GM and one of best in North West.	**Actions agreed:-** • The report was noted.
Turnover analysis		• BoD requested a review of turnover rate due to spike in July and August. • Committee noted that the Trust had made very good use of students in the pandemic (287) and the spike was a result of these colleagues leaving.	**Actions agreed:-** • The report was noted. • Update on Exit Interview process to be provided in December
Headcount report		• The overall headcount recorded and paid through ESR has steadily increased from a starting point in Apr 2018 of 5333 headcount, to a headcount of 5712 in August 2020. Albeit this increase has remained relatively stable in the last 12 months. • The Committee provided details as to the reasons for these headcount movements (business cases, TUPE, improved recruitment approaches) • It was noted that were headcount increases had taken place there were decreases in the amount of Agency staff used.	**Actions agreed:-** • The report was noted. • Report to be provided to the Finance & Investment Committee

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

NHS Bolton NHS Foundation Trust

Maternity Workforce Improvement Update		• Committee noted that a Maternity Improvement Group has been established to triangulate concerns and areas for improvement across the department.	**Actions agreed:-** • The report was noted. • Regular reporting to be provided to the People Committee (quarterly)
Staff Experience Update		• The report provided an update on the Trust's Go Engage 2020/21 quarter 2 survey results and the steps being taken to help increase response rates in the 2020 NHS national staff survey • The Trust achieved an overall engagement score of 4.02. Overall the Q2 results highlight a moderate to high level of engagement within Bolton FT. • Our engagement feeling scores – dedication, focus and energy – have declined compared to the previous quarter. It is clear from speaking to staff that they are feeling weary and concerned about working through winter pressures whilst dealing with the challenges of the COVID pandemic.	**Actions agreed:-** • The report was noted. • Report back on further actions that can be taken to support staff on the 'engagement feeling scores'
Apprenticeship programme		• Since 1st April 2020 a total of 32 staff have started an apprenticeship. There has been a significant drop in the number of employees starting and completing an apprenticeship qualification due to the COVID-19 pandemic. All GM trusts are experiencing similar reductions and nationally the total number of people starting an apprenticeship programme across the UK has significantly decreased from 19,300 in February 2020 to 8,000 in May 2020. • Finance colleagues have been briefed on the impact of this reduction against our levy. • The paper noted the range of enabling actions that are being implemented to increase apprentice take up and increase the Trust's levy spend.	**Actions agreed:-** • The report was noted. • Report back in three months' time on the actions being taken to increase uptake.

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Educational Governance next steps		• The Committee agreed a proposal to re-establish the group with a refreshed remit and membership.	**Actions agreed:-** • The proposals were agreed.
Medical Appraisal & Revalidation Update		• The Committee received an update on Medical appraisal including changes resulting from Covid 19. Given that this report will be presented to BoD in November no further commentary is noted in this section.	**Actions agreed:-** • The report was noted. • Report to be submitted to Board of Directors.
Workforce & OD Dashboard		• The Dashboard was very well received. • The report triangulated key workforce data to support informed discussions. • Members positively noted that the Trust benchmarked well on key Workforce & OD metrics. Improvement was noted on the appraisal rates, which declined during Wave 1 of Covid.	**Actions agreed:-** • The report was noted.
Assurance from reporting Committees • Staff Health & Wellbeing Group • Staff Engagement Group • Workforce Digital Group		• All reports were noted and risks being managed. No matters required escalation to Trust Board	
Risks escalated None – matters being managed within Committee			

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

Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	November, 2020	Date of next meeting:	December, 2020
Chair:	M Brown	Parent Committee:	Trust Board
Members present/attendees:	A Studdard, M North, I Ismail, J Mawrey, F Noden, S Martin, M Forshaw, F Andrews, E Steele, A Chilton, P Henshaw, C Sheard, L Gammack and all the clinical divisions present	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Key Points	Action/decision
International Recruitment		• Increasing ethical international recruitment forms a key part of the NHS People Plan. Furthermore NHSE have indicated that monies are available to support those Trusts wishing to recruit from oversees. • Despite the Trust's strong recruitment position the Trust has indicated that they would be interested in accessing this national support and await further guidance on this matter.	**Actions agreed:-** • The update was noted and it was agreed a report would be provided when further guidance is provided.
Covid resourcing Update		• It was noted that our vacancy rates are low when compared to peer organisations (Bolton 4.85%, National average 7.63% • 100% of our High risk staff have received a Risk Assessment and over 90% of all staff. • Positive recruitment event was recently held for HCSW in November. • Staff Swabbing service saw 687 staff tested in October. • Attendance figures whilst spiked remain best in GM and one of best in North West. • 54.95% of our staff have received a flu vaccination (up by 10% from this time last year). • Plans are in place for lateral testing from 30th November (all staff), pilot in place from 23rd November.	**Actions agreed:-** • The report was noted.

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

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

GOSW Report		• The Committee noted that there had been 35 exception reports vs 96 last quarter. 31 related to working additional hours and not having breaks. No immediate safety concerns raised. It was noted improvements in reporting in Surgery was required. To date no fines levied by the GOSW	**Actions agreed:-** • The report was noted. • Surgery to review how can improve reporting
Wellbeing Update		• The Committee were provided with an update on the Wellbeing offer. As the BoD are receiving a paper on this matter no further narrative is included.	**Actions agreed:-** • The report was noted.
FTSU report		• The number of FTSU cases increased, with 29 being reported in Quarter 2. The Committee viewed this positively. Inappropriate behaviour was the main reason for concerns raised. Matters raised were appropriately being actioned. • FTSU Guardian updated the Committee on the positive Audit Committee report. • FTSU Guardian was commended for all her positive communications during October FTSU month.	**Actions agreed:-** • The report was noted.
Excellence Reporting		• Following the QAC, the People Committee received an update on the action being taken and appropriate assurances were provided.	**Actions agreed:-** • The update was noted.
Workforce & OD Dashboard		• The Dashboard was well received. • The report triangulated key workforce data to support informed discussions. • Members positively noted that the Trust benchmarked well on key Workforce & OD metrics.	**Actions agreed:-** • The report was noted.

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

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

Mandatory Training – NG Tubes		• The Committee approved making NG Tube X ray interpretation module mandatory for all medical staff except diagnostic Division.	**Actions agreed:-** • The report was noted.
Assurance from reporting Committees • Staff Health & Wellbeing Group • Workforce Digital Group		• All reports were noted and risks being managed. • No matters required escalation to Trust Board	**Actions agreed:-** • Update to be provided on Occupational Health via the Health & wellbeing Chair report.
Risks escalated None – matters being managed within Committee			

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

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

Agenda Item

Title:	Safeguarding Adults, Children and Looked After Children Annual Report 2019-2020

Meeting:	Board of Directors	**Purpose**	Assurance	x
Date:	26th November 2020		Discussion	x
Exec Sponsor	Marie Forshaw		Decision	

Summary:	The report, authored by both The Named Nurse for Safeguarding Children and the Lead Nurse for Adult Safeguarding, provides an overview and assurance of the Trust's Safeguarding provision and activity. The Trust is mandated to provide assurance to NHS England against 81 safeguarding standards on an annual basis. The report presents the principal standards and provides an overview of assurance required for the principal standard's sub-categories. The report includes both quantitative data and narrative summaries as this best meets the assurance requirements in this complex area of work.

Previously considered by:	Safeguarding Committee

Proposed Resolution	The Board of Directors are asked to note the work of the safeguarding team for April 2019 to march 2020.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓

*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Fiona Farnworth Sandra Crompton	**Presented by:**	Marie Forshaw

Glossary – definitions for technical terms and acronyms used within this document

BoSCA	Bolton System of Care Accreditation
BASB	Bolton Adult Safeguard Board
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DHR	Domestic Homicide review
DoLs	Deprivation of Liberty Safeguards
FGM	Female Genital Mutilation
GMMH	Greater Manchester Mental Health Trust
HQIP	Healthcare Quality Improvement Partnership
LAC	Looked after Children
LeDeR	Learning Disability Mortality review
MASSS	Multi-Agency Safeguarding Screening Service
MCA	Mental Capacity Act
MHA	Mental Health Act
OCG	Organized Crime Gang
SLA	Service level agreement

NHS
Bolton
NHS Foundation Trust

Safeguarding

Adults, Children and Looked after Children Annual Report 2019 -2020

Everyone's Responsibility

VISION OPENNESS INTEGRITY COMPASSION EXCELLENCE

Contents

1.What is 'safeguarding' and why is it important?

Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.

Those most in need of protection include:

- Children and young people
- Adults at risk, such as those receiving care in their own home, people with physical, sensory and mental impairments, and those with learning disabilities.

All staff, whether they work in a hospital or in providing community care have a responsibility to safeguard children and adults at risk of abuse or neglect.

Bolton NHS Foundation Trust is committed to ensuring that safeguarding is a part of core business and recognises that safeguarding children, young people and adults at risk is a shared responsibility with the need for effective joint working between services and with partner agencies.

Responsibilities for safeguarding are included in international and national legislation and demonstrate an ever widening scope of practice and responsibilities

Statutory safeguarding responsibilities include:

- Under Section 11 of the Children Act (1984,2004)
- Safeguarding vulnerable adults in line with the Care Act 2014 and Department of Health Care and Support Statutory Guidance
- Mental Health Act (2007), Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (2009)
- Mandatory reporting of Female Genital Mutilation (FGM)
- The Counter terrorism and Security Act (2015) Prevent
- Promoting the Health of Looked after Children 2015
- Working Together to Safeguard Children Statutory Guidance 2018
- Intercollegiate guidance on roles and competencies for healthcare staff in respect of Children, Looked after Children and Adult safeguarding.

The annual report for 2019-2020 is based on the expected safeguarding standards and assurance provided on an annual basis. The number and range of standards identified demonstrates that safeguarding is an area where all Trust services and staff have an important role to play. This report highlights some of the expectations as a minimum requirement for the Trust and examples of assurance provided in 2019/2020

2.Safeguarding Assurances and Contractual Standards

Clinical Commissioning Groups (CCG) across Greater Manchester developed a safeguarding children, young people and adults at risk contractual standards collaborative document providing clear service standards against which healthcare providers are monitored to ensure that all service users are protected from abuse or the risk of abuse. These standards are built on the principles outlined in the *Safeguarding Vulnerable People in the NHS –Accountability and Assurance Framework* (NHS England 2015).

The 2019/2020 contractual standards consist of **81 safeguarding standards:**

- Safeguarding: including organisational governance; leadership; processes; policies; supervision, training and development; Children and Adults at risk (31 standards)
- Looked After Children (11 standards)
- Mental Capacity Act (2005) (10 standards)
- Prevent (20 standards)
- Lampard: Themes and lessons learnt from NHS investigation into matters relating to Jimmy Savile (9 standards)

The Trust is required to complete an annual self-assessment / audit against the standards and submit to the CCG with onward submission to NHS Improvement and NHS England. Evidence is provided in the first instance and a RAG rating set against each standard. For areas not fully compliant actions are identified to strengthen safeguarding arrangements. There is collaborative working between the CCG Safeguarding team and the Named Nurse for Safeguarding Children/ LAC and the Lead Nurse for adult safeguarding to explore the assurance provided. The Named Nurse and Lead Nurse for Adult safeguarding work with others across the Trust who are identified to have responsibilities for arrangements that support safeguarding – for example safe recruitment.

3.SafeguardingStandard
Organisational Governance, Leadership and Accountability, processes and policies, supervision, training and development Children and Adults at risk

A culture that safeguarding children and adults is everyone's responsibility is demonstrated by the wide variety of teams, services and managers who identity concerns or ask for advice and guidance when a safeguarding concern arises. The Trust Board lead for safeguarding children, looked after Children and adults at risk is the Director of Nursing - their job description identifies this safeguarding role and responsibility. The Trust Safeguarding Governance structure is in place and is reviewed as part of the function of the Trust Safeguarding Committee that meets bi-monthly. The purpose of the Trust Safeguarding Committee is to ensure there are robust arrangements in place and these are regularly reviewed.

The Assistant Director of Nursing is a board member for the Adult Safeguarding Board.
There have been changes in Safeguarding Children arrangements during the timescale of the annual report – following a number of drivers including Working Together 2018.The duty for establishing multi-agency Safeguarding Arrangements for their local child population is held by three partners from the Local Authority, the Police and the CCG.

All multi-agency safeguarding children meetings and forums are currently subject to review through the Trust Safeguarding Committee to ensure the Trust is represented at the required level of seniority within safeguarding children arrangements.
Named professionals for children and the Lead Nurse Adult Safeguarding contribute to the work of sub groups and partnerships including:

- Neglect task and finish group (Children)
- Child Sexual Exploitation (CSE) and Missing Steering Group
- OCG Strategic Partnership
- FGM group
- Channel Panel- as part of the National 'Prevent' Agenda
- Domestic Abuse and Violence Partnership
- Safeguarding Executive
- MARAC steering group
- Learning and Improvement Panel (now as Chair of the Child Safeguarding Practice Review group)
- Exploitation task and finish group
- All high risk panels –Public Protection, Exploitation, Domestic Abuse

4.Safeguarding Adults at Risk

4.1 Adult Safeguarding Service Provision

The service is provided by The Lead Nurse for Adult Safeguarding/MCA/ DoL's supported by 2 part- time Band 6 Safeguarding Specialists

The service in addition to managing safeguarding referrals provides training, advice and support in respect of -

- Mental Capacity Act 2005, including Best Interest Decision Making
- Deprivation of Liberty Safeguards
- Mental Health Act 1993 working in partnership with GMMH
- Prevent
- Missing persons

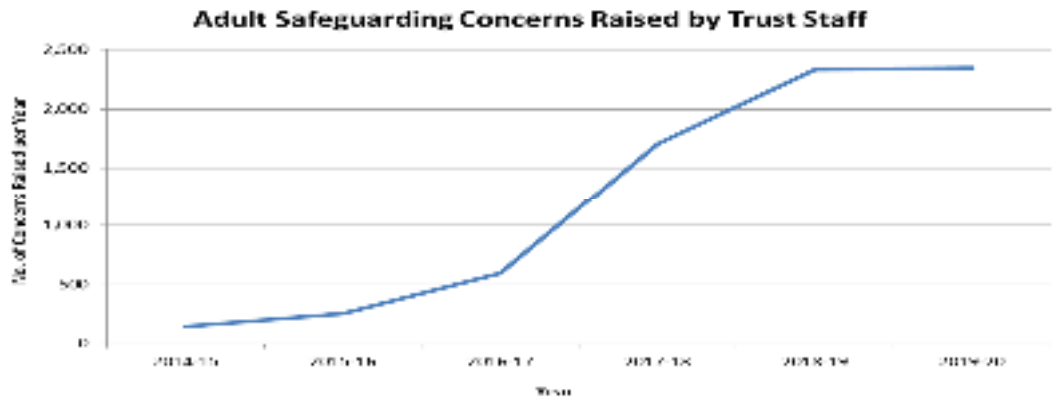
Later in the report these are fully described

The Safeguarding Specialist Nurses also contribute to the Trust's 'Harm Free' agenda, especially in respect of pressure sores, falls and enhanced care provision.

The Lead Nurse is also responsible for representing the Trust on joint partnership committees and the Bolton Adults Safeguarding Board Executive committee.

4.2 Referral Rates

The Trust's Adult Safeguarding provision has received on average 180 referrals / month from Hospital services and 24 referrals/month from Community Services.



2019-20 has seen a significant rise in respect of complex safeguarding concerns within Community settings identified by teams within the Integrated Community Division. Evolving concerns have been identified at a much earlier point and escalated to the multi- agency partnership minimising the risk of significant harm underpinned by effective collaborative working.

The Accident and Emergency Department, which generates approximately 90% of Trust safeguarding adult referrals have also been facilitating awareness raising events for both service users and staff to support and promote safeguarding initiatives.

Adult safeguarding concerns that have been identified by Trust Staff are far ranging with the main concerns being: -

1. Domestic Abuse and Violence
2. Self –Neglect
3. Mental Health related concerns
4. Physical abuse
5. Omissions in care by independent care providers and unpaid carers
6. Financial Abuse
7. Human Trafficking and Slavery

5. Learning Disability Service /LeDeR

Standard: There is a system for flagging adults in inpatient care who have learning disabilities or dementia

The service has been provided by Jainab Desai, Learning Disability Specialist Nurse but funding has been secured via the Trust's Safeguarding agenda for a second nurse who will commence in June 2020.

Learning Disability Awareness Training has been delivered to a wide range of staff including student nurses, specialist staff, trainee nurse associates and health care staff on the Care Certificate programme.

During 2019, the service introduced Learning Disability link champion training workshops to support a network of over 40 link champions throughout the hospital including wards and departments

The commitment from the hospital Learning Disability Nurses to the link champions includes the following:

- To offer support and advice in the management of patients with a Learning Disability and their carers.
- To support hospital staff in the implementation of reasonable adjustments to ensure service delivery is appropriate to person centred care which meets individual needs.

There is an expectation of commitment from the Learning disability champions which includes:

1. To work in partnership with the Learning Disability Nurses and be a point of contact for their team/department colleagues regarding Learning Disability issues
2. A responsibility to keep their colleagues/teams updated with learning disability development (information that the Learning disability nurse will provide) Feedback concerns, issues, good practice examples.
3. Promote Learning Disability good practice within their own area of work including promoting and implementing specific learning disability documentation e.g. Keep me safe in Hospital and reasonable adjustments.

The feedback from the link champions who have attended the Learning Disability Link champion training from the evaluation forms has been overwhelmingly positive.

5.1 Diagnostic Pathway for Adults with a Learning Disability requiring primary Care diagnostics in Hospital

It is well documented that people with a Learning disability have greater health needs and are likely to die younger than the general population yet they experience many barriers and challenges to access health care services that can appropriately meet their needs.

We identified that there are people with a Learning disability who due to their complex needs for example, profound anxiety and fears regarding health interventions, are unable to access even basic diagnostic tests e.g. blood test, ECG or physical examination.

As a result, NHS Bolton CCG and Bolton NHS Foundation trust have been working collaboratively to develop a pathway which supports people with a Learning disability to undertake diagnostic tests in a timely manner promoting person centred approach minimising distress to the individual ad optimising the potential for successful health outcomes. Working in accordance with the Mental Capacity framework.

This pathway was tested with two patients and it highlighted a wealth of learning which reinforced the need for the pathway. ‘One size doesn’t fit all’. This pathway addresses the needs of some of the most vulnerable people in our society who at times are simply unable to access basic diagnostic tests.

5.2 Future Development

The Deputy Director of Operation within Integrated Community Service Division has chaired the pathway steering group from the outset and has applied for funding to support the pathway.

5.3 Learning Disability Sub Group Meeting

The Learning Disability sub-group is a sub-group of the safeguarding committee and patient experience, inclusion and Partnership Committee.

The main objectives of the group are to:

1. Promote and safeguard the rights and dignity of all patients with a Learning Disability and their carers
2. Drive improvement in the quality of acute health care service delivery for people with a learning Disability
3. Work towards reducing premature mortality and health inequalities for people with a Learning Disability
4. Identify Learning and sharing of good practice to contribute to the improvement and appropriate access to health care for people with a Learning Disability

5.4 Learning Disability Mortality review

The Learning Disability mortality review (LeDeR) Programme is commissioned by Health Care Quality Improvement Partnership (HQIP) on behalf of NHS England.

The Bolton LeDeR steering group annual mortality review has been completed however it is currently going through the ratification process to the various Executive Board.

6. Safeguarding Adult Reviews / Domestic Homicide reviews

From April 2019-March 2020, Trust Staff have contributed to three Safeguarding Adult reviews and one Domestic Homicide Review (DHR) where an elderly gentleman was found guilty of the murder of his wife. Trust staff knew both perpetrator and victim very well, and although the DHR process was very distressing staff found it beneficial and supportive. This case has raised significant awareness into the changing picture of Domestic abuse and Violence, where abuse of older people is on the rise. It is seen as an emerging, national problem that Safeguarding Boards are having to address with Bolton Adult Safeguarding Board prioritising this issue in the 2020-2021 Business Plan.

7.Bolton Adult Safeguarding Board (BASB)

The BSAB, in 2019-2020 has worked to promote a zero-tolerance culture towards abuse and neglect of adults who are vulnerable. The Boards work is underpinned by the following ethos and principles all of which Bolton NHS Foundation Trust has implemented.

1. Living a life free from harm and abuse is a fundamental human right of every person.
2. Safeguarding adults at risk and their carers is everyone's business and responsibility.
3. All organisations and local communities have a responsibility to ensure that they foster a culture which takes all concerns seriously and enables transparency, reporting of concerns and whistleblowing.
4. All staff and volunteers in whatever the setting have a key role in preventing abuse or neglect occurring and in taking prompt action when concerns arise.
5. Adults at risk and their families, carers or representatives must have access to information regarding the standards, quality and treatment they can expect to receive from any individuals (paid or unpaid), services or organisations involved in their lives.
6. A 'Making Safeguarding Personal' approach is essential to ensure that any support offered or provided is person centred and tailored around the needs, wishes and the outcomes identified by the adult. The person at risk at the centre of any safeguarding process must stay as much in control of decision making as possible
7. All organisations must have processes aimed at preventing abuse from occurring in the first instance and to enable support to be offered at an early stage.
8. When abuse does take place, it must be identified early and dealt with swiftly and effectively, and in ways that are the least intrusive and most proportionate.
9. People supporting adults with care and support needs and/or their carers must the appropriate level of skills, knowledge and training to safeguard adults from abuse.

7.1 During 2018-2020 the Board agreed five priorities to which Bolton NHS Foundation Trust committed:

1. Ensure safeguarding processes are effective
2. Making all safeguarding personal and embedded into all service delivery across the partnership
3. Improve Engagement with Service-Users and the wider community to promote Safeguarding
4. Workforce Development and Effective Practice
5. Strengthen collaboration between Safeguarding Boards and the Community Safety Partnership.

The Trust's Lead Nurse for Adult Safeguarding has chaired the effective practice group that has been responsible for supporting Partner Members in-

1. Fulfilling their mandated safeguarding duties
2. Implementing legislation in respect of the Mental Capacity Act 2005
3. Promoting the 'Missing Person' agenda in collaboration with Greater Manchester Police

4.Seeking assurance on behalf of The Board that Partner agencies are fulfilling their mandated safeguarding duties.

8.Safeguarding processes

A programme of safeguarding audit and review is in place that enables the organisation to evidence the learning from reviews, incidents and inspections

Audits are an effective way to identify that systems and processes are in place and that they contribute to safe practice and improved outcomes for adults, children and young people. Safeguarding audits completed within the timeframe of this annual report include a number of multi-agency and Trust wide audits. Findings, learning points and recommendations are reported to individual staff members and managers and the Trust Safeguarding Committee.
Audits may be part of an annual programme – for example LAC Health Assessment audit or may be prompted by a case, theme or identified concern. Audit activity may include a records review, face to face contact with staff or looking at combined multi-agency chronologies to analyse the effectiveness of multi-agency working.

8.1 Audit of contacts and referrals to the Multi-agency Safeguarding Screening Service (MASSS)

In September 2019 the Safeguarding Children team completed an audit as part of a wider review of contacts with/referrals to Children's Social Care. They also attended a learning event to provide feedback and discuss findings. In total 50 contacts with Children's Social Care within a specific time frame were identified to be from a health professional and all cases were reviewed. Contacts and referrals from education providers were also included in the wider audit.

8.2 Findings and recommendations

Contact with the duty Social Workers based in the MASSS was predominantly from the Corporate safeguarding children team. The majority of contacts were to enquire about children who presented in A&E, to gather information to gain a better picture of risk and protective factors and to establish if the child had an allocated social worker. There were cases where the reason for contacting the duty social worker, including out of hours, was due to clear concerns that a child had suffered significant harm. The request for information in all cases was based on a good rationale with appropriate use of local thresholds.
There is a clear difference between a contact and a referral; it was identified that the majority of cases did not result in a referral to a social worker but follow up was required by the community case holder (Health Visitor, Midwife or School Nurse). There was learning for the Corporate safeguarding team that has prompted further work in relation to consent to share information particularly where concerns arise during an adult with caring responsibilities attendance and the development of a pathway agreed with GMMH.

9.Child Protection Plan Audit

Contribution to a multi-agency audit was carried out in March to evaluate the quality and effectiveness of multi-agency working where children were subject to a Child Protection Plan. The sample of 30 included a focus on children living with neglect, sexual abuse or domestic abuse. The quality of assessments, interventions and plans for each child was reviewed. The audit included single agency evaluation in each case, a multi-agency learning event and an evaluation report and recommendations.
Findings about the contribution of Trust services (predominantly Health Visiting and Outreach Midwives) demonstrated;

- Good record keeping
- Chronologies in some cases included more than significant events making it difficult to quickly review the child's experience over time
- Analysis was difficult due to the volume of information held in the records including both historical and recent concerns
- Parental substance use was often present, including cannabis use
- Evidence of effective multi-agency working and communication between core group members
- There was a lack of consideration of analysis or root cause where parents were resistant or did not engage
- Good practice was identified by Radiology staff who noted mum attended with facial bruising – this was attributed to an accident however the staff member was sufficiently concerned to share information
- Children in the sample were generally making developmental progress
- Parental engagement was identified however in some cases parents were prioritising their needs over the needs of the child.

10. Bolton System of Care Accreditation (B.O.S.C.A.)

As part of a regular review of safeguarding arrangements the safeguarding team apply criteria under domains for vulnerability and safeguarding as part of the BOSCA process. To ensure all Ward areas and District Nursing Teams are maintaining the NHS England Safeguarding Standards a member of the Safeguarding Team assesses each area on an annual basis using the Bolton System of Care Accreditation (B.O.S.C.A) The team have identified some excellent practice and knowledge across the Trust as per the Annual BOSCA report 2019-20.

(*https://sys290.xrbh.nhs.uk/BFTReports/Pages/Report.aspx?id=15*)

In addition, the Trust has been assessed against the NHS England standards for Adult Safeguarding by the Clinical Commissioning Group with all being achieved.

11.Safeguarding policies

Robust safeguarding policies and procedures are in place that reflect local, regional and national legislation and guidance. Safeguarding policies and procedures are updated regularly and are available to all staff on BOB.
In addition to Trust policies and guidance there are multi-agency local and regional policies in place.
Protocols are in place to support information sharing with other services and agencies.

The Safeguarding Children policy and Adult at Risk policy include guidance on a range of issues reflecting the wide range of areas included in safeguarding practice.

- Human Trafficking
- Domestic Abuse
- Forced Marriage
- Honour Based Violence
- Female Genital Mutilation
- Self-Neglect
- Human Slavery
- Chaperone

The organisation is required to have a restraint policy that includes MCA in line with CQC guidance and MCA/Mental Health Code of Practice.

Where appropriate, staff who may be required to use restrictive physical interventions with children or adults have received specialist training.

Evidence to demonstrate compliance can include and the policy includes reference to:

- The use of restraint within the best interest decision process
- Where restraint is used, it is documented and followed by an assessment of the person restrained for signs of injury and any emotional or psychological impact
- Restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that harm is prevented and that the person and others around them are safe
- The levels of training required
- Restraint Policy
- Capacity assessment
- Risk assessments
- Care plans
- Advocacy
- Clear evidence of consideration of MHA for informal patients when restraint/seclusion is used in psychiatric inpatient care
- Training- training package and training data

12. Safeguarding Adult, Children and Looked after Children Training

It is important to recognise that all staff require safeguarding training that is indicated by their work role and responsibilities. Staff are required to develop both knowledge and skills in safeguarding and looked after children practice based on Intercollegiate Guidance for Children, Adults and Looked after Children.

Learning opportunities include face to face training and e-learning as well as other forms which could include; contributing to national campaigns; key messages shared at team meetings and safety huddles and shared briefings and reports.

As of March 2020, The Trust employed 5293 staff and volunteers who were required to complete Level 1 training and 3946 clinical staff who required Level 2 training.

12.1 Adult Safeguarding training

Training compliance achieved by March 2020

Level 1 98 % (target 95%)

Level 2 97 % (target 95%)

The Trust also implemented a programme of Level 3 Adult safeguarding training which has also been offered to and attended by managers from the multi-agency partnership. This will continue through 2020-21 using a variety of platforms both face to face and virtual. This training has included input from our Safeguarding Partners at The Community Partnership, Fortalice and Greater Manchester Police.

The Trust's Safeguarding provision has also provided numerous bespoke training sessions for various Specialities across the Trust and for Multi-Agency Partners.

12.2 Safeguarding Children Training compliance by March 2020

Level 1 – 97.7% (Target 95%)

Level 2 – 98% (Target 95%)

12.3 Level 3 Children Safeguarding Training

Following the CQC Inspection in 2016 the Trust Safeguarding Committee approved that all staff identified to require Level 3 Safeguarding Children training would attend a full day face to face training session.

A new training package was developed and training was provided by the Trust Safeguarding Children team.
A number of staff from outside the safeguarding team provided support to run the sessions and to contribute to group work.

The number of staff identified to require Level 3 training was 894.This was based on clearly identified staff groups and through discussion with Practice Education Leads and managers across the Divisions. Exercises to clarify who needed to attend level 3 training included divisional scoping exercises and competency matching through ESR. This was reviewed throughout the 3-year programme.

In total the number of training sessions provided from November 2016 to November 2019 was **67** and **1270** staff were trained.

Additional numbers of staff who attended from the original cohort identified included larger numbers of therapists, Radiology, ICU, some students, support workers (for example play therapists and Nursery Nurses) and following an agreement that all staff in a department would attend the training (A&E). This reflects 95.6% compliance with adjusted competency matching.

Evaluations were positive with 95% indicating that staff felt they had increased knowledge and skills and felt they could put into practice learning from the day. Of the responses that were negative this related to the teaching environment/size of the room.

Following the updated Intercollegiate Guidance in 2019 a new training package was developed and a new cycle of Level 3 face to face training commenced in January 2020.

13. National Adult Safeguarding Week – November 2019

Over the week the Trust and Safeguarding Partners across Bolton focused on different the key themes of:

- Self-neglect
- Modern slavery
- Online bullying and cyber security
- Disability hate crime
- Financial abuse
- Forced marriage
- The Prevent Agenda
- Safeguarding adults in sport and activity

Safeguarding awareness week was an opportunity to promote Safeguarding Adults in Bolton with both our partners and the public with a number of events held across the Trust.

14. Safeguarding and Looked after Children Provision

There are staff in a specialist role working within the Corporate Safeguarding Team and the Family Care division. This meets the requirements set out in Intercollegiate Guidance for Named medical, nursing, midwife and specialist nurse roles. Named Professionals have a key role in promoting effective safeguarding practice within the Trust, supporting multi-agency local systems and processes, providing advice and expertise for any professional seeking guidance and ensuring that safeguarding children supervision and training is in place.

Oversight of safeguarding and Looked after Children (LAC) clinical activity and function includes; child protection medicals; child death processes; services provided for LAC, including the provision of Initial Health Assessments; participation in all statutory reviews including Rapid Reviews, Child Safeguarding Practice Reviews and Domestic Homicide reviews.

There are a number of services across the Trust who can be identified to have specific and regular safeguarding responsibilities. This includes community based services who are case holders for all children subject to a Child Protection Plan or who are Looked after and also hospital based services who have limited contact with a child and family but where a concern may be identified. Close working with community and hospital based staff provides the safeguarding team with oversight of the child's journey between services and their individual risk and protective factors.

From a Children's safeguarding perspective there have been a number of briefings shared with staff and teams to be included in safety huddles and team meetings:

- Care Leavers
- Outcome of the Multi-agency Child Protection Audit

14.1 Daily duty response to referrals from A&E

The Safeguarding Children Team receive daily referrals for:

- children (up to 18 years)
- adults who may be parents or carers of children
- Mental Health Liaison Team share all assessments for children up to the age of 18
- Mental Health Liaison Team share all assessments and adults who may be parents or carers
- Concerns about an attendance for an adult in a position of trust.

The number of referrals from A&E alone has continued to rise within the timeframe of this report – noted a 41% increase in 2018/2019 and a further increase to almost 3000 in total for 2019/2020.

15. Contribution to Safeguarding Reviews

The safeguarding children team have contributed to a number of statutory reviews within the time frame of the annual report. This includes providing reports based on agreed terms of reference regarding children and adults in the family home and their contact with Trust services. There is also a requirement to attend panel meetings, practitioner learning events, sign off panels to agree final reports and meetings about publication and publicity arrangements. All reviews include children and families that reside in Bolton and also those who live in other areas but who have accessed Bolton FT services.
In addition to writing reports there is a requirement to meet with staff who have provided services to the family. It is to be remembered that often a serious injury or death has prompted the review and staff need to be updated about identified learning and offered support.

Domestic Homicide Reviews (DHR) are convened by the Community Safety Partnership as a multi-agency review into the circumstances of the death of a person over the age of 16 that has been as a result of violence, abuse or neglect by a person to whom they were related or who they have been in an intimate relationship with or another family or household member.
There have been two reviews within the timeframe of this report. These reports have not yet been completed or published. One DHR was in relation to the death of a female in Bolton and the second the death of a female out of area.

Rapid Reviews and Child Safeguarding Practice Reviews are held to consider serious child safeguarding cases where a child has died or has suffered serious harm. A number of reviews were taking place within the timeframe of the annual report (4 local reviews and 2 reviews out of area) including the death of a mother and her children, suicide of a young person, historical sexual abuse of a child already known to services, infant deaths and injuries to a child where parents were known to mental health services.

There are 3 standards that relate to adults and children in specific circumstances with clear expectations that processes are in place.

Following learning from an adult presentation at A&E and admission resulting in a Serious Case Review for a dependent child, systems are in place to ensure staff make enquiries about caring responsibilities.

Key questions to form part of any assessment should include:

- Who lives with you at home
- Do you have caring responsibilities for anyone else
- Is there a support/social worker involved with you or another member of your family?

Routine enquiry is monitored by record reviews in A&E, reported within departmental meetings and to the Trust Safeguarding committee

The Child's GP and health visitor/school nurse (depending on the age of the child) are notified of admissions/discharges for children under 18 years to A&E, ambulatory care units, walk in centres and minor injury units and wards/units.

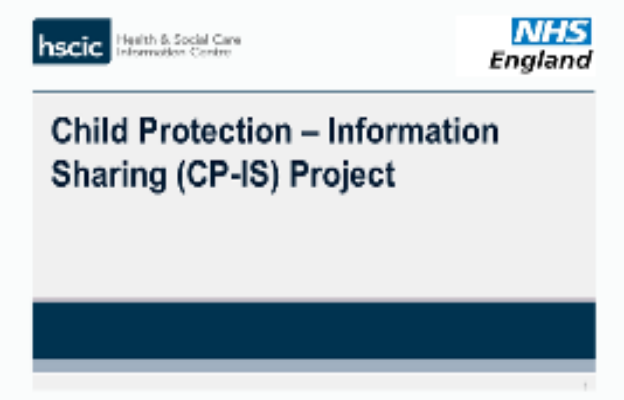
This administrative process is in place and is more efficient for Trust community staff now using EPR. The safeguarding children team operate a duty day system to enhance information sharing about children and young people attend.

There is good communication between GPs, community nursing services (i.e. health visiting, school nursing and community midwifery services) in respect of children for whom there are concerns and Looked After Children.

There is a detailed communication agreement in place to support effective working between GP practices and community nursing teams in respect of children. Working arrangements for all Bolton GP practices and community nursing teams were reviewed within the timeframe of the annual report by the Named Nurse for Safeguarding Children and the Matron for 0-19 service.

This was an extensive review that supported updating the communication agreement to include guidance about children and families where information should be shared to support the provision of care, contribution to the practice meetings and the role of the GP link within the neighbourhood teams.

16. CP-IS Child Information Sharing



The requirement to adopt this system is included as a distinct standard. The CP-IS programme is embedded in processes across the Trust at the point a child has contact with a number of specific services at the point of attendance. This alerts a Social Worker that a child has attended for urgent care prompting contact with the Corporate Safeguarding Team who the share information about the attendance if this has not already taken place.

17. Female Genital Mutilation – FGM

Definition -FGM is a collective term for a range of procedures which involve partial or total removal of external female genitalia for non-medical reasons. It is sometimes described as female circumcision or cutting. It is classified by the World Health Organisation into 4 major types –for classification purposes may be further defined

The Serious Crime Act (2015) stipulates mandatory reporting when FGM is identified. Since April 2015 the Trust has been required to collect mandatory FGM data in order to submit a monthly report to NHS England. To support this there are guidelines in place to recognise and record FGM.

FGM is identified predominantly in maternity services where there are clinical pathways in place and a risk assessment to identify if further actions are required for female children in the family.

The number of cases identified fluctuates each month. In all cases the safeguarding children team identify if there are any female children in the family and having implemented the FGM risk indicator process (FGM-RIS) This includes adding an alert on the child's Summary Care Record that there is a family history of FGM to support decision making by any health professional who sees the child.

The Named Nurse for safeguarding children and Looked after Children attends the local FGM Steering group and links to community groups to provide information about Trust services and response to FGM and to gather information to support service delivery.Examples include providing clarity about the FGM risk assessment and also providing information about the FGM clinical pathway to support improved attendance for hospital appointments.

Figure 1 FMG Contacts monthly 2019/2020

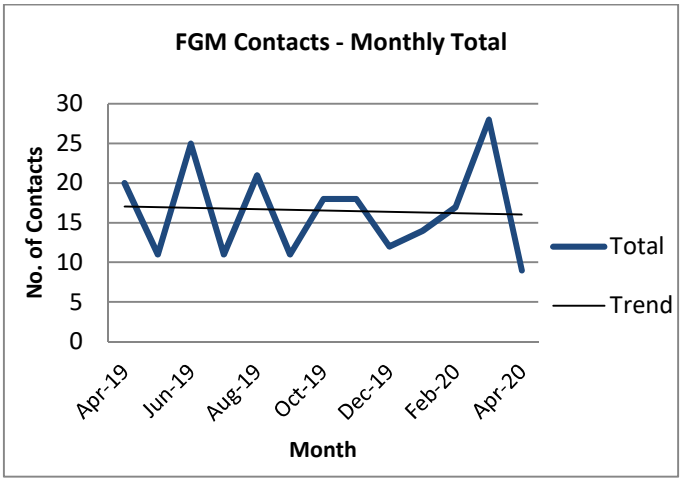
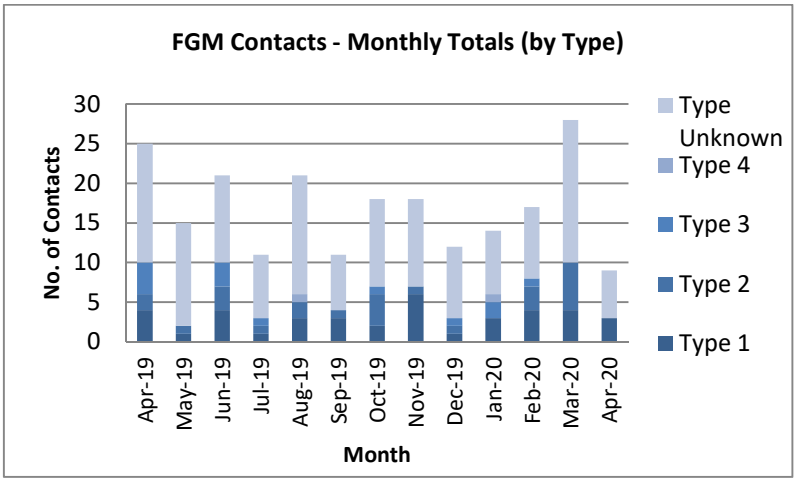


Figure 2 FMG Contacts monthly by type 2019/2020



18. Standard - Looked after Children (LAC)

The Trust arrangements for named professionals and staff in a specific role are not fully aligned to Intercollegiate guidance. This arrangement is subject to review; however, it is in keeping with arrangements for other organisations across Greater Manchester. Regular review is based on clinical workload and capacity of those in a specific role to continue to offer detailed oversight of Trust services to Looked after Children.

Named professionals and those in a specialist role contribute to multi-agency working as medical advisors to the adoption and fostering panels and are linked to the Corporate Parenting Board and Permanency Panel and health economy wide meetings and forums.
The Trust LAC group has a distinct action plan based on the safeguarding standards and this feeds into the Trust Safeguarding Committee.

Monthly LAC data is gathered in relation to the compliance with timescales for statutory health assessments for children in care and it is reviewed within the Trust and submitted to the CCG. The majority of Looked after Children in Bolton enter care due to abuse and neglect so the timeliness and quality of statutory health assessments is an area of practice that requires scrutiny and prompt action if concerns arise. The compliance data provides evidence of the effectiveness of agreed LAC pathways. On a monthly basis actions are taken where barriers are identified. Most children who are looked after in Bolton previously resided locally however there are children who enter placements in Bolton from other areas and responsibility for the provision of health assessments is with the Trust. The numbers of children who require statutory health assessments varies widely every month depending on the circumstances of children identified to be suffering significant harm.

18.1Initial Health Assessments (IHA)

These should be completed within 20 days of becoming looked after with an expected compliance of 95%. From April 2019 to March 2020 a total number of 141 of IHA were completed 98 of which were completed on time. The reasons for late health assessments is monitored monthly and in over 80% of cases this was due to services outside the Trust (delay in providing the Trust LAC team with paperwork) or that children were not brought to the appointment. As a flexible and timely response to support completion of IHA the number of children seen out of timescales but within month by offering additional appointments is often over 95% demonstrating a continued priority for administrative and medical staff of the importance of assessment of health needs of children entering care.

18.1.2 Review Health Assessments (RHA)

RHA are completed by community based nurses (Health Visitors, School Nurses Special School Nurses, Specialist Nurse LAC) either every 6 months for children under the age of 5 or annually for children over the age of 5. There has been an improved annual compliance with statutory timescales noted with health assessments completed within month providing evidence of the priority and flexible provision to Looked after Children. The number of RHA completed in 2019/2020 is 423 of which 375 were completed on time.

18.2 LAC Quality Assurance process and audit

An audit programme is in place for LAC assessments. All completed LAC health assessments are quality assured by Team Leaders and Specialist Nurse for LAC. There is an annual audit with the CCG Deputy Designated Nurse for Safeguarding and LAC. The aim of all audit activity is to show continuous learning and improvement rather than being purely a focus on compliance with timescales.

18.3 The child or young person should "<u>jump off the page</u>"

A specific records audit is carried out bi-annually to assess the Voice of the Child using LAC health assessments. The focus on the individual circumstances for a child is valuable in identifying health assessments that are of excellent quality with the practitioner able to analyse information and plan future care

The areas considered include:

- Direct observations of the child
- Views of carers
- Views of other professionals
- A Day in the life of the child
- Knowledge of the child's journey, placement and legal status
- Ways in which the child's wishes and feelings have been identified and understood
- Likes, dislikes and preferences
- Important relationships to the child

Findings from this audit are shared with case holders and team leaders with examples of good practice.

19.Standard –Prevent self-assessment

National Prevent Agenda

Prevent forms part of the Counter Terrorism and Security Act 2015 and one aim is to work to ensure that children and vulnerable adults are not radicalised to carry out terrorist activity. The Trust is mandated as per the NHS contract to adhere to the National Prevent Agenda which is a strand of the National 'Contest' Strategy which is the National overarching counter terrorism strategy.

In the past 12 months there have been no changes to legislation or training requirements but a review has been commissioned by NHS England but is not expected until August 2021.

Both the Trust's Adult and Children's Safeguarding Leads represent the Trust on the Bolton Channel Panel' where local Prevent referrals are appraised/ risk assessed and action plans implemented by a multi-disciplinary team including the Local Authority, CCG Community Partnership and Bolton Counter Terrorism Officers.

The majority of referrals are received in the region are from Schools with a ratio of 85% male to 15% female. This is in line with the National Average.

The Trust is mandated to provide Prevent training for all staff at Level 1 and all clinical staff at Level 3

As of 31st March 2020 the Trust was fully compliant with an expected target of 85% at both levels.

Level 1 - 97% compliance (5,135 / 5,293 employees & volunteers and I FM)

Level 3 - 91% compliance (3,592/ 3946 clinical staff)

Despite training delivered, referrals generated by Trust Staff remain very low but this reflects the Borough as being regarded as a low risk area.

The Trust has a statutory requirement to submit training compliance and referral data to NHS England and Bolton CCG on a quarterly basis via the NHS Digital portal and this has been achieved.

The Trust is fully compliant with the Standard

20. Standard: Adherence to Mental Capacity Act 2005

During 2019-2020 numerous bespoke training sessions have been delivered across the Divisions as this has proven to be a subject where staff require ongoing support.

In October 2019, with the implementation of the electronic patient record (EPR) this gave the Trust the opportunity to ease access to mental capacity assessments and documentation.

There have been excellent examples of good practice in respect of Best Interest Decision making and collaborative working of the Multi-Disciplinary Teams in a variety of settings to ensure optimal care delivery to some of our most vulnerable patients.

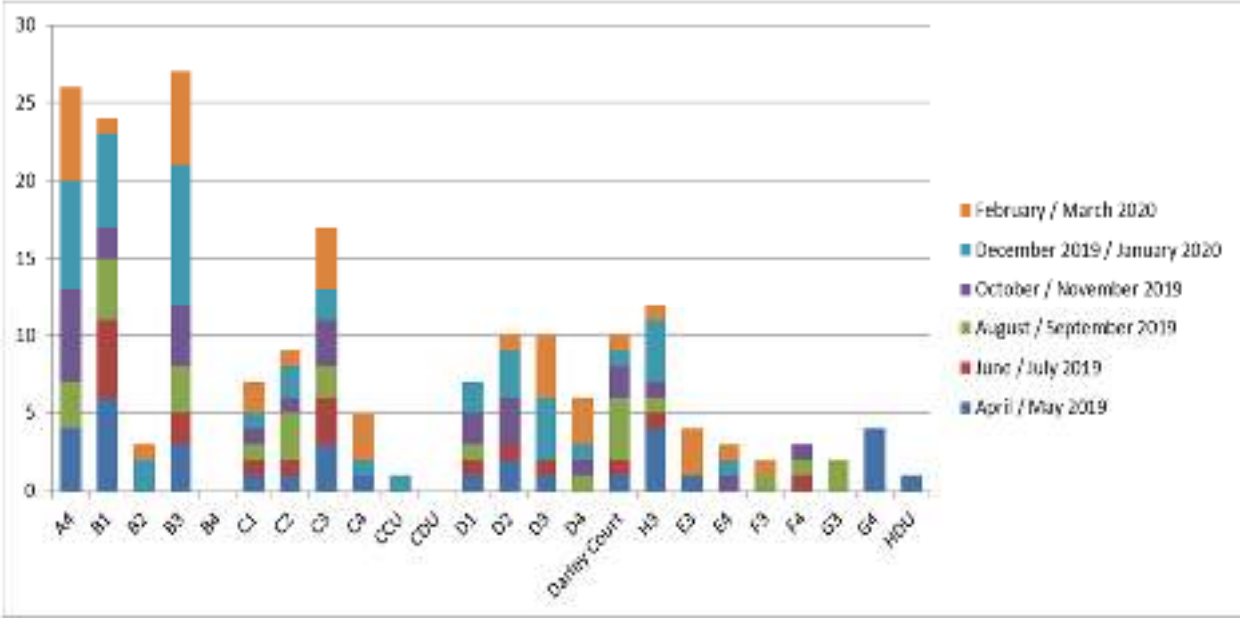
The Trust continues to engage the services of the Bolton Advocacy Hub for the provision of Independent Mental Capacity Advocates.

Mental Capacity Act Training has also been delivered in Q1 of 2020 to over 70 staff in the Family's Division in readiness for the introduction of Liberty Protection Safeguards which have now been deferred to April 2022 from October 2020 due to the COVID-19 Pandemic which will also be relevant for the consideration for the detention of 16 and 17 year olds in both the Hospital and Community settings.

20.1 Deprivation of Liberty Safeguards (DoL's)

On average, the Trust imposes 15 Dol's / month with the Acute Adult Wards having the greatest activity. This is to be expected as this reflects the high acuity of patients, especially within complex care wards. The CQC have been notified of all impositions as per the statutory requirements of the Trust's Registration to detain patients under the Mental Capacity Act 2005.

DoL's Impositions by Ward Area 2019-2020



Impositions of DoL's is supported Trust wide by enhanced care initiatives and the Harm Free Care agenda. In the Trust, Ward Sisters /Managers, Matrons and Clinicians impose Dol's which reduces the risk of inappropriate detentions and promotes best practice in respect of mental capacity assessments.

21. Mental Health Act 2007 (MHA)

The Trust is registered to detain patients under the Mental Health Act 2007. This activity does not have a specific standard within the safeguarding standards, but the Trust must achieve its registration requirements with the CQC. At the CQC inspection the Trust was assessed as meeting all requirements.

The Trust continues to work in partnership with Greater Manchester Mental Health Trust (GMMH) under a Service Level agreement to detain patients to the hospital under the Mental Health Act 2007. The SLA is reviewed on an annual basis.

In 2019-2020, 46 patients have been detained to the care of the Trust whilst they were receiving medical care. This is in addition to patients who are detained to other Mental Health Care providers who access care across the Trust.

The Lead Nurse for Adult Safeguarding represents the Trust on the joint partnership Mental Health Act Steering group and co-ordinates day to day detention activity and recording of detentions as per CQC requirements. The Director of Nursing and the Lead Nurse for Adult Safeguarding have also attended MHA Governance meetings at GMMH headquarters.

22.Standard -Lampard self –assessment

Kate Lampard's report from her review was published in 2015.The themes identified in the report are used directly within the Safeguarding Standards framework. The influence on

current policies from historical matters is clear in the areas where organisations are required to provide assurance. An extract from the report is below-

"Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissistic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that that access, influence and power gave him to commit sexual abuses on a grand scale. However, features of the story have everyday implications and relevance for the NHS today.

The findings of the separate NHS investigations about the cultures, behaviours and governance arrangements that allowed Savile to gain access and influence in the various NHS hospitals, and gave him the opportunity to carry out abuses on their premises over many years are strikingly consistent. The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

• Security and access arrangements, including celebrity and VIP access
• Role and management of volunteers
• safeguarding
• Raising complaints and concerns (by staff and patients)
• Fundraising and charity governance
• Observance of due process and good governance

Assurance through having policies, training and safe recruitment processes in place is provided in relation to the areas highlighted above covering;

- Visits by celebrities
- Voluntary services arrangements
- Staff and volunteer safeguarding training
- DBS checking at periodic intervals and recruitment
- Internet and social media policy
- Associations with celebrities and major donors

To Conclude

The annual report highlights a year of significant activity and scrutiny of safeguarding across the Trust. The Trust has demonstrated through the Safeguarding Standards submission that mechanisms for effective safeguarding practice for children, Looked after Children and adults at risk are in place but this is recognised as a continual learning cycle in a practice area that will always be complex and challenging. Safeguarding Children and Adults remains a practice area that requires a timely response, highly specialised skills and the appreciation of an ever evolving and changing demographic. Referral rates to the Team are increasing year on year and reflects an ever increasing awareness by Trust Staff, our partner agencies and the Public. The Board is asked to accept and approve the report

Fiona Farnworth

Named Nurse for Safeguarding Children & Looked after Children

Sandra Crompton

Lead Nurse for Adult Safeguarding, MCA & DoL's *October 2020*

Glossary – definitions for technical terms and acronyms used within this document

BoSCA	Bolton System of Care Accreditation
BASB	Bolton Adult Safeguard Board
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DHR	Domestic Homicide review
DoLs	Deprivation of Liberty Safeguards
FGM	Female Genital Mutilation
GMMH	Greater Manchester Mental Health Trust
HQIP	Healthcare Quality Improvement Partnership
LAC	Looked after Children
LeDeR	Learning Disability Mortality review
MASSS	Multi-Agency Safeguarding Screening Service
MCA	Mental Capacity Act
MHA	Mental Health Act
OCG	Organized Crime Gang
SLA	Service level agreement

Level 3 training

Level 3 safeguarding children training since beginning of April 2020 – outside the timescale of the annual report.

Unable to continue face to face training so commenced national e-learning training package. System in place for staff who become non-compliant to enroll to complete the e-learning via ESR.7 modules – can be completed in one or several sessions which allows flexibility.

At the end of October 2020 358 staff had completed the training and 195 had enrolled on the training but not completed all modules. All divisions are following this up with individual staff members. Current compliance is 64.7%.

FGM

FGM April 2020 – outside the timescale of the annual report. Unusually lower number of FGM identified for 1 month– this does not appear to be an error as systems for identifying and reporting FGM are still in place. There are several points where FGM is identified during maternity care so this may represent a drop in attendance at early pregnancy appointments at the beginning of lockdown however the reporting for the following months is within usual parameters.

Voice of the child

"Jump off the page" – this is a reference to Voice of the Child – a big focus of work with Looked after Children and a distinct audit of health assessments to look at VOTC is carried out bi-annually.

Named nurse for Safeguarding and LAC

The Intercollegiate Guidance recommends a Named Nurse for Safeguarding and a Named Nurse for LAC. Trust arrangements do not reflect having 2 distinct Named Nurses :

Many children and y/p known in the safeguarding arena become looked after so they are not always two completely distinct groups

Responsibility for both safeguarding and LAC is on an equal footing in terms of corporate responsibility under one Named Nurse – previously responsibility for LAC sat within the Family Care division

Clear roles and responsibilities for LAC within the Trust have been shared with the CCG Safeguarding and LAC team

The arrangement is similar to arrangements for many Trusts across GM

Agenda Item
16

Title:	Mortality Report

Meeting:	Trust Board	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	✓
Exec Sponsor	Dr Francis Andrews, Medical Director		Decision	

Summary:	Mortality data is presented in terms of crude mortality, RAMI, SHMI and HSMR and underlying analysis. The impact of the first wave of Co19vid is described briefly. Work undertaken to understand higher than expected figures is detailed and a conclusion drawn around co-morbidity recording and further work required for this.

Previously considered by:	N/A

Proposed Resolution	Board are asked to note the report and discuss

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Dr Francis Andrews	**Presented by:**	Dr Francis Andrews

Glossary – definitions for technical terms and acronyms used within this document

HSMR	**Hospital standardised mortality ratios**
RAMI	**Risk adjusted mortality indicator**
SHMI	**Summary hospital mortality indicator**

1 Introduction

Sadly, for many people, death under NHS care is a tragic yet inevitable outcome of illness or injury. While we fully expect an individual to receive excellent treatment and care from the NHS in the time leading up to their death, it is highly important that Trusts have established surveillance programmes to ensure that quality care has been delivered and that mortality is reduced to its lowest possible level.

Bolton NHS Foundation Trust has a programme in place led by the Learning From Deaths Committee which robustly reviews deaths in line with national guidance and escalates cases for divisional review and scoping for serious incidents. The Mortality Reduction Group undertakes regular monitoring of data which is reported quarterly to the Board of Directors.

This quarterly mortality report provides the most recent data available to the Trust to support reduction of the Trust's mortality ratio.

2 Summary of Quarterly Performance

Appendix one describes the measures that can be used to indicate mortality ratio. It is included in this report to help explain the range of ways that mortality rates can be measured and what the differences are.

Appendix two describes performance against each of the measures described, using the most currently available data which is summarised as follows:

Crude mortality – increased by .5% to 2.6% from (September 2019-August 2020) compared to 2.1% in the previous comparison year.

Risk Adjusted Mortality Indicator (RAMI) – index increased from the comparison year, currently at 123.1 (September 2019 – August 2020) compared to 99.5 in the previous year. The index is higher than the selected peer value of 109.9

Summary Hospital-level Mortality Indicator (SHMI) – The index is at 117.6 for the latest published period (June 2019 – May 2020), it is still significantly higher than the national average and is identified as being worse than expected in September's CQC outlier alert. SHMI is not adjusted to reflect deprivation.

Hospital Standardised Mortality Rate (HSMR) – ratio increased to 115.8 for the latest period (September 2019 – August 2020) from 107.9 in the previous year is identified as being worse than expected in September's CQC outlier alert. Morbidity measured by HSMR shows deteriorations in both weekday and weekends. HSMR does take deprivation into consideration.

- The overall SHMI and HSMR remain higher than expected.
- Each measure indicates that mortality rates have increased during 2020 and would appear to be higher than national average or peer rates.

- All indicators that have not been adjusted to take into consideration COVID-19 have shown steep increases in March and April before falling back to a comparable range ahead of a second period of rises in wave two.

- The proportion of deaths taking place in hospital and those taking place within 30 days of discharge is in line with the national average.

This quarter's report contains supplementary data on the crude mortality rate covering the first wave of COVID-19 which can be found in Appendix three.

3. Assessment of issues influencing mortality rates

3.1 Quality of care assessment

Mortality data and quality of care is monitored through the Trust Learning from Deaths Committee and Mortality Reduction Group. These groups have extensively looked at specific conditions that are the most common causes of death: pneumonia and heart failure; concluding that the quality of care did not give rise for concern.

This is confirmed by the CQC, which now reports that there are no outliers for mortality for the individual groups conditions that they monitor and the SHMI for the most common causes of death is now within normal limits for all groups.

This suggests that our higher than average ratios relate to factors other than quality of care.

3.2 Reviewing the impact of miss-coding

The Medical Director has undertaken a detailed review of how patient information is coded and recorded. Initially it was felt that the introduction of electronic paper records could resolve some issues but this has not been the case. Further analysis has highlighted where further improvements or investigations can be made.

3.2.1 Primary diagnosis coding

- Good practice states that the first diagnosis recording should be diagnosis not a condition (for example pneumonia rather than breathlessness).
- Bolton Foundation Trust has a higher than average record for correct entries (13% compared with 8.4% nationally).
- Following good practice has a negative effect on our mortality figures, albeit marginally, but this is not something we wish to discourage.

3.2.2 Palliative care coding

- A patient receives input from the palliative care team, is termed 'specialist palliative care input' and, under national coding rules, can be coded as a palliative care death Such cases then are counted as expected deaths and can markedly alter the how mortality ratios are calculated.

- 26% of our deaths had a palliative care coding compared with 36% nationally.
- In June 2020 an audit of 59 patients who received specialist palliative care in June 2020 showed that only two cases had been incorrectly coded.
- There is no national benchmark for the provision of specialist palliative care services but a project has begun to understand whether there needs to be more provision for end of life palliative care referrals at our hospital.
- Quality of palliative care is monitored by the division and through the end of life committee for assurance and a lower level of referral does not imply a poorer standard of care.

3.2.3 Depth of coding

- Depth of coding – particularly among the co-morbidity condition groups increases the expected mortality risk which in turn affects the number of expected deaths for both SHMI and HSMR: the more co-morbidities that are recorded, the greater the risk of death resulting in a greater expected mortality risk.
- Our depth of coding for elective admissions is 4.8 compared with the English average of 5.3, but for non-elective admissions this falls to 4.3.
- In-depth review of pneumonia deaths in November 2019 showed that 18% of records did not include correctly record co-morbidities.

3.2.4 Effect of excluding emergency ambulatory care patients in the data

- Unlike virtually all other Trusts, since April 2018, Bolton NHS FT has excluded recording emergency care patients who are managed as same day ambulatory cases from the data used to calculate ratios.
- The advice mortality experts from AQUA (Advancing Quality Alliance) is that this is the major factor affecting our SHMI and that this is even more of a factor than rectifying comorbidity coding.

4. Conclusion and recommended actions

Data for the last quarter shows that Bolton NHS Foundation Trust continues to have higher than expected mortality ratios, above national and peer averages. Continued review and analysis undertaken by the Learning from Deaths Committee concludes that quality of care is not the issue driving this position.

Further investigation confirms continued anomalies arising from coding practice in relation to primary diagnosis, depth of coding and the exclusion of emergency ambulatory care patients form the data.

Review of data has also highlighted a potential negative impact of lower than average referrals for end of life palliative care.

The following actions are being undertaken. The Board is asked to discuss and approve the report and actions.

Issue	Actions	Reporting and Timescales
Improvement of co-morbidity recording	1. Medical Director to re-issue communications to all medical staff around the importance of recording comorbidities. 2. Clinical Coding Manager to improve feedback to individual consultants around the inclusion of comorbidities within the first consultant episode. 3. Business case to be developed for audit support to continuously audit charlson comorbidity recording for 3-6 months. Francis Andrews to discuss with clinical audit November 2020. 4. EPR team to incorporate Charlson co-morbidity checklist in medical clerking document which in effect will mandate recording of co-morbidities. 5. Complete coding education package to be delivered to ACCD in 2021.	November 2020 November 2020 Clinical Audit November 2020 Digital Transformation Board December 2020
Ambulatory care patient data	With agreement from the CCG, from April 2020, all emergency care patients managed as same day ambulatory cases will be included within the data collection. This will impact SHMI only. A reduction in SHMI to within normal limits may not be seen until potentially the end of 2021 if this is the dominant factor.	April 2020
Palliative care provision	The Palliative Care team is undertaking a review of their service, led by the Clinical Director	Report to Quality Assurance Committee. February 2021

Appendix 1: Understanding Mortality Rates – CRUDE, HSMR, RAMI and SHMI; definitions and differences

Crude Mortality Rate (Crude)
A hospital's crude mortality rate looks at the number of deaths that actually occur in a hospital in a specific time period and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. It tells you how a Trust's mortality rate changes over time; however, it cannot be used in a meaningful way to compare or contrast between hospitals as it does not include adjustments for population demographics or other factors that may impact on mortality expectations.

Risk Adjusted Mortality Indicator (RAMI)
This is standardised mortality ratio compiled by our external healthcare intelligence provider CHKS which has been risk adjusted to take into account age, admission type, clinical condition, sex, length of stay and secondary diagnoses. Anything lower than 100 is interpreted as fewer deaths than expected. It includes deaths occurring in hospital only. The advantage of using RAMI is that the data is more up to date and a peer group with similar healthcare resource groups can be selected.

Summary Hospital-level Mortality Indicator (SHMI)
This is the nationally developed mortality ratio designed to allow comparison between NHS organisations and is the NHS official indicator of mortality, published quarterly. It is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
Different variable factors are taken in to account in calculating the scores - the principle one of these is that SHMI includes deaths following a patient's discharge (within 30 days). As SHMI includes all deaths post discharge it is always at least 6 months behind the current date due to data being include from the Office for National Statistics.

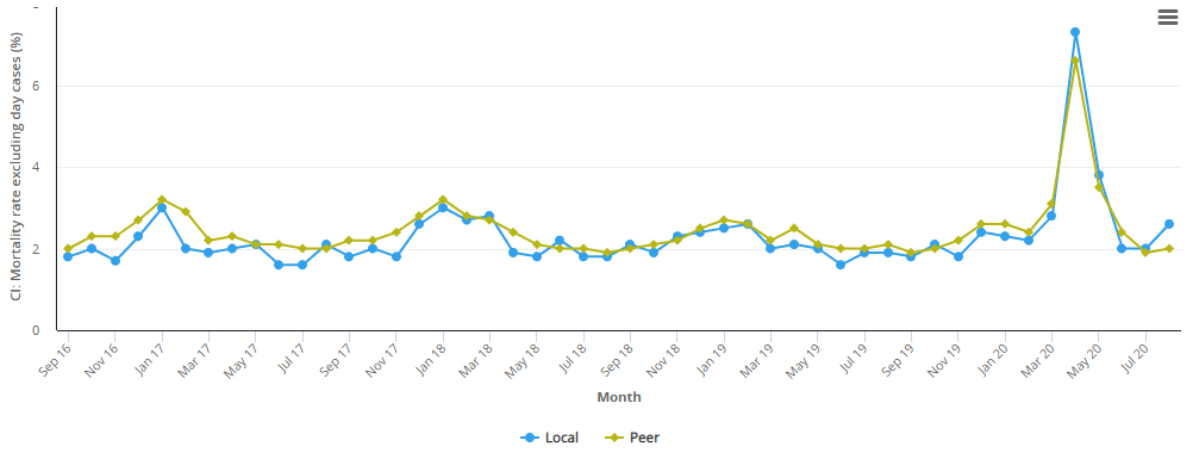
Hospital Standardised Mortality Rate (HSMR)
The HSMR uses a subset of diagnoses which gives rise to around 80% of in-hospital deaths. It compares mortality levels in different years, or between different hospitals by calculating a ratio is of observed to expected deaths, multiplied conventionally by 100. If mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100 if it is lower the HSMR will be lower than 100. This methodology allows comparison between outcomes achieved in different trusts, and facilitates benchmarking.

	Crude Mortality Rate (crude)	Risk Adjusted Mortality Indicator (RAMI)	Summary Hospital-level Mortality Index (SHMI)	Hospital Standardised Mortality Rate (HSMR)
Numerator	Actual number of deaths	Total number of observed in hospital deaths	Total number of observed deaths in hospital and within 30 days of discharge from the hospital	All spells culminating in death at the end of the patient pathway, defined by specific diagnosis codes for the primary diagnosis of the spell: uses 56 diagnosis groups which contribute to approx. 80% of in hospital deaths in England
Denominator	Number of discharges	Expected number of deaths	Expected number of deaths	Expected number of deaths
Risk Adjustments		• Age - six groups • Admission type - elective or non-elective • Primary clinical classification - all CCS groups • Sex • Length of stay - specific groups only • Most significant secondary diagnosis	• Sex • Age group • Admission method • Co-morbidities based on Charlson score • Year index • Diagnosis group No adjustment is made for palliative care. Details of the categories above can be referenced from the methodology specification document at http://www.ic.nhs.uk/services/summar y-hospital-level-mortality-indictorshmi	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • History of previous emergency admissions in last 12 months • Month of admission • Socio economic deprivation quintile (using Carstairs) • Primary diagnosis based on the clinical classification system • Diagnosis sub-group • Co-morbidities based on Charlson score • Palliative care • Year of discharge
Exclusions	Excludes day cases, still births and well born babies.	None	Excludes specialist, community, mental health and independent sector hospitals; Stillbirths, Day cases, regular day and night attenders. Palliative care patients not excluded.	Excludes day cases and regular attendees. Palliative care patients not excluded
Whose data is included		Admissions to all trusts/boards in England, Wales and Northern Ireland	All England non-specialist acute trusts except mental health, community and independent sector hospitals via SUS/HES and linked to ONS data for out of hospital deaths. Deaths that occur within 30 days are allocated to the last hospital the patient was discharged from.	England provider trusts via SUS/HES

Appendix 2: Mortality rates by type of measure

A2.1 Crude Mortality Rate

Figure 1. Crude mortality time series by selected hospital peer group (July 2019 – June 2020)



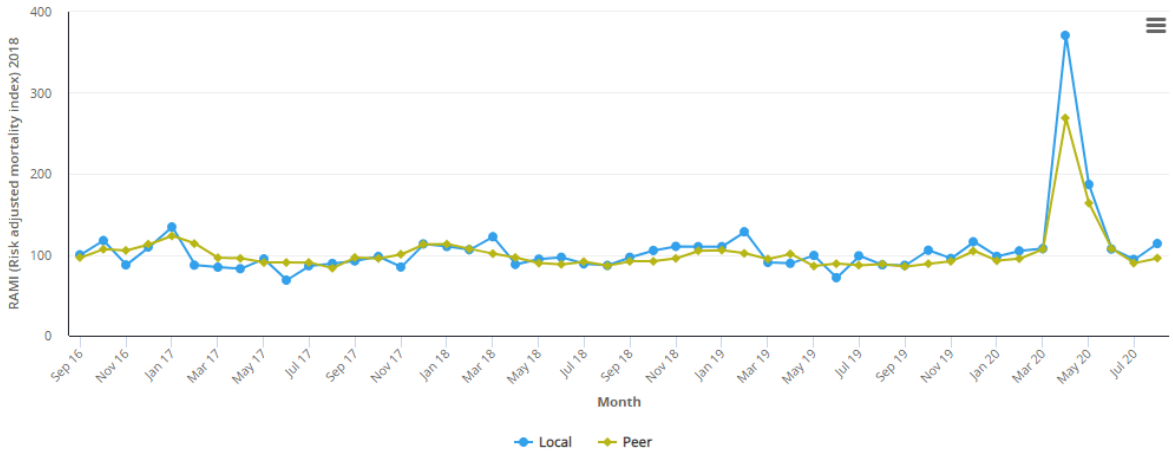
Deaths are higher in winter compared to the summer, although deaths in January and February 2020 were lower than the same months in previous years. There was in increase in March and April 2020 compared to previous years due to COVID19 where deaths in the Trust were at a peak due to the pandemic. Deaths since June have fallen back to the normal range. Numbers in October 2020 and November 2020 are higher than in previous years due to the second wave of the pandemic.

Table 1: Actual deaths by month

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	107	105	88	87	102	95	106	92	124	156	95	96
2017/18	91	106	76	77	96	90	104	96	130	143	117	140
2018/19	94	89	104	90	86	99	101	117	113	124	125	101
2019/20	99	101	77	92	88	86	108	89	119	113	97	115
2020/21	221	132	72	77	99	89	119					

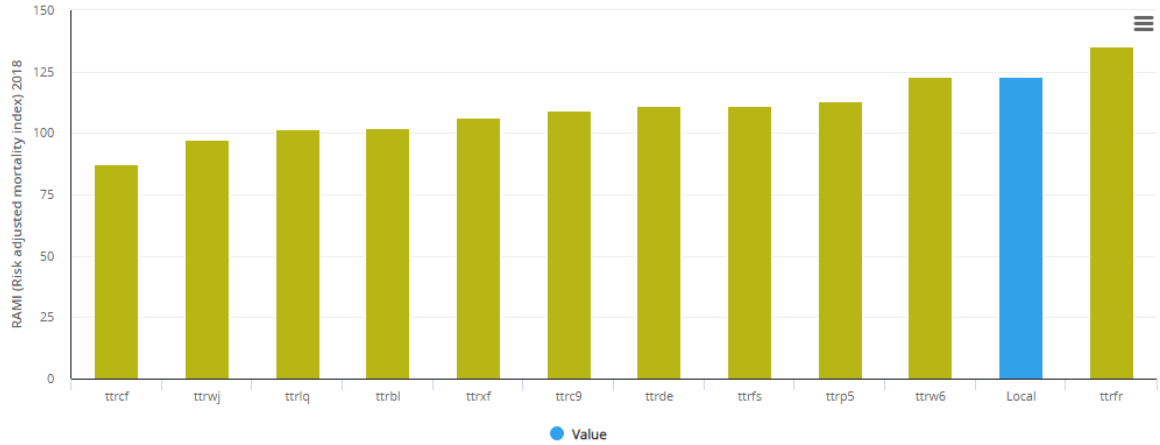
A2.2 Risk Adjusted Mortality Index – RAMI

Figure 2. RAMI time series (September 2019-August 2020)



The monthly RAMI fluctuates widely but roughly follows the pattern of the selected hospital peer groups. The index has been at a higher level than the peer group in nine out of the final 12 months of the reporting period. This indicator is also not adjusted for Covid19; therefore, all deaths are included which explains the index almost quadrupling in April 2020 from the previous month.

Figure 3. Peer distribution (September 2019 – August 2020)

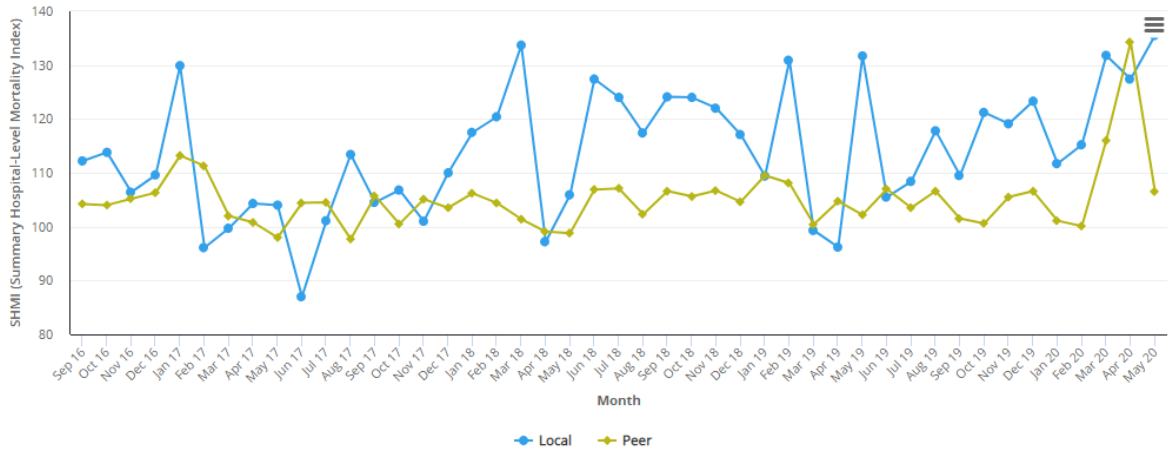


A comparison peer group comprising similar Trusts to Bolton, using the distribution of activity by healthcare resource groups (groups performing similar activities) shows that Bolton FT is in the upper range of the table when compared against the selected hospitals with a RAMI of 123.1 within a peer range of 87.5 to 135.1 (This is the 12-month average from Sept 2019 to Aug 2020 so includes the first wave of the pandemic (RAMI isn't

adjusted for Covid19). Previous to the pandemic, the rolling average to February 2020 for Bolton RAMI was 95.

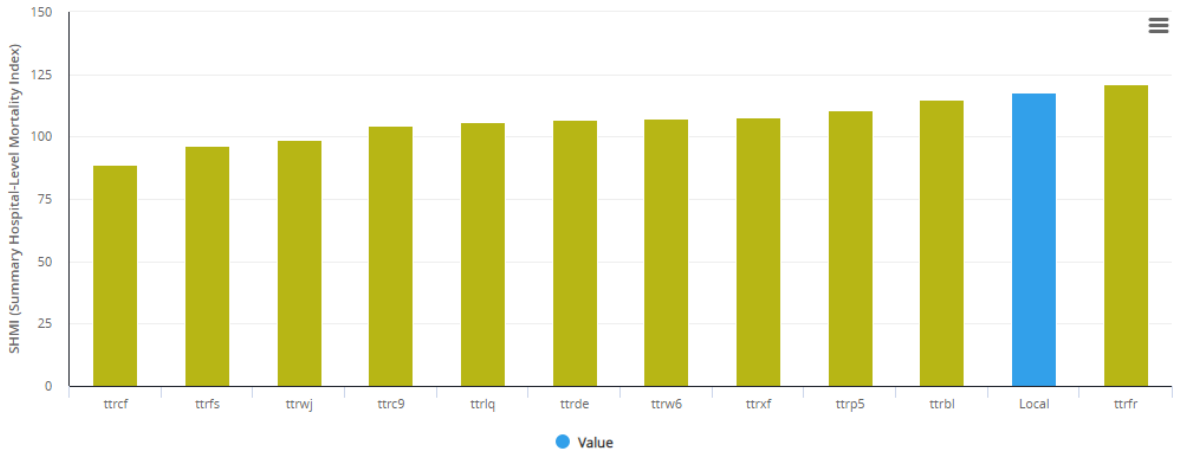
A2. 3 Summary Hospital-level Mortality indicator – SHMI

Figure 4: Monthly SHMI values (June 2019 – May 2020)



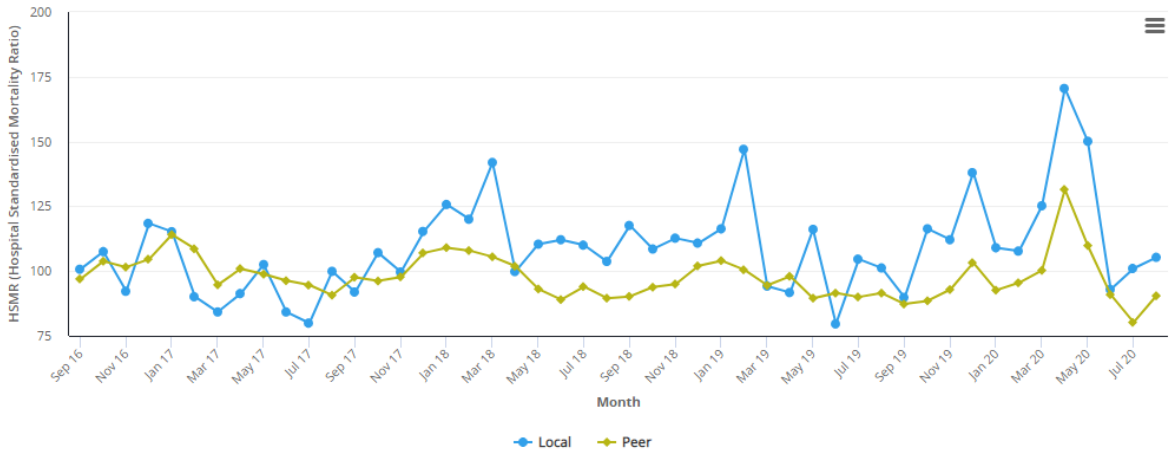
The most recently published SHMI 12-month rolling average for the period June 2019 – May 2020 is 117.6 which is a higher than expected rate.

Figure 5: SHMI Peer distribution (April 2019 – May 2020)



A2.4 Hospital Standardised Mortality Ratio (HSMR)

Figure 5. HSMR time series



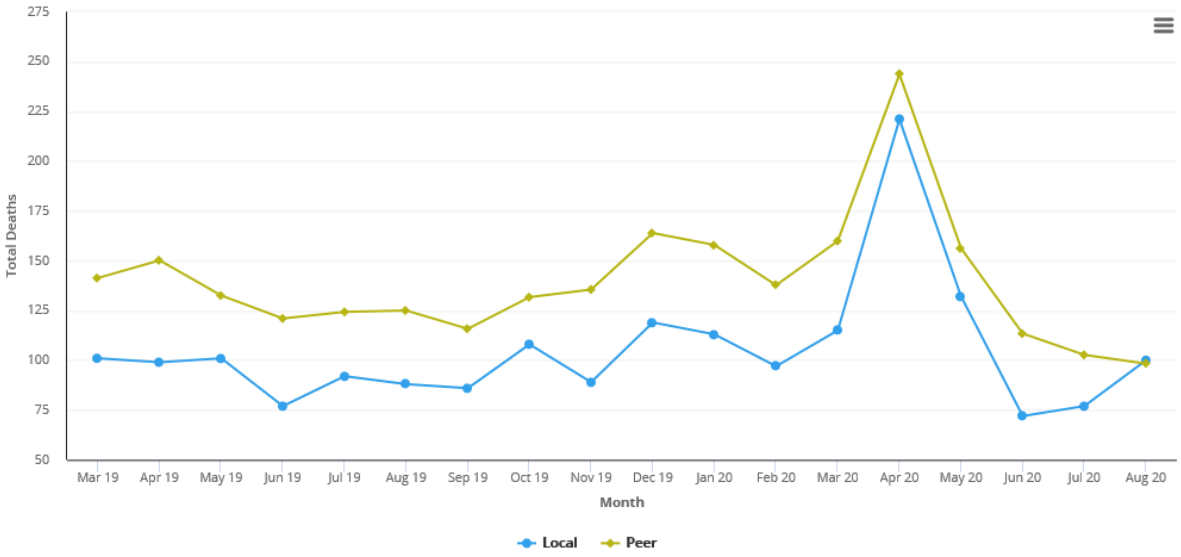
The monthly HSMR is the highest among the peer group of the most similar Trusts. Which ranges between 88.54 to our rate of 115.8. During the reporting period, the HSMR has not fallen below that of the peers. Morbidity measured by HSMR shows deteriorations in both weekday (121.3) and weekend (115.7)

Appendix 3: COVID - 19 deaths

Total deaths within the Trust increased by 28.5% for the period March 2020 – August 2020 compared with the previous year, with the number of deaths coded with confirmed COVID -19 being 228 and a further 86 with suspected within that period. The mortality rate per spell (excluding day cases) for the reporting period is 3.3%; this is almost 70% higher than the previous year.

The time series charts below show the change over time for mortality indicators. The total deaths at Bolton fluctuate on a monthly basis but had been relatively stable prior to the pandemic period with the normal cyclical increase over the winter period. The total deaths show an increase in April followed by a reduction until June 2020 when the deaths have begun to increase again.

Figure 6. Total Deaths Bolton and Peer group



Agenda Item
17

Title:	Learning From Deaths Board Report

Meeting:	Trust Board	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	✓
Exec Sponsor	Francis Andrews		Decision	

Summary:	Trusts are required to collect and publish, on a quarterly basis, specified information on deaths. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review.

Previously considered by:	Learning from Deaths and Mortality Committees

Proposed Resolution	Board are asked to discuss and approve this report

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*		*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	
*To continue to use our **resources** wisely so that we can invest in and improve our services*		*To develop **partnerships** that will improve services and support education, research and innovation*	

Prepared by:	Francis Andrews	**Presented by:**	Francis Andrews

Introduction

Trusts are required to collect and publish, on a quarterly basis, specified information on deaths. It is recommended that the information and learning points are presented to the Board of Directors. This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, we are required to provide estimates of how many deaths were judged more likely than not to have been due to problems in care, and be accompanied by relevant qualitative information and interpretation. This report covers in-patient deaths in patients age 18 and over, noting that maternal, neonatal and paediatric deaths are subject to different nationally directed processes, this information has been included in this report to give a comprehensive overview.

Challenges

Given the impact of the first and second wave of COVID-19, the biggest challenge has been to ensure the priority of the Learning From Deaths Committee (LFDC) meetings as well as having sufficient time for front-line clinicians to undertake timely reviews. As a result, there has only been four learning from deaths meetings this year in February, March, July and September and therefore quarterly board reports for April (Q4 2019-2020), July (Q1 2020-2021) and October (Q2 2020-2021) have been deferred and a single report produced to cover these periods. Monthly meetings have now been reinstated but challenges remain regarding completing reviews in the second wave.

Methodology

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

Escalation of cases

Clinical audit provide oversight for all escalations and actions are updated with feedback to the committee meetings.

Since January 2020 there have been five Standard Judgement Reviews which have been sent for Divisional Review and one Standard Judgement Review which has been sent for Scoping Review

Of those:
N=2 have a completed Divisional Review (1 still in draft)
N=3 have been acknowledged by the Division, awaiting review
N=1 has been to a Scoping Panel and declared a Divisional Review

Please note: 2 cases which required a Divisional Review prior to Quarter 4 2019-2020, have been presented at LFDC in September 2020

The points below are recent examples of learning points from the completed Divisional Review. This review was presented at the appropriate divisional governance meeting and the learning points disseminated.

- Reinforce that NEWS2/NEWS scores are escalated and documented appropriately as per RCP guidance.
- The need for education and training of staff members looking after individuals who are at risk of falls with regards to assessment and implementation of fall management plan.
- Given the CoVid19 restrictions, family members should be provided with regularly communicated by any members of the multi-disciplinary team to provide them with an update of their relatives' condition. This is especially true for patients with sensory and cognitive impairment who might struggle to keep in touch with their families remotely.
- Minimising ward transfers occurring late in the night/early hours of the morning. The majority of patients who are admitted into hospital are at risk of delirium and moving these individuals at such hours will precipitate delirium and ultimately increase the risk of falls.
- Careful interpretation of negative CoVid19 result in those who are clinically suspicious for CoVi19. Flow team should work closely with senior clinicians when moving this group of patients rather than rely solely on CoVid19 swab results.

In addition, the LFDC asks for directorates to look at more local and less serious issues where there is still learning. These are tracked for responses and evidence.

Recent examples include a patient with cirrhosis who sadly died, the learning points around decisions to escalate were taken up by the gastroenterology directorate who reviewed the case and developed an action plan.

Results

These are shown in table 1 below.

Table 1. Details of cases by source and score for Q4 2019-2020 and Q1-2020-2021

	Quarter 4			Quarter 1			Quarter 2		
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept
number of inpatient deaths	135	114	143	245	144	88	90	111	106
Number Cases (Sample)	30	11	33	55	35	21	12	23	15
Excluded due to COVID/winter Pressures	5	6	14	23	0	0	0	0	
COMPLETED	25	5	19	27	30	15	10	11	
Outstanding Cases									
Not Yet Received - Within Deadline	25	5	19	3	0	0	0	0	0
Outstanding -Surpassed Deadline	0	0	0	1	5	5	2	12	
Missing notes unable to find	0	0	0	1	0	1	0	0	
Cases requiring reallocation	0	0	0	0	0	0	0	0	
n	**25**	**5**	**19**	**5**	**5**	**6**	**2**	**12**	
Source									
Mandated Death (Alert Diagnosis)	6	3	10	3	4	2	6	3	
Unexpected Death	-	-	-	-	-	-	-	-	
LD Death	2	-	2	3	1	1	-	1	
Mental Health Death	12	7	12	22	17	10	5	9	
Random sample	8	0	9	22	12	8	-	10	
Requested by cons/matron/family	-	1	-	-	1	-	1	-	
Diabetes Death	-	-	-	-	-	-	-	-	
NELA Death	-	-	-	-	-	-	-	-	
Community Death	-	-	-	5	-	-	-	-	
Unknown	2	-	-	-	-	-	-	-	
	30	11	33	55	35	21	12	23	15
Overall Score									
1 (Very Poor)	3	0	1	0	0	0	0	0	0
2 (Poor)	2	0	3	3	5	2	1	2	
3 (Adequate)	5	2	1	9	4	3	2	3	
4 (Good)	11	2	14	11	19	7	7	3	
5 Excellent	4	1	0	4	2	3	0	2	
	25	5	19	27	30	15	10	10	0

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

Of the deaths reviewed in Q4 2019-2020 none were considered to be more than likely due to problems in care.
For Q1 2020-2021 no meetings were held and for Q2 none of the deaths were considered to be more than likely due to problems in care. However, given the impact of covid19, the number of SJRs completed was 132 (60%) of cases identified for review so this estimate is based on lower numbers.

Learning

At each LFDC and for each case where the care was judged to be poor or very poor, a secondary review is completed by the committee and learning points are collated in and disseminated via a learning presentation from clinical governance to clinical governance and quality assurance committee and the divisions for circulation. The learning presentations are distributed each month via the Better Care Together Group for cascade and distribution at ward level. Copies of the learning presentations are then made available to the organisation via the governance page on the intranet.

Further issues

The number of cases with completed reviews has fallen due to the impact of COVID-19 and 40% of SJRs for the three quarters (93 cases) remain to be reviewed. Under the direction of the chair, a decision was made during the first wave to prioritise cases, especially learning disability deaths. The committee will need to plan to deal with the backlog of reviews as this is a very substantial workload between all the reviewers. Options to be developed include the prioritisation of patients from particular risk groups and the potential to repeat a random sample across the groups.

Conclusion

The learning from deaths programme continues to evolve but the first and second wave of COVID-19 has impacted the number of committee meetings taking place and the capacity of reviewers to undertake reviews in a timely manner. All cases escalated for divisional reviews and scoping are tracked until feedback has been received. Lessons learned continue to be disseminated via learning presentations distributed by the governance team.

Recommendation

The recommendation is that Trust Board discuss and approve the contents of this paper.

Appendix 1

Maternal, still birth and neonatal deaths

Details of maternal deaths, still births, neonatal deaths and childhood deaths are given in Table 2 to provide an overall position of Trust mortality and it should be noted that these cases are subject to a separate process of investigation and reporting

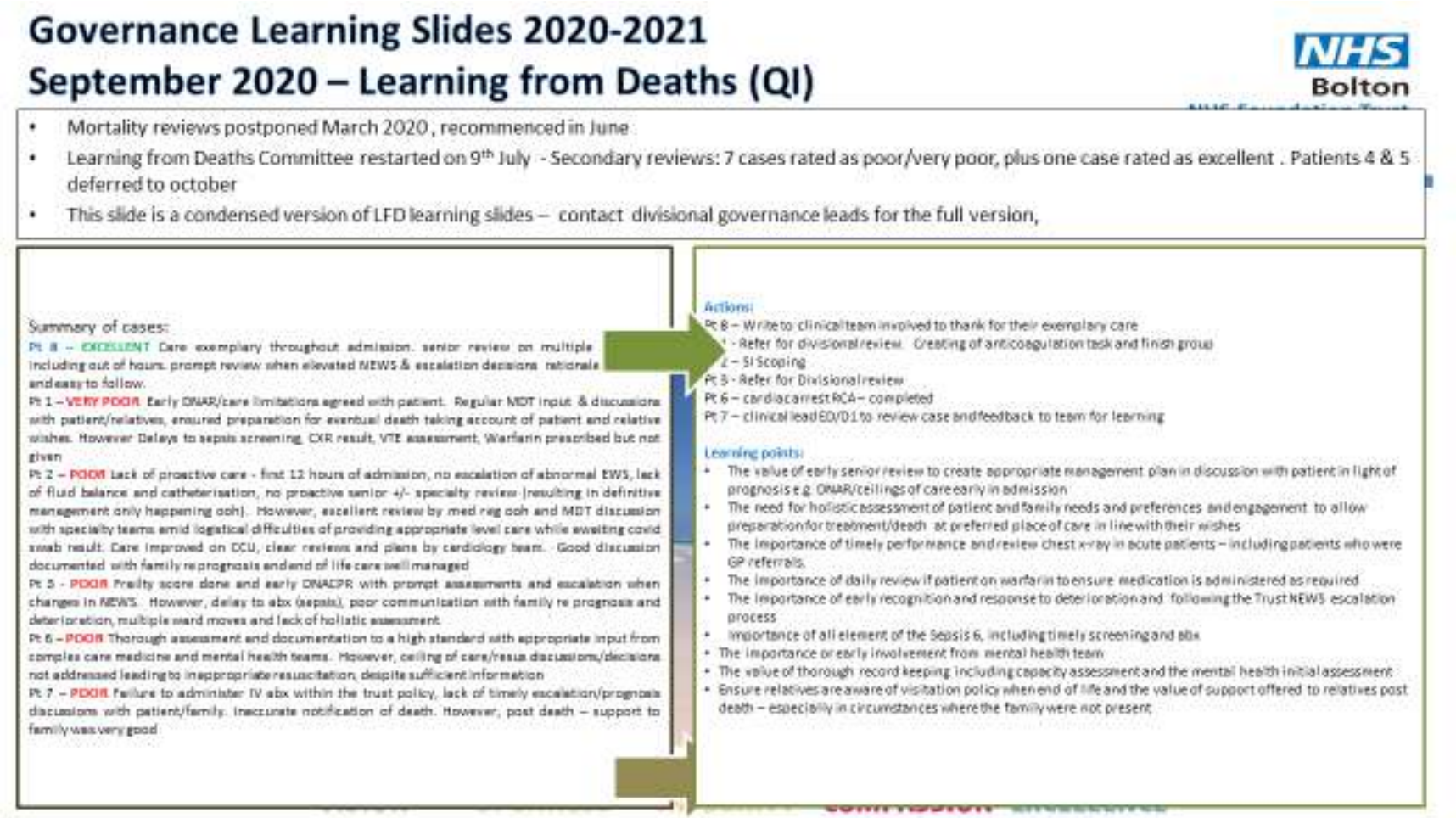
Table 2: Deaths for Q4 2019-2020 and Q1 2020-2021: Maternal, stillbirths, neonatal and childhood deaths

	Q4 Jan-March 20	Q1 April-June 20	Q2 July-Sept 20	Investigated (divisional or HSIB)
Maternal Deaths	0	0	0	0
Still births	5	9	4	5
Neonatal deaths	3	5	1	1 coroner
Child deaths (excluding stillbirth and neonatal death)	0	0	0	0

Details of stillbirths
Q4: Rapid review of all cases and all unavoidable
Q1: Rapid review of all cases, 2 had further divisional reviews and 1 referred to HSIB. All deemed unavoidable following reviews including HSIB. Some learning points identified following divisional reviews
Q2: Rapid review of all cases, 3 unavoidable, one divisional review then still under investigation by HSIB

Details of neonatal deaths
Q4: Rapid review of all cases, one divisional review, all deemed unavoidable
Q1: Rapid review of all cases, all deemed unavoidable.
Q2: Non-viable baby born at home prematurely with signs of life-rapidly died before ambulance arrived. Coroner since agreed to class as a stillbirth

Appendix 2: Governance presentation example from September 2020



Governance Learning Slides 2020-2021
September 2020 – Learning from Deaths (QI)

NHS Bolton

- Mortality reviews postponed March 2020, recommenced in June
- Learning from Deaths Committee restarted on 9th July - Secondary reviews: 7 cases rated as poor/very poor, plus one case rated as excellent . Patients 4 & 5 deferred to october
- This slide is a condensed version of LFD learning slides – contact divisional governance leads for the full version,

Summary of cases:

Pt 8 – EXCELLENT Care exemplary throughout admission. senior review on multiple including out of hours. prompt review when elevated NEWS & escalation decisions rationale and easy to follow.

Pt 1 – VERY POOR Early DNAR/care limitations agreed with patient. Regular MDT input & discussions with patient/relatives, ensured preparation for eventual death taking account of patient and relative wishes. However Delays to sepsis screening, CXR result, VTE assessment, Warfarin prescribed but not given

Pt 2 – POOR Lack of proactive care - first 12 hours of admission, no escalation of abnormal EWS, lack of fluid balance and catheterisation, no proactive senior +/- specialty review (resulting in definitive management only happening ooh). However, excellent review by med reg ooh and MDT discussion with specialty teams amid logistical difficulties of providing appropriate level care while awaiting covid swab result. Care improved on CCU, clear reviews and plans by cardiology team. Good discussion documented with family re prognosis and end of life care well managed

Pt 3 - POOR Frailty score done and early DNACPR with prompt assessments and escalation when changes in NEWS. However, delay to abx (sepsis), poor communication with family re prognosis and deterioration, multiple ward moves and lack of holistic assessment.

Pt 6 – POOR Thorough assessment and documentation to a high standard with appropriate input from complex care medicine and mental health teams. However, ceiling of care/resus discussions/decisions not addressed leading to inappropriate resuscitation, despite sufficient information

Pt 7 – POOR Failure to administer IV abx within the trust policy, lack of timely escalation/prognosis discussions with patient/family. Inaccurate notification of death. However, post death – support to family was very good

Actions:

Pt 8 – Write to clinical team involved to thank for their exemplary care
[illegible] - Refer for divisional review. Creating of anticoagulation task and finish group
[illegible] – SI Scoping
Pt 3 - Refer for Divisional review
Pt 6 – cardiac arrest RCA – completed
Pt 7 – clinical lead ED/D1 to review case and feedback to team for learning

Learning points:

- The value of early senior review to create appropriate management plan in discussion with patient in light of prognosis e.g. DNAR/ceilings of care early in admission
- The need for holistic assessment of patient and family needs and preferences and engagement to allow preparation for treatment/death at preferred place of care in line with their wishes
- The importance of timely performance and review chest x-ray in acute patients – including patients who were GP referrals.
- The importance of daily review if patient on warfarin to ensure medication is administered as required
- The importance of early recognition and response to deterioration and following the Trust NEWS escalation process
- Importance of all element of the Sepsis 6, including timely screening and abx
- The importance or early involvement from mental health team
- The value of thorough record keeping including capacity assessment and the mental health initial assessment
- Ensure relatives are aware of visitation policy when end of life and the value of support offered to relatives post death – especially in circumstances where the family were not present

Agenda Item

Title:	Annual Strategy Review 2020

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	26 November		Discussion	
Exec Sponsor	Sharon Martin		Decision	o

Summary:	In ***Our 2019-24 Strategy…for a better Bolton***, the Trust committed to conducting an annual review of progress against the six strategic ambitions and associated objectives. This document describes achievements in 2019-20, 2020-21 and priorities for 2021-22. It includes an updated *Strategy into Action* section which details progress against objectives and highlights any changes in their timescales for delivery. The review is informed by extensive consultation with staff and Foundation Trust members (results presented to the Board in October). It is proposed that this document is circulated to staff, made available on the Trust website and shared with key stakeholder.

Previously considered by:	Executive Team

Proposed Resolution	The Board is asked to provide comments on the draft and – subject to any suggested changes - approve for publication.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Rachel Noble, Deputy Director of Strategy	**Presented by:**	Sharon Martin, Director of Strategy & Transformation

Annual Strategy Review 2020

Strategy review: 2020

Introduction

In our ***2019-24 strategy…for a better Bolton***, we committed to conducting an annual review of progress against our six strategic ambitions and objectives. This is for three simple reasons:

- To ensure that our ambitions remain the right areas of focus
- To check our progress against our strategic objectives
- To make any necessary changes to the strategy

Our five-year strategy describes our collective vision and ambitions for Bolton NHS FT and is the roadmap to achieving our aspirations. As we all play a part in achieving our priorities, it is essential that we make time annually to review our approach, assess our progress and change direction as necessary.

Review process and summary of feedback

Our strategy was created with input from our staff, the public and our key stakeholders and our annual review document has been developed in exactly the same way. We are grateful to the hundreds of staff and members who provided feedback through the online strategy survey, through their divisional meetings or during one of four Trust-wide virtual sessions. The terms of the review were simple: we sought feedback from our staff and members on whether our ambitions and objectives remained the right areas of focus and invited respondents to suggest amendments. In total, we received 158 survey responses from staff and 7 from members. The results demonstrated that:

- 92% agreed or strongly agreed that our ambitions remained the right areas of focus
- 90% agreed or strongly agreed that our objectives remained the right targets

In addition to this endorsement of our priorities, we received constructive feedback and suggested additions, all of which have been discussed and many of which are reflected in this review document.

Reviewing our strategic objectives

In addition to seeking feedback, the Strategy team conducted an in-depth review of progress against our 5-year strategic objectives as outlined in the *Strategy into Action* which has been presented to staff, governors and the Board. This review demonstrated that, despite the challenges of 2020-21, exceptional progress has been made on a number of our objectives, whereas others have rightly been de-prioritised to support our response to the pandemic. We are confident that none of the delayed objectives will have a fundamental impact to the achievability of our 5-year ambitions, but it is clear that we must remain ready to adapt our activities in the short-term based on the circumstances we find ourselves in. As this review exercise will be repeated annually, we will have future opportunities to make more significant changes to the strategy, should we require them.

Strategy into Action

Based on feedback and our review of objectives, we have included a revised *Strategy into Action* at Appendix A of this document. Each objective now includes a status report and is categorised in a way that demonstrates progress and reflects any changes made, which was a request made by a number of survey respondents:

- **Completed** – an objective from the 2019-24 strategy that has been completed
- **On track** – an objective from the 2019-24 strategy that is unchanged and progressing on schedule

- **New deadline** – an objective from the 2019-24 strategy where timescales have been amended
- **On hold** – an objective from the 2019-24 strategy that is on hold without an agreed timescale for reinstatement at the time of writing
- **Amended** – an objective from the 2019-24 strategy where the wording has been changed (deleted text is indicated with text strike-through)
- **New** – an entirely new objective that was not included in the 2019-24 strategy

The *Strategy into Action* and the objectives described there will be used to inform divisional delivery plans over the next financial year to support our strategic progress.

Our ambitions

The chapters that follow describe the progress made against each of our six ambitions in 2019-20 and 2020-21 and highlight the key priorities that we will focus on in 2021-22. The detailed strategic objectives for each ambition and their timescales for delivery can be found at Appendix A.

Ambition 1: Provide safe, high quality care

Safety has always been our number one priority, and this has taken on new meaning in 2020. More than ever, our staff have worked tirelessly to provide the highest levels of safety and the best standard of care in operationally and, at times, emotionally challenging circumstances. We are immensely proud of how our staff have adapted to working in new ways, always with an enthusiasm to overcome obstacles in pursuit of one goal: to care for our patients with compassion.

It is impossible to list all of the many achievements we have seen this year that support the achievement of this ambition, but it is right that we highlight some:

- Maintenance of our elective surgical programme and haematology services in partnership with BMI Beaumont
- Provision of 24hr COVID-19 testing
- Provision of safe, supportive maternity and paediatric services
- Introduction of virtual outpatient services
- Development of innovative models of care including a drive-through glaucoma testing service
- Development of a community referral hub
- Implementation of remote monitoring in care homes
- Delivery of a number of successful capital bids and estates developments, including progress on Same Day Emergency Care (SDEC) facilities
- Maintenance of safe staffing levels and redeployment of staff to support the response to the pandemic
- Introduction of daily communications to ensure access to the most up-to-date information for all staff
- EPR and Windows 10 roll-out
- Delivery of new PANTHER pathology platform

Focus for 2021-22 and changes to the Strategy into Action

Access to services

When we wrote our strategy, we were operating in a very different landscape. NHS performance metrics have shifted to accommodate growing waiting lists and the step-down of the majority of elective services earlier this year has had a profound impact on time-to-treatment in a number of high-demand specialties in Bolton and across Greater Manchester. Our commitment to maintaining and improving access to safe services is, therefore, our highest priority for the coming year and will continue apace under the leadership of our Bronze, Silver and Gold command teams.

Adapting our estate

Linked to Ambition 4, we will continue to adapt our estate to provide safe, socially-distanced environments for patients and staff. Work will continue on SDEC and critical care/HDU, and improvements will be made to our community buildings. Using the learning from the recent health planning exercise, we will continue to improve the utilisation of our hospital and community estate to deliver the clinical space we need.

COVID-19 aftercare and population health

We know that recovery from COVID-19 is not a straightforward process for everyone. Over the coming year, expanding our offer to provide much-needed aftercare in hospital and in the community will be of critical importance. Linked to Ambition 5, we will work with our local authority colleagues on a public health framework to support people to stay well.

Quality Improvement, National Patient Safety Strategy and GIRFT

We will continue to drive our quality, safety and improvement agenda under the auspices of our new QI Strategy, developing our approach to Human Factors and making best use of data to improve what we do.

Ambition 2: To be a great place to work

As described in ***Our Strategy…for a better Bolton,*** our staff are our greatest asset, a fact that has been proven time and again over the past 12 months: we have so many reasons to be proud of our incredible team. We remain more committed than ever to providing an environment in which our staff can flourish and achieve their potential, but we acknowledge that 2020 has – at times – been more about surviving than thriving. Despite this, we have achieved some great things:

- At the peak of the first wave of the pandemic, we achieved the lowest rates of absence of any Trust in Greater Manchester: a demonstration of our team's commitment to serving our community – and each other - safely
- We have reviewed our Trust values and launched a new set of supporting behaviours
- A number of programmes including reverse mentoring, the BAME Leadership Forum and the Quality Improvement Apprenticeship Programme have commenced
- New wellbeing apps and coaching support have been made available to support staff wellbeing

Focus for 2021-22 and changes to the Strategy into Action

Staff wellbeing

More than ever, our individual wellbeing is of critical importance and it is vital that we work together to maintain our collective resilience. The *Strategy into Action* now reflects our ongoing commitment to providing staff with access to wellbeing support services to ensure that everyone is able to get help and support when they need it.

Thanks to the magnificent fundraising efforts of Sir Captain Tom Moore earlier in 2020, Bolton NHS FT has – to date – received £180,000 to invest in schemes that will support staff and patients through the pandemic. For staff, this generous donation has facilitated investment in the sports and social club, the provision of new shower facilities and the installation of cycle racks, with further investment in additional wellbeing and rest facilities for staff planned for the coming months.

The People Plan

The NHS has launched its people strategy which describes the aspirations for our collective workforce. The Plan sets new targets for Trusts and – over the coming 12 months – we will be working on their implementation to ensure that we provide the right conditions for all staff to succeed.

Infrastructure

Wellbeing is not just about how we look after ourselves, but is linked to the resources we have to enable us to complete our work. Through the strategy survey, we received feedback that estate, environment, connectivity and equipment have a huge impact on wellbeing, particularly where staff feel that improvements are required. Over the past three months, we have worked with our clinical divisions on a health planning exercise and are currently expanding the space available for a number of clinical areas to ensure that they can meet new safety requirements whilst delivering the volume of activity our population requires. Under the auspices of our forthcoming Digital Strategy, we will work hard to improve connectivity across our sites to make it easier to deliver services virtually.

Agile working

The pandemic has prompted us to think differently about how we work and we have created an Agile Working Group to maximise this transformational opportunity. The concept of agile working relies on focusing on the activity of work, rather than being defined by the environment in which the work takes place. This project has the potential to transform how we work and use our estate in the future.

Ambition 3: To use our resources wisely

The NHS financial landscape remains challenged as a result of the pandemic, but our approach has always been to act as careful stewards of public money and make sound investments in our services.

Despite the myriad unanticipated costs of 2020, we approach the end of the financial year in a stable financial position. This is not an opportunity for us to rest on our laurels: we know that our economic environment will be challenged for some years to come, thus we are committed to working with our partners within Bolton and across Greater Manchester to identify opportunities to make system savings without compromising the quality of service we provide.

Focus for 2021-22 and changes to the Strategy into Action

Cost Improvement Programme

Our Cost Improvement Programme continues to yield savings not only within the Trust but across the Bolton system. Work will continue through 2021-22 to identify further opportunities and will be conducted alongside service transformation workshops.

Model Hospital

The Model Hospital portal provides information which enables us to identify potential areas for further improvements and cost-savings based on comparative data from our peers. The programme will continue in the new financial year to implement further opportunities.

System architecture changes

The pandemic has provided opportunities for closer-working across integrated care systems and greater collaboration to identify solutions to our shared problems. Nationally, the NHS policy direction points to the need for a revised approach to commissioning to ensure that it remains agile in the face of changing demands. Bolton has an excellent track record of collaboration across acute, community, local authority and commissioning, and we will continue to work together to provide the right care in the right place at the right time for the benefit of our population.

Productivity improvements

Our five-year strategy describes a number of priority programmes to support an improvement in our operational productivity by 2024, including delivering an improvement in theatre utilisation, reducing the volume of face-to-face outpatient appointments and reducing length of stay. Whilst these programmes have shifted in scope, our present circumstances and swift implementation of new technologies have led to rapid progress on our ambitions for outpatient services. As we move forward, we will implement learning from our theatre transformation programme to ensure optimum utilisation and therefore provide maximum safe capacity as surgical services are reset. As a result of current circumstances, we have postponed our length of stay reduction programme for the time being.

Benefits realisation and business case process

In order to ensure that our investments are delivering value for money, we have begun a process of reviewing the benefits identified in high-value business cases to ensure that we have fully realised the financial, quality and efficiency benefits outlined in those cases. Where benefits have a significant impact and

are yet to be fully realised, work will be undertaken to progress their achievement. Starting with reviews of EPR, Malinko and unified communications, we are hopeful that – not only will this review deliver further savings – it will also provide opportunities for staff to gain more expertise in the fantastic technologies that has been implemented across the Trust in recent years.

Alongside this, work on a revised, simplified business case process will be completed.

Ambition 4: To develop an estate that is fit for the future

Our ambition for our estate is to design for the future, but the events of 2020 have resulted in a sharp focus on the here-and-now. Over the past nine months, our hospital and community estate has had to adapt to new challenges, changing safety requirements and, as we approach winter, to cope with unprecedented demand.

To facilitate our response to the pandemic, we acted quickly to reconfigure aspects of our estate in a way that enabled us to deliver safely. Alongside this, upgrades to our critical care and high dependency units, increased oxygen capacity, the commencement of improvements to Darley Court in the community, the development of Same Day Emergency Care (SDEC) facilities, and the creation of additional side room capacity have all been critical steps forward to provide the right environments for our patients and our staff.

Our workforce has played a significant role in easing some of the limitations of our estate, and we are grateful to those services, teams and staff members who have adapted to working in new locations and in new ways to provide space for additional capacity on the main hospital site. We know that these changes have not always been easy and we are grateful to everyone who has relocated to support the response.

All of this has clearly demonstrated that our strategic ambition to deliver a future-proofed estate is the right one, and 2021-22 will see us take a step forward in realising the potential that exists within our estate.

Focus for 2021-22 and changes to the Strategy into Action

Health Infrastructure Plan bid

The size and opportunity within our estate is considerable and, in 2020, we engaged a team of health planning experts to help us determine the future requirements of our Women & Children's services, and to support us in identifying additional capacity for high-demand clinical services during the pandemic. This planning exercise has provided us with the information we need to prepare a bid for investment through the Government's Health Infrastructure Plan (HIP) in early 2021.

Our bid, which will be developed over the coming months with input from our clinical and operational teams, will describe the vision for a £100m+ investment in a new flagship build on the Royal Bolton site and – if successful - will enable us to take a significant step towards the transformation of our ageing estate. We will work with our local authority and GM partners to develop a compelling case that describes the necessity for investment in our site and the benefits this will yield for our population.

Community estate

Our community estate faces some challenges, particularly regarding connectivity. Through the health planning exercise and the development of the Digital Strategy, remedial action taken to improve WiFi access across the community estate, providing staff with the infrastructure they need to deliver services in new ways.

Optimal estates utilisation

Linked to Ambition 2, the Agile working programme will be closely-linked to our developing estates strategy and will inform plans for the future of our accommodation. We will look to learn from innovative organisations who have already implemented an agile approach to enable us to make best use of the estate we have, whilst on the longer-term journey of estates transformation. We will also continue to pursue the development of an onsite medical sciences facility to train the next generation of staff.

Car parking

Our plans to improve car parking will continue over the next financial year to ensure that we provide adequate space for our patients, our service users and our staff.

Ambition 5: To integrate care

The future of our services lies in integration and the underpinning objectives for this ambition are some of the most important targets for Bolton NHS FT and our Integrated Care Partnership (ICP). In our five-year strategy, we committed to supporting local people to enjoy the best of health, to deliver services over a wider number of settings to target inequalities, and to progress the development of our ICP to ensure we have the ability to affect meaningful, positive change for our population.

In light of the challenges of 2020, we can be rightly proud of the progress made on integration across Bolton prior to the onset of the pandemic. It has enabled us to work seamlessly across the acute and community settings to provide care in the right place, and to get people home from hospital or into intermediate care as soon as they are able. This has been invaluable in enabling us to maintain flow through the hospital at times of high demand and provides a better experience for our population.

The provision of care through our nine neighbourhood teams will continue to facilitate partnership-working with residents to help them build strong, connected and engaged communities. By wrapping services around people in their own communities, we will help them to stay well, connected and at home for as long as they are able, as well as reducing the demands on our hospital.

Focus for 2021-22 and changes to the Strategy into Action

Delivering more care in the community and focusing on 'Home First'

Protecting hospital capacity to provide acute care has never been more important, and over the coming year, we will continue to expand the services we provide in the community and through virtual follow-up to avoid people having to make unnecessary trips to hospital. We will continue to focus on the needs of our community, and design services that are accessible and meet the requirements of the people we serve.

For people who are admitted to hospital, our clinical teams will continue to roll-out the 'Home First' model, which seeks to minimise delays to discharge, benefitting both individual and hospital-system alike.

Clinical pathways – frailty and elderly mental illness

Over the past 12 months, our clinical teams have made significant strides in the continued development and implementation of pathways to support people with frailty and those who present with elderly mental illness or cognitive impairment. Caring for our patients with dignity, compassion and in a way that delivers the best outcomes will be a continued focus for 2021-22. In addition to the recent investment in additional frailty consultants, our Admiral Nurse has recently won the Best Dementia Care Practitioner 2020 award at the National Dementia Care Awards, placing us in an excellent position to continue to provide an outstanding service to our frail and elderly patients.

Service reviews and commissioning models

In partnership with the CCG, we will continue the process of reviewing service specifications and commissioning models to ensure that we have appropriate contractual arrangements in place for all of our community services.

Technology to support wellbeing

Linked to Ambition 1, we have introduced a suite of wellbeing apps in partnership with ORCHA, the world's leading health app evaluation organisation. This development will support people to manage their conditions between clinical appointments using evidence-based applications to guide them. This

investment was made possible by the generous donations made to Sir Captain Tom Moore's fundraising efforts earlier in 2020.

Ambition 6: To develop partnerships

Our aspiration has always been to look beyond our boundaries and work with passionate, creative, expert partners to deliver the fully-integrated health and care services that we aspire to provide. Alongside this, we know that joint-working with our partners across the system has the potential to provide the resilience and capacity to meet our population's needs.

We note in our five-year strategy that, 'to meet increasing demand, we need to create more sustainable services…and work collaboratively with our partners across Greater Manchester.' We could not have predicted the extent to which we would collaborate with our NHS and private sector partners in 2020, but this partnership-working will continue to shape our experience over the coming years as we work collectively to provide safe, resilient services and equity of access to care to the population of Greater Manchester. More than ever, delivery across the system depends on the resilience of individual providers.

Focus for 2021-22 and changes to the Strategy into Action

A focus on Bolton

We have excellent and well-established relationships with our local authority, commissioning, academic, and community and voluntary sector colleagues, and over the coming years, we will continue to work together to realise our collective aspirations for the people of Bolton as described in the *Vision 2030* plan.

In the short term, our collective efforts will focus on opportunities to reduce system financial pressures and to work together to support our community through the impacts of the pandemic.

A focus on Greater Manchester

At the time of writing, we remain in Command and Control at a GM-level, which means that all 10 acute Trusts are working collaboratively on the response to the pandemic. The GM system has a number of high-priority objectives that Bolton will contribute to over the coming months, including the identification and development of 'green' sites where COVID-secure treatment can be provided. This will include the provision of some cancer services and services where a significant GM-wide backlog has accumulated.

Sector Surgical Transformation

As part of the *Healthier Together* programme, Salford Royal NHS FT has received confirmation of investment into the construction of an Acute Receiving Centre (ARC) which will provide high-risk surgical services for the North West Sector of Greater Manchester. Alongside this, Bolton NHS FT and Wrightington, Wigan & Leigh NHS FT will receive funding to invest in our Surgical Ambulatory Care Units to support delivery across the sector. We expect to see further progress over the coming 12 months, and will work closely with our Anaesthetics & Surgical Services division under the leadership of the Medical Director.

Research and development

Our clinical research teams have embraced the challenge of improving our understanding of the impacts of COVID-19, and will continue to participate in national programmes focused on understanding risk factors and efficacy of treatment to improve the care we provide.

Resilient clinical support services

We continue to seek opportunities to improve the resilience of our clinical support services, for which demand is growing year-on-year. Our review of laboratory services will continue and we will work to identify opportunities to utilise new technologies to improve our Radiology reporting capacity, alongside the implementation of the new GM-wide Picture Archiving and Communication System (PACS).

Appendix A: Strategy into Action

The *Strategy into Action* describes our strategic objectives and their timescales for delivery which will support the achievement of each of our six ambitions. It builds on the version published in our 2019-24 strategy and describes progress, changes made and the outcomes we expect to achieve.

Ambition	Programme	Year 1 (2019/20)	Year 2 (2020/21)	Year 3 (2021/22)	Year 4 (2022/23)	Year 5 (2023/24)	KPI achieved by 2024
Ambition 1 **To provide safe, high quality care**	**ON TRACK:** Develop, implement and deliver the plan for Outpatient Transformation programme with the aspiration of reducing outpatient appointments by 33% by 2024	✓	✓	✓	✓	✓	Outpatient appointments reduced by 33%
	NEW: Establish and deliver a Reset programme which supports the Trust's recovery from the impacts of COVID-19		✓	✓	✓	✓	Restoration of services in line with or exceeding national targets
	ON TRACK: Develop and implement programmes of continuous quality improvement focused on: • Improving mortality • Preventing harm • Enhancing patient/carer experience	✓	✓	✓	✓	✓	BFT rated 'outstanding' by CQC for safe care In top 10% of Trusts for safety and patient experience We will be one of the top 10% of hospitals for mortality and avoidable harm

	COMPLETED: Select and train divisional quality improvement experts	✓	✓				All staff are trained in QI techniques
	ON TRACK: All new staff to receive QI training as part of the induction programme		✓	✓	✓	✓	
	ON TRACK: QI training rolled out to all staff			✓	✓	✓	
	ON TRACK: Getting it Right First Time (GIRFT) plans in place for all relevant specialties and included in regular performance reporting	✓	✓	✓	✓	✓	All GIRFT-reviewed specialties have implemented all appropriate GIRFT recommendations
	ON TRACK: Launch phase 1 of the Electronic Patient Record	✓	✓	✓	✓	✓	All patient records are available electronically by 2024
	ON TRACK: Review and transformation of clinical pathways		✓	✓	✓	✓	All specialties have a five year vision and an action plan for transformation
	NEW DEADLINE: Full implementation of 'Making Every Contact Count' (MECC)			✓	✓		All specialties receive training in the delivery of MECC
	ON TRACK: Enable patient and carer access to health records			✓	✓	✓	100% of patients and carers have access to records

	ON TRACK: Review and implement technologies to support patients in self-management (in line with the Outpatient Transformation Programme). **NEW:** Introduction of ORCHA		✓	✓	✓	✓	100% patients receive advice on technologies that can support them in management of their condition
	ON TRACK: Implement all recommendations from Better Births			✓	✓		Bolton FT is fully compliant with Better Births recommendations
	AMENDED: Implement the Long Term Plan recommendations for Urgent Care and Cancer and participate in GM recovery actions regarding the delivery of cancer services	✓	✓	✓	✓	✓	Bolton FT delivering LTP recommendations for Urgent Care and Cancer, and delivering equity of access to services across GM
Ambition 2 **To be a great place to work**	**NEW:** Support the delivery of the NHS People Plan by implementing local recommendations	✓	✓				Maintain our 'outstanding' rating for 'Well led' services from CQC To be in the top 20% of NHS organisations for staff engagement as measured by the NHS staff survey
	COMPLETED: Launch BAME Leadership programme		✓				
	NEW: Establish Agile Working programme		✓				
	COMPLETED: Review Trust values and introduce a new set of behaviours to support the appraisal process		✓	✓			
	NEW DEADLINE: Develop a talent and succession planning programme to identify future leaders			✓	✓		

	AMENDED: Implement health and wellbeing measures to and ensure that we support staff to stay healthy and well and that sickness levels are below 4.2% by 2024		✓	✓	✓	✓	
	ON TRACK: Continue to achieve the Workforce Racial Equality Standard	✓	✓	✓	✓	✓	
	ON TRACK: Continue to achieve the Workforce Disability Equality Standard	✓	✓	✓	✓	✓	
	NEW DEADLINE: Extend the use of job plans to all staff who manage patient caseloads			✓	✓		
	NEW DEADLINE: Provide a suite of multi-disciplinary clinical skills training				✓		
	NEW DEADLINE: Expand and develop the apprentice workforce	✓	✓	✓	✓	✓	
	ON TRACK: Maintain and improve the quality and compliance levels of appraisal, mandatory and statutory training	✓	✓	✓	✓	✓	
Ambition 3 **To use our resources wisely**	**NEW:** Deliver a financial break even position		✓				Trust break even delivered in 2020-21
	NEW DEADLINE: Annual divisional 'strategy into action' dashboards introduced and agreed		✓	✓	✓	✓	To be rated 'outstanding' by CQC for use of resources
	ON HOLD: Publish the Commercial Strategy and pursue identified commercial opportunities	✓	✓				BFT generating annual revenue from sale of Digital Services

	NEW DEADLINE: Review of clerical pathways			✓	✓	✓	New technologies in place to support the delivery of clerical services
	ON HOLD: Annual review of service level agreements	✓	✓	✓	✓	✓	100% of SLAs will be reviewed and refreshed as required
	NEW DEADLINE: Capital Plan fully aligned to Estates Master Plan			✓	✓	✓	Capital Plan is informed by the plan for the development of BFT's estate
	NEW DEADLINE: Review of job plans			✓	✓	✓	100% of medical workforce have received a review of the job plan
	ON TRACK: Ongoing review and implementation of Model Hospital opportunities	✓	✓	✓	✓	✓	BFT to enter the top 20% of Trusts for total costs per weighted average unit of activity on the Model Hospital portal
	NEW DEADLINE: New business case process agreed and implemented			✓			All new business cases to follow the new process
	NEW: Explore opportunities to invest in new technologies to support transformation and deliver efficiencies			✓			Implementation of Attend Anywhere and development of virtual hubs

	AMENDED: ~~Negotiation and agreement on gain share with the CCG~~ Contribute to the development of a revised financial regime for GM			✓			To support the delivery of system financial changes
	ON HOLD: Length of stay programme to commence	✓					Average length of stay reduced by 5%
	NEW: Undertake a programme to identify and realise benefits outlined in past high-value business cases		✓	✓			Financial and productivity benefits realised and reported on
Ambition 4 **Sustainable estate**	**NEW DEADLINE:** Board to approve the Estates Master Plan for Bolton FT		✓	✓			Master Plan published and development programme in place
	NEW DEADLINE: Bolton College of Medical Sciences development			✓	✓	✓	College open
	NEW: Complete estates work on: Critical Care/HDU: enhanced side room capacity; delivery of Same Day Emergency Care; installation of new vacuum insulated evaporator (VIE) for bulk oxygen storage		✓				Our estate will support the safe and resilient delivery of services
	NEW: Develop a visionary bid for funding from the national Hospital Investment Programme with our partners across Bolton		✓	✓			To provide a hospital estate that is fit for the future
	NEW: Undertake a health planning exercise to define future requirements for our women & children's estate	✓	✓				
	NEW: Undertake a health planning exercise to improve estates utilisation in response to COVID-19, focusing on		✓				

	outpatients, ophthalmology, community, and virtual appointment hubs						
Ambition 5 **To integrate care**	**ON TRACK:** Technologies for community services fully rolled-out. Technologies will also be refined and developed, and reviewed annually to ensure their impact		✓	✓	✓		All our community services have access to developed technologies
	NEW: To improve connectivity across our community and hospital estate		✓	✓			Improved network availability to support the delivery of virtual consultations
	ON TRACK: Roll-out of EPR/shared care record to local health communities			✓	✓	✓	All local providers able to share patient records
	ON TRACK: Full roll-out of streaming and 'home first' model in A&E	✓	✓				All patients to be streamed in A&E
	NEW DEADLINE: Publish the Digital Strategy		✓				Document published
	NEW DEADLINE: Publish the Communications and Engagement Strategy			✓			Document published
	ON TRACK: Neighbourhood model and public sector reforms fully aligned. Vertical integration for the development of services	✓	✓	✓	✓	✓	Development and implementation of a new clinical model
Ambition 6 **To develop partnerships to**	**ON HOLD:** Implement the recommendations of the Greater Manchester Improving Specialist Care programme	✓	✓				BFT delivering specialist services as determined by

improve services							Greater Manchester
	AMENDED: Work with our health partners across GM to provide resilient services and equity of access to care	✓	✓	✓	✓	✓	BFT contributes to the equitable delivery of services across GM
	NEW DEADLINE: Research and development strategy to be published	✓					Document published
	NEW: To identify opportunities to partner with local Trusts to improve service delivery		✓	✓			

Agenda Item 19

Title:	Audit Committee Chair Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	
Exec Sponsor:	A Walker		Decision	

Summary:	The attached Chair reports are from the Audit Committee meetings held on 8 October and 24 November.

Previously considered by:	Audit Committee.

Proposed Resolution	The Board are asked to note the report.

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	A Walker	**Presented by:**	A Stuttard

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	8th October 2020	Date of next meeting:	24th November 2020
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Bilkis Ismail, Martin North, Malcolm Brown *In attendance:* Annette Walker, Esther Steel, Andy Chilton, Catherine Hulme, Lesley Wallace, Richard Sachs, Collette Ryan, Alan Stuttard, Karen Finlayson (PwC, Othmane Rezgui (PwC), Ibby Ismail (Shadow NED)	Quorate (Yes/No):	Yes
		Key Members not present:	Tim Cutler (KPMG), Chris Paisley (KPMG)

Key Agenda Items:	RAG	Key Points	Action/ decision
Internal Audit Progress Report		The Committee received and noted an update on activities undertaken during the year to date including progress against the Plan and a KPI report which had been produced in line with the agreed protocol.	For noting.
Internal Audit Reports		The following Internal Audit reports were received and noted: • iFM Bolton - Enterprise Asset Management (EAM) - advisory • iFM Bolton – Medical Devices Asset Maintenance - medium risk • Non-financial Performance Reporting/Data Quality - low risk • Workforce OD: Recruitment and Sickness Absence - low risk • Freedom to Speak Up (FTSU) - low risk	For noting.
Local Counter Fraud Specialist Progress Report		The Committee received the latest report which outlined the activities undertaken by the Local Counter Fraud Specialist from May to September 2020. The annual counter fraud survey of staff is currently being undertaken, the results of which will be presented to November's meeting.	For noting.

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

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

Committee/Group Chair's Report

Risk Management Policy	N/A	The Committee received the Risk Management Policy which defines the processes that will promote and embed an integrated and consistent approach across all parts of the organisation to managing risk. The policy has been reviewed and updated to ensure it is aligned with the new Risk Management Strategy.	The Committee noted its own responsibilities in regard to the Policy.
Review of Audit Committee Effectiveness		It is good practice to undertake a regular review of the Audit Committee's effectiveness. In this regard a questionnaire is to be circulated to Committee Members and attendees for completion. An update will be provided in November.	For noting.
Register of Interests, Gifts and Hospitality		The Committee received the full Register of Interests, Gifts and Hospitality for review. Work is being undertaken with Internal Audit in relation to the Register as part of a Governance review. ES noted there is still some work to do to encourage reporting.	The full register for both the FT and iFM will be presented to the Committee in March 2021.
Register of Waivers	N/A	The Committee received and noted the Register of Waivers for both Bolton FT and iFM Bolton. Work is being undertaken with the Procurement Team on how to support the organisation to ensure there is a reduction in waivers and that we are SFI compliant. Some waivers were required due to Covid but there is to be additional focus in this area across the organisation.	For noting.
Losses and Special Payments Reports – Bolton FT	N/A	Report noted.	For noting.
Losses and Special Payments Reports – iFM Bolton	N/A	No losses within the reporting period.	For noting.

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

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

Committee/Group Chair's Report

(Version 2.0 August 2018, Review: July 2020)

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	24th November 2020	Date of next meeting:	2nd March 2021
Chair:	Alan Stuttard	Parent Committee:	Board of Directors
Members Present:	Martin North, Bilkis Ismail, Malcolm Brown *In attendance:* Annette Walker, Andy Chilton, Lesley Wallace, Catherine Hulme, Esther Steel, Richard Sachs, Ibby Ismail, Collette Ryan, Karen Finlayson (PwC), Othmane Rezgui (PwC), Chris Paisley (KPMG)	Quorate (Yes/No):	Yes
		Key Members not present:	Tim Cutler (KPMG)

Key Agenda Items:	RAG	Key Points	Action/decision
Health Technical Update	N/A	KPMG provided their Technical Update for the Committee. Particular attention was drawn to the new requirements for value for money reporting. This places a significantly increased requirement on the Trust to provide evidence covering three criteria namely Financial Sustainability, Governance and Improving Economy, Efficiency and Effectiveness. The External Auditors are required to provide a public facing commentary which will be published at the same time as the Annual Report and Accounts.	To note.

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

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

Committee/Group Chair's Report

Internal Audit Progress Report		PwC presented the Internal Audit Progress Report. Since the last Audit Committee the following activities have been performed: • Completed planning/scoping meetings for four reviews • Issued three Terms of References • One internal audit review has been completed with a final report issued in the period • Continued to progress the fieldwork for three reviews • A further internal audit review is planned to commence during December 2020 However it was noted by the Committee that as a consequence of the restrictions arising from the impact of Covid-19 there was a risk that some elements of the Internal Audit Programme might not be completed. PwC advised that they would be in regular contact with the Director of Finance and Director of Corporate Governance over the coming months to take account of any impact. PwC indicated that they felt the Trust was in a much stronger position this year for the audits to be completed.	To note.
Internal Audit Reports		There was one Internal Audit Report that had been completed relating to conflicts of interest which had been reported as a medium risk. The Director of Corporate Governance, in response, provided an update on the actions that had been agreed from the report.	To note.
Local Counter Fraud Specialist Progress Report		The Local Counter Fraud Specialist (LCFS) gave an update on the work undertaken since the last Committee. The LCFS reported on the outcome from the Annual Fraud Survey. There was a very positive response from over 700 staff within the Trust. In addition the LCFS gave an update on a number of investigations mainly relating to concerns about staff working while off sick.	To note.

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

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

Committee/Group Chair's Report

Updated Standing Orders and Matters Reserved for the Board	N/A	The Director of Corporate Governance presented the updated Standing Orders for consideration by the Audit Committee. There were a small number minor changes to the previous version and the Audit Committee recommended the Standing Orders for approval by the Board.	For approval.
Updated Standing Financial Instructions and Scheme of Delegation	N/A	The Director of Finance presented the updated Standing Financial Instructions and Financial Scheme of Delegation for consideration by the Audit Committee. A number of changes had been made to the previous version particularly aimed at making them easier to understand and user friendly. There were a few further updates to be made to the final version for consideration by the Board. The Audit Committee recommended the approval of the SFIs and Scheme of Delegation to the Board noting that the Director of Finance, Director of Corporate Governance and Audit Chair would oversee the final version.	For approval.
Audit Committee Effectiveness Review		In line with good practice Audit Committees should assess their effectiveness on a regular basis. A survey was issued to all Audit Committee Members, the results of which were used to inform the review. The review showed a positive outcome but there were a few areas for improvement and an improvement plan had been drawn up for the Committee.	To note.
Board Assurance Framework	N/A	The Audit Committee considered the full version of the Board Assurance Framework (BAF) including a section on the Covid Assurance Framework. The Committee discussed a number of aspects of the BAF and noted the intention for the Board to have a development session on the BAF at its meeting in February. The Internal and External Auditors were both asked for their views on the BAF and commented that it was a very comprehensive and clear document that was well presented. It was noted that NHS organisations generally tend to be risk averse given the nature of services being provided.	To note.
Bolton FT Register of Waivers	N/A	The Director of Finance presented the Register of Waivers since the last Audit Committee and it was noted that there was a reduced number of waivers that had been required.	To note.

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

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

Committee/Group Chair's Report

iFM Register of Waivers	N/A	The iFM Director of Finance presented the Register of Waivers since the last Audit Committee and it was noted that there was a reduced number of waivers that had been required. It was noted that one of the suppliers had been on the Register before and that this was now subject to a tendering exercise to avoid future waivers.	To note.
Bolton FT Losses and Special Payments Report	N/A	The Committee considered the Losses and Special Payments Report. It was explained that the Pharmacy losses mainly related to out of date stock and breakages but that this was a very small proportion of the total expenditure on drugs.	To note.
iFM Losses and Special Payments Report	N/A	The Committee considered the Losses and Special Payments Report. There was only one item to report for a debt written off.	To note.
iFM Bolton Statutory Accounts Year Ended 31st March 2020	N/A	The Committee considered the iFM Bolton Statutory Accounts for the Year Ended 31st March 2020. These had already been considered by the Board of iFM and would be presented at the iFM AGM on 26th November. The External Auditors reported on the Accounts and there were no issues to report.	To note.

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

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

Agenda Item

20

Title:	Standing Orders and Matters Reserved for the Board

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	26 November 2020		Discussion	
Exec Sponsor	Esther Steel		Decision	✓

Summary:	These documents, together with the Trust's Constitution; the Standing Financial Instructions and the Scheme of Delegation 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 possible accusation that they have acted less than properly. Members of the Board of Directors and all members of staff should be aware of the existence of and work to these documents. The version provided within the Board pack is scheduled for discussion at the Audit Comittee meeting on 24 November 2020. Any further changes proposed as a result of Audit Committee debate will be included as a late addendum to this paper

Previously considered by:	Previous version approved by the Board in September 2019

Proposed Resolution	Board members are asked to approve the revised Standing Orders and Matters Reserved

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	✓
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	✓

Prepared by:	Esther Steel Director of Corporate Governance	**Presented by:**	Esther Steel Director of Corporate Governance

Bolton
NHS Foundation Trust

STANDING ORDERS

November 2020

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 a "Schedule of matters reserved" and a "Scheme of Delegation". Which, 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. 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.

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 2012 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 as amended by the Health and Social Care Act 2012 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 2012 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 boards to draw up a schedule of matters 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 (Schedule of Matters Reserved). That document has effect as if incorporated into the Standing Orders.

Wherever the title Chief Executive, Chief Finance Officer, or other nominated Officer is used in these instructions, it shall be deemed to include such other directors or employees as have been duly authorised to represent them,

1 INTERPRETATION

1.1 Save as permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders

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 with responsibility for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

“ACT” means the NHS Act 2006 as amended by the Health and Social Care Act 2012 or any future parliamentary act covering the role and function of NHS service provision.

"TRUST" means Bolton NHS Foundation Trust.

"BOARD OF DIRECTORS" shall mean the Chair 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;

"CHAIR" 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 Chair of the Trust” shall be deemed to include the Senior Independent Director of the Trust if the Chair 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 CHAIR” shall be the Senior Independent Director of the Trust.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution.

Directors for the purpose of SO/SFI and Scheme of Delegation are those board members reporting directly to the Chief Executive.

"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.

"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 as amended by the Health and Social Care Act 2012 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, composition of the Board of Directors of the Trust shall be:

The Chair 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 Chair and Directors** - *The Chair and non-executive directors are appointed by the Governing Body and the appointments will be in accordance with the constitution.*

2.8 **Terms of Office of the Chair and Directors** - The regulations governing the period of tenure of office of the Chair 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 Chair) of the Trust is as prescribed in section 22 of the constitution.*

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

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 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 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.

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 Chair may call a meeting of the Board of Directors at any time. If the Chair 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, or if, the Chair does not call a meeting within seven days after such requisition has been presented,* at the Trust's Headquarters*, 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, shall be delivered to every director, at least three clear days before the meeting.*

3.8 In the case of a meeting called by directors in default of the Chair, 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) will be posted on the Trust's web site at least three clear days 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, will 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 should make this request in writing to the Chair 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 Chair.

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

3.13 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair 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 Act.

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 Chair, 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 Chair.

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 Chair to propose a motion to the same effect within six months, however the Chair may do so if considered 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 Chair of the meeting, the amendment negates the substance of the motion.

3.20 **Chair's Ruling** - The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their 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 Chair 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, their 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 will have the voting rights of that executive director. An officer attending the Board of Directors to represent an executive director without formal acting up status may not exercise the voting rights of the executive director.

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 may be expected to attend some or 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 Chair.

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 Chair 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 meeting.*

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

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 the Director of Corporate Governance acting on their behalf.

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 Chair) 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 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) they will 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 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 Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair 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 to perform personally and shall nominate officers to undertake the remaining functions for which the CEO will still retain an accountability to the Board of Directors.

4.5 The Chief Executive shall prepare a Scheme of Delegation, 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.

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, 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 formally established by the Board of Directors are:

Audit and Risk Committee

Quality and Safety Committee

Finance and Investment

People Committee

Nomination and Remuneration

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 in accordance with the "*Standards of Business Conduct Policy"* 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 Director of Corporate Governance.

6.5 Any changes in interests should be declared at the next Board of Directors' meeting following the change. It is the obligation of the director or governor to inform the Director of Corporate Governance in writing within seven days of becoming aware of the existence of a relevant or material interest.

6.6 The names of directors holding 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 a governor meeting, 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 Chair having the casting vote.

6.8 **Register of Interests** - The details of directors' and governors' interests recorded in the Register will be reviewed on a quarterly basis by the Audit and Risk Committee.

6.9 Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge. The Chair 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, they will 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 they may think fit to impose ,remove any disability imposed by this Standing Order in any case in which it appears 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 they have 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 Chair 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) they or a close associate of theirs, 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) they or a close associate of theirs 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;.*

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 membership of a company or other body, with no beneficial interest in any securities of that company or other body;

b) of an interest in any company, body or person 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 and the total nominal value of shares of any one class does not exceed one hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them 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 the duty to disclose an 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 they are also a director of the Trust) as it applies to a director of the Trust.

For the purposes of these Standing Orders a "Close Associate" is taken to cover the following:

- *Married persons and those in Civil partnerships or cohabiting. In which case, 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.*
- *Interests of parents, siblings or children*
- *Interests of current and former business partners*

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 they have any pecuniary interest not being a contract to which they are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive of the fact. 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 any other employment or business or other relationship of theirs or a close associate as previously defined,, 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 them 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 Prior to acceptance of an appointment directors should disclose to the Trust whether they are related to any other director or holder of any office within 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 Director of Corporate Governance in a secure place in accordance with arrangements approved by the Board.

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

9.3 On approval by the Board, or by the Chair 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 Chair, or other Officer duly authorised 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 annually. (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 their duty as a Director, but not otherwise, inspect any document which has been considered by the Chair or Chief Executive or senior officers under the terms of their delegated powers, or by the Board, provided that the Director shall not knowingly inspect ore request a document relating to a matter in which they are professionally interested or in which they have directly or indirectly any pecuniary interest.

This Standing Order shall not preclude the Chief Executive 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 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 the Standing Orders and SFIs.
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11.2 **Review of Standing Orders** - Standing Orders shall be reviewed bi-annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

Bolton
NHS Foundation Trust

SCHEDULE OF MATTERS RESERVED FOR THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS

July 2020

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Introduction

The Code of Accountability and the NHS Code of Governance requires that there should be a formal schedule of matters specifically reserved to the Board of Directors. The purpose of this document is to define those powers specifically reserved to both the Board of Directors and the Council of Governors.

The overall responsibility, and liability, for the actions of those directing the foundation trust rests with the board of directors, and to a certain degree the accounting officer. It is therefore essential that directors, both executive and non-executive, give clear guidance and establish thorough reporting systems to ensure that they make the appropriate decisions about the overall direction of the trust and make sure those decisions are enacted.

As each director is jointly and severally liable, it is important that decisions are taken by the board as a whole, meeting together in order that they may hear arguments either in favour or against a decision before casting a vote on a proposal. It is the responsibility of the chief executive, and senior management team where appropriate, to implement the decisions of the board and report back via the agreed monitoring process.

All powers of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to a committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies those functions to be performed by the Chief Executive and those which are delegated to other Board members and officers.

In the absence of the Chief Executive the powers delegated to the CEO may be exercised by the Chair after taking appropriate advice from the Director of Finance.

Matters which the board considers suitable for delegation are contained in the terms of reference of its committees.

In addition, the board will receive reports and recommendations from time to time on any matter which it considers significant to the foundation trust.

Developed from ICSA specimen matters reserved (ICSA 2015)

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Key

HSCA Act 2003 refers to the Health and Social Care Act 2003

NHSA 2006 refers to the NHS Act 2006

HSCA 2012 refers to the Health and Social Care Act 2012

NHS FT code refers to the FT Code of Governance (March 2014)

REID refers to the Monitor guidance Risk Evaluation of Investment Decisions by NHS Foundation Trusts

References to Audit, Nomination &Remuneration, Quality Assurance Committee, Finance and Investment Committee refer to the Board of Directors' committee which will consider the item and make recommendations to the board for its final decision

References to the Governors' Nomination and Remuneration (GNR) committee refer to the Council of Governors' committee which will consider the item and make recommendations to the board for its final decision.

Where consultation with governors is necessary, one of the Governor working groups will oversee the process and ensure that both the Board of Directors and Council of Governors have discharged their responsibilities.

Items marked with an asterisk (*) are not considered suitable for delegation to a committee of either the board of directors or council of governors. This may be because of requirements contained in legislation or because they are the responsibility of an audit, nomination or remuneration committee under the recommendations of the NHS Foundation Trust Code of Governance, with the final decision required to be taken by either the board of directors or council of governors as a whole.

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
1	**General Enabling Provision**				
1.1	An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions	NHSA s47			
1.2	An NHS foundation trust must exercise its functions effectively, efficiently and economically	NHSA s63, NHS FT supporting principle A.1.h			
1.3	The constitution must provide for all the powers of the corporation to be exercisable by the board of directors on its behalf	HSCA 2003 Schedule 1, NHSA Schedule 7			
1.4	The board of directors may determine any matter, for which it has delegated or statutory authority, it wishes in accordance with its statutory powers, constitution or licence	constitution			
2	**Strategy and Management**				
2.1	Responsibility for the overall management of the foundation trust (and group), in compliance with its licence, constitution, legislation, regulatory guidance and contractual obligations	FT supporting principle A1 Constitution		X	
2.2	Setting the strategic aims of the Trust and ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance	FT A1 Constitution		X	After consulting with Governors

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
2.3	Settling the Trust's vision, values and standards and ensure its obligations to members, patients and other stakeholders as understood, clearly communicated and met	FT A1		X	After consulting with Governors
2.4	Approval of an annual business plan.	Constitution FT F1		X	After consulting with Governors
2.5	Oversight of the Trust's operations, ensuring: • Competent and prudent management • Sound planning • An adequate system of internal control • Adequate accounting and other records • Compliance with statutory and regulatory obligations	FT A1		X	Audit Committee
2.6	Review of performance in the light of the Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken	FT A1 SFI		X	
2.7	Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Healthcare Commission and other relevant NHS bodies.	FT A1		X	Quality Assurance Committee
2.8	Extension of the Trust's activities into new business or geographic areas.	NHS (45)-(47)		X	
2.9	Any decision to cease to operate all or any material part of the Trust's business	NHS (45)-(46)		X	With the approval of the Regulator

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
2	**Structure and Organisation**				
2.1	Changes to the Trust's Constitution	NHS (37)	X		Constitution
2.2	Major changes to the Trust's management and control structure	FT		X	
2.3	The establishment of Board of Directors' sub-committees, their Terms of Reference and the delegation of authority to them. Monitoring reports from these committees in respect of their exercise of delegated powers			X	
2.4	The establishment of Council of Governors' sub-committees and their Terms of Reference.	Constitution 8.18	X		
2.5	Approve any proposal to merge, acquire, dissolve or separate	REID	X	X	
2.6	The establishment of subsidiary companies, charities, partnerships, joint ventures or other corporate entities linked to or managed by the Trust	NHS 46(5)		X	
3	**Financial Reporting and Controls**				
3.1	*Approval of annual report and accounts [including the annual governance statement and remuneration report]	HSCA 2003 s27, NHSA s27, Constitution		X	Audit
3.2	Receiving the annual report and accounts, auditor reports and annual reports at a general meeting	Constitution 8.14.1	X		
3.3	Approval of any significant changes in accounting policies or practices			X	Audit

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
3.4	Approval of treasury management policies, including external funding (borrowing arrangements), banking arrangements and operating cash management policy	SFI		X	Finance committee to review
4	**Internal Controls**				
4.1	Ensuring maintenance of a sound system of internal control and risk management including: • Receiving reports on and reviewing the effectiveness of, the Trust's risk and control processes to support its strategy and objectives • Undertaking an annual assessment of these processes • Approving an appropriate statement for inclusion in the annual report	FT F2		X	Audit
5	**Contracts**				
5.1	Major capital projects (>£2.0m)	SFI		X	
5.2	Contracts which are material strategically or by reason of size, entered into by the Trust [or related subsidiary] in the ordinary course of business, for example, bank borrowings with a repayment period of over one year or acquisitions or disposals of fixed assets [above £ 1 million].	NHS (45)-(47)		X	
5.3	Contracts of the Trust [or any subsidiary] not in the ordinary course of business, for example loans with a repayment period of over one year or major acquisitions or disposals [above £1 million]	NHS (45)-(47)		X	
5.4	Major investments [including the acquisition or disposal of interests or more than 5% in the voting shares of any company or the making of any takeover offer]	NHS (45)-(47)		X	

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
5.5	All investments which fall within the Regulator's definitions of High Risk Investments	REID		X	
6	**Communication**				
6.1	Approval of resolutions and corresponding documentation to be put forward to governors at a general meeting	constitution		X	
7	**Board membership and other appointments**				
7.1	Changes to the structure, size and composition of the board of directors, following recommendations from the nomination committee	NHS Sch7 NHSA schedule 7, NHS FT code provisions B.2.1, B.2.3, Nomination committee		X	Nomination and Remuneration Committee
7.2	Changes to the structure, size and composition of the Council of Governors and membership	NHS (37)	X		Constitution
7.3	*Appointment and removal of the Chair of the board	NHS Sch7 Constitution 6.2 (b)	X		
7.4	Appointment and removal of the Chief Executive	NHS Sch7 Constitution 9.7.4			Nomination & Remuneration Committee

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
		HSCA 2003 s17, NHSA s17, NHS FT B.2.12, MCC 31.1			Governors must approve appointment at a General Meeting
7.5	Appointment of Non-Executive Directors to the board	NHS Sch7 Con8.14.1	X		
7.6	Appointment and removal of Executive Directors to the board, following recommendations by the Nomination Committee	HSCA 2003 s17, NHSA s17, nomination Committee Constitution 9.7.5		X	Nomination & Remuneration
7.7	Appointment of acting directors	Constitution		X	NEDs
7.8	Appointment of the Senior Independent Director	FT A3.3		X	In consultation with Council of Governors
7.9	Continuation in office of any director at any time, including the review of suspensions, termination of service of an executive director as an employee of the Trust, subject to the law and their service contract	NHS Sch7 Constitution 9.7.5		X	Nomination & Remuneration

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
7.10	Continuation in office of non-executive directors at the end of their term of office, and otherwise as appropriate	NHS FT code provision B.7.1	X		
7.11	Appointment, reappointment or removal of the external auditor	NHS Sch7 Constitution 6.2b	X		GD-GA
7.12	Appointment of directors to boards of subsidiaries			X	Nomination and remuneration
8	**Remuneration**				
8.1	Determining the remuneration policy for the executive directors	NHS Sch7 Constitution 9.7.6 FT E1&E2		X	Nomination and remuneration
8.2	Determining the remuneration of the non-executive directors	NHS Sch7 Con8.14.1 FT E1&E2	X		
8.3	The introduction of any performance related remuneration or bonus scheme for directors or staff	FT E1-E2		X	Nomination and remuneration
9	**Delegation of authority**				

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
9.1	Subject to any directions to the contrary by NHSI or the Trust itself, any of the powers of the board of directors may be delegated to a committee of directors or to an executive director			X	
9.2	*The division of responsibilities between the Chair, the chief executive [and other executive directors] should be in writing			X	
9.3	*Approval of terms of reference of board committees *Receiving reports from board committees on their activities			X	
10	**Corporate Governance matters**				
10.1	Holding the Board of Directors to account for the performance of the trust, including ensuring it acts so that the trust does not breach the terms of its authorisation	FT B1	X		
10.2	Undertaking a formal and rigorous review [annually] of its own performance, that of its committees and individual directors	FT D2	X	X	
10.3	Determining the independence of directors	FT A3		X	
10.4	Considering the balance of interests between members, governors, employees, patients and public	FTB1	X	X	
10.5	Review of the Trust's overall corporate governance arrangements	FT F2		X	
10.6	Establishing effective mechanisms for ensuring that the views of the Trust's stakeholders are taken into account	FT G1	X	X	
10.7	Establishing the values and standards of conduct for the trust and its staff and operating a code of conduct that builds on these values	FTA1		X	

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
10.8	Use of the foundation trust's seal	constitution		X	
11	**Policies**				
11.1	Standing Orders for the Board of Directors	Constitution 10.1		X	Audit Committee
11.2	Standing Orders for the Council of Governors	Constitution 8.18	X		Governors Constitution
11.3	Standing Financial Instructions, Scheme of Delegation and Matters Reserved for the Board of Directors and Council of Governors	Constitution 10.1		X	Audit Committee
11.3	Approval of corporate policies and procedures where the board has overarching responsibility for ensuring compliance with statutory and regulatory obligations, including (but not limited to): • Risk Management policy • Document Control Policy • Health and Safety policy	SOs		X	Exec Directors
12	**Other**				
12.1	Approval of the appointment of the Trust's principal professional advisers (excluding external audit)	Constitution 4.3(g)		X	
12.2	Prosecution, defence or settlement of litigation [involving above £x million or being otherwise material to the interests of the Trust]	Constitution 4.3 (k)		X	

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Ref	Matter Reserved to the Board	Source	CoG	BoD	Comments
12.3	Approval of the overall levels of insurance for the Trust including Directors' and Officers' liability insurance [and indemnification of directors]	Constitution 4.3 (h)		X	

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Appendix 1 - Role of the Chair and Chief Executive

Chair		Chief Executive	
1.	**Reporting Lines**		
1.1	The Chair reports to the Board of Directors and Council of Governors	1.1	The Chief Executive reports to the Chair (acting on behalf of the Board of Directors) and to the Board of Directors directly.
1.2	The Chair is not responsible for executive matters regarding the Trust's business. Other than the Chief Executive and the Trust secretary, no executive reports to the Chair, other than through the Board of Directors.	1.2	The Chief Executive is responsible for all executive management matters affecting the Trust. All members of executive management report, either directly or indirectly, to the CEO
2.	**Key responsibilities**		
2.1	The Chair's principal responsibility is the effective running of the Board of Directors and Council of Governors and that the two boards work together effectively.	2.1	The Chief Executive's principal responsibility is running the Trust's business.
2.2	The Chair is responsible for ensuring that the Board of Directors and Council of Governors play a full and constructive part in the development and determination of the Trust's strategy and overall commercial objectives.	2.2	The Chief Executive is responsible for proposing and developing the Trust's strategy and overall commercial objectives, in close consultation with the Chair and the Board of Directors.
2.3	The Chair is the guardian of both boards' decision-making processes.	2.3	The Chief Executive is responsible, with the executive team, for implementing the decisions of the Board of Directors and its Committees.
3. Other Responsibilities			
3.1	Running both the board of Directors and Council of Governors and setting their agendas.	3.1	Providing input to the Board of Directors' agenda
3.2	Ensuring that the agendas of both boards take appropriate account of the important issues facing the Trust and the concerns of all board members. There should be an emphasis on strategic, rather than routine, issues. Ensuring that non-executive directors have an input to the Board of Directors' agendas.	3.2	Maintaing a dialogue with the Chair on the important and strategic issues facing the Trust and proposing Board of Directors' agenda items to the Chair which reflect these.

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Chair	Chief Executive
3.3 Ensuring that both boards receive accurate, timely and clear information on:- • the Trust's performance • the issues, challenges and opportunities facing the Trust and • matters reserved to either board for decision.	3.3 Ensuring that the executive team gives appropriate priority to providing reports to the boards which contain accurate, timely and clear information.
3.4 Ensuring, with the advice of the Trust secretary where appropriate, compliance with both boards' approved procedures, including the schedule of Matters Reserved to either board for its decision and the Terms of Reference of all committees of both boards.	3.4 Ensuring, in consultation with the Chair and the Trust secretary as appropriate, the executive team comply with the Board of Directors' approved procedures, including the schedule of Matters Reserved to the board for its decision and the Terms of Reference of all committees of the Board of Directors.
3.5 Arranging informal meetings of the members of the Board of Directors, including meetings of the non-executive directors at which the executive directors are not present, as required, to ensure sufficient time and consideration is given to complex, contentious or sensitive issues.	3.5 Ensuring that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust of which she might not otherwise be aware.
3.6 Proposing to both boards, in consultation with the Chief Executive, Trust secretary and committee chairmen as appropriate: • a schedule of Matters Reserved to either board for its decision • Terms of Reference for each committee of both boards and • Other policies and procedures of both boards.	3.6 Providing an input to the Chair and Trust secretary as appropriate on changes to the schedule of Matters Reserved to both boards and the Terms of Reference for each committee of both Boards
3.7 Chairing the Remuneration Committee and committees appointing executive directors, and, in that role, initiating change and succession planning in appointments to the Board of Directors to retain and build an effective and complementary board, and to facilitate the appointment of effective and suitable members and chairmen of board committees.	3.7 Providing information and advice on succession planning for the Board of Directors, to the Chair, the Remuneration Committee, committees appointing executive directors and other members of the board, particularly in respect of executive directors.
3.8 Initiating change and succession planning in appointments of partner organisation governors to the Council of Governors.	
3.9 Proposing, in conjunction with the Remuneration Committee, the membership of committees of the Board of Directors and their chairmen.	3.9 Serving on committees appointing executive directors.

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Chair	Chief Executive
3.10 Ensuring that there is effective communication by the Trust with its stakeholders, including by the Chief Executive, Finance Director and other Directors, so that the members of both boards develop an understanding of the views of the Trust's major stakeholders. Ensuring that constructive relations exist between the executive and non-executive directors, and between the Board of Directors and the Council of Governors.	3.10 Leading the communication programme with stakeholders.
3.11 Taking the lead in providing a properly constructed induction programme for new directors and governors, facilitated by the Trust secretary.	3.11 Commenting on induction programmes for new directors and ensuring that appropriate management time is made available for the process.
3.12 Taking the lead in identifying and seeking to meet the development needs of individual non-executive directors, governors and of both boards as a whole, assisted by the Trust secretary.	3.12 Ensuring that the development needs of the executive directors and other senior management reporting to them are identified and met.
3.13 Ensuring that the performance of both boards, their committees, and individual non-executive directors are formally and rigorously evaluated at appropriate intervals.	3.13 Ensuring that performance reviews are carried out at least once a year for each of the executive directors. Providing input to the wider evaluation process for the Board of Directors.
3.14 Promoting the highest standards of integrity, probity and corporate governance throughout the Trust and particularly at board level.	3.14 Promoting and conducting the affairs of the Trust with the highest standards of integrity, probity and corporate governance.
4. Status of this Statement	
4.1 Any amendments to this statement are a Matter Reserved to the board.	
4.2 This statement is to be annexed to the Chief Executive's Job Description. In the event of any conflict between this statement and the Chief Executive's Job Statement in so far as they may relate to their role as Chief Executive, this statement shall take precedence.	

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Appendix 2 - Governance Arrangements, Roles and Responsibilities of the Council of Governors and Board of Directors

Council of Governors	Board of Directors	Non-Executive Directors[1]
Appointment, Removal & Remuneration		
At least 50% elected by members with some appointed directly by partner organisations (NHS Act 2006) Non-voting advisors can be proposed by the Board of Directors, but must be approved by Council of Governors	Executive Directors are appointed by the Chair, Chief Executive and Non-Executive Directors Chief Executive is appointed by the Non-Executive Directors and approved by Council of Governors (NHS Act 2006)	Appointed by the Council of Governors in a General Meeting (NHS Act 2006)
Elected members' period of office is three years, with eligibility for re-election at the end of that period (NHS Act 2006) Constitution extends this to all governors and also stipulates a 9 year limit for all governors	Period of office for Chief Executive and Executive Directors decided by the Remuneration Committee of NEDs (Constitution).	Period of office for Chair and non-executive directors agreed in the terms and conditions of office decided by the Council of Governors at a general meeting (Constitution) FT Code of Governance states re-appointment of NEDs should take place at intervals of no more than three years
Restrictions on bankrupts and prisoners (NHS Act 2006) Constitution extends this restriction to staff dismissed from healthcare organisations for reasons of probity and dismissed/suspended healthcare professionals. Constitution also restricts on mental health capacity basis.	Restrictions on bankrupts and prisoners, staff dismissed from healthcare organisations for reasons of probity and dismissed/suspended healthcare professionals (Constitution). No restrictions on mental health capacity basis	Restrictions on bankrupts and prisoners, staff dismissed from healthcare organisations for reasons of probity and dismissed/suspended healthcare professionals (Constitution). No restrictions on mental health capacity basis
Trust decides rates of reimbursement for travel and expenses (NHS Act 2006) Governors are not to receive remuneration (Constitution)	Remuneration and allowances and terms and conditions of office of executive directors determined by non-executive directors in a remuneration committee (NHS Act 2006)	Remuneration and allowances and terms and conditions of office decided by Council of Governors in a general meeting (NHS Act 2006) The Council of Governors should consult external professional advisers to market-test

[1] This column shows the roles and governance arrangements which are specific to the non-executive directors (NEDs). These are additional to the duties that the NEDs share with executive directors as members of the Board of Directors, as shown under the Board of Directors column.

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Council of Governors	Board of Directors	Non-Executive Directors[1]
		the remuneration levels of the Chair and other non-executives at least once every three years and when they intend to make a large change to the remuneration of a non-executive/Chair.
Not so large as to be unwieldy – of sufficient size for the requirement of its duties. Roles, structure, composition and procedures should be reviewed regularly. (Code of Governance)	Not so large as to be unwieldy – of sufficient size that the balance of skills and experience is appropriate for the requirements of the business and with a strong presence of both executive and non-executive directors (Code of Governance)	
Meetings		
Constitution must provide for meetings of the Council of Governors to be open to members of the public, with exclusions for special reasons (NHS Act 2006)	Formal meetings must be open to the public (NHS Act 20060	
Minimum of three meetings a year (Constitution) and maximum of four times except in exceptional circumstances. FT Code states it should meet sufficiently regularly to discharge its duties effectively and a record of attendance supplied to the members on request.	No minimum or maximum number of meetings stated in the NHS Act or Constitution. FT Code states it should be sufficiently regular to discharge its duties effectively and a record of attendance supplied to the board of governors on request	
The Council of Governors may appoint committees consisting of its members but may not delegate any of its powers to these committees	Audit Committee and Remuneration Committee are required by the Constitution	
Responsibilities		
	The powers of the Trust are to be exercisable by the Board of Directors on its behalf (Constitution), any of which may be delegated to a committee of directors or an executive director	

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Council of Governors	Board of Directors	Non-Executive Directors[1]
Determining remuneration, allowances and terms of office of Non-Executive Directors in a General meeting(NHS Act 2006)	Determining and declaring the independence (or otherwise) of the NEDs. (Code of Governance)	Determining remuneration, allowances and terms of office of the Chief Executive and Executive Directors (NHS Act 2006)
Approving appointment of Chief Executive(NHS Act 2006)		Appointing and removing Chief Executive (NHS Act 2006). With Chair and Chief Executive, appointing and removing EDs (Constitution)
Appointing and removing the Chair and Non-Executive Directors(NHS Act 2006)		
Appointing and removing the auditor(NHS Act 2006)		An Audit Committee of Non-Executive Directors to perform such monitoring, reviewing and other functions as are appropriate (NHS Act 2006)
To give the views of the Council of Governors to directors for the purposes of the preparation (by directors) of the Trust's annual plan (NHS Act 2006)	Preparing the Annual Plan in accordance with the form outlined by NHSI and provide it to Monitor(constitution)	
To consider the annual accounts, the auditor's report and the annual report (NHS Act 2006)	Keeping and preparing accounts. Approving the annual accounts, auditors' report and annual report and presenting them to the Council of Governors at a general meeting Laying the accounts etc. before parliament and sending copies to the Independent regulator (Constitution)	
To respond as appropriate when consulted by the directors (Constitution)		
To keep under review the Trust principles and vary from time to time in accordance with the provisions of the Constitution		
Code of Governance Provisions		
Responsible for representing the interests of NHS foundation trust members and partner organisations in the local health economy in the governance of the NHS foundation trust.	Collectively responsible for the exercise of the powers and the performance of the NHS Foundation Trust	

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Council of Governors	Board of Directors	Non-Executive Directors[1]
Should hold the board of directors to account for the performance of the trust, including ensuring the board of directors acts so that the trust does not breach the terms of its authorisation.	Active leadership of the Trust within a framework of prudent and effective controls	
Regularly feed back information about the trust, its vision and performance to the constituencies and stakeholder organisations that either elected or appointed them	Compliance with the Trust's terms of authorisation, constitution, mandatory guidance, statutory requirements and contractual obligations	
Discuss and agree with the Board of Directors how they will undertake these and any other additional roles	Setting strategic aims, taking into consideration the views of the Council of Governors, ensuring the necessary financial and human resources are in place and review management performance	
Receive and consider other appropriate information, for example clinical and operational data, required to enable it to discharge its duties.	Responsible for ensuring the quality and safety of healthcare services, education, training and research and applying the principles of clinical governance. Ensuring the trust exercises its functions effectively, efficiently and economically	
	Setting the trust's values and standards of conduct and ensuring that its obligations to members, patients and other stakeholders are met	
Must act in the best interests of the NHS foundation trust and adhere to its values and code of conduct	Taking decisions objectively in the interests of the trust	
The Chair is responsible for leadership of both boards but the governors have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives as appropriate. In these meetings, they may raise questions of the	Within the board of directors, all directors have joint responsibility regardless of individual skills or status and all share the same liability. All directors have responsibility to constructively challenge the decisions of the board	Non-executive directors have a particular duty to ensure such challenge is made. NEDs should scrutinise the performance of the management in meeting agreed goals and objectives and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information and that

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Council of Governors	Board of Directors	Non-Executive Directors[1]
Chair, deputy Chair or any other director present about the affairs of the trust.		financial and clinical quality controls and systems of risk management are robust and defensible
The governors should establish a policy for engaging with the directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the terms of authorisation or the welfare of the trust. The governors should inform NHSI if the Trust is at risk of breaching the terms of its authorisation if these concerns cannot be resolved locally	The Board of Directors must present a balanced and understandable assessment of the trust's prospects and position in all public statements and reports to regulators and inspectors. The board must also notify NHSI and the Council of Governors without delay any developments which are likely to effect the assets, liabilities, financial position, financial well-being, healthcare delivery performance or reputation and standing	
Governors should acknowledge the responsibility of the board of directors for running the trust and should not try to use their powers to veto board decisions. The Council of Governors should only exercise its power to remove the chair or any NEDs after exhausting all other means of engagement with the board of directors	The board of directors should set out clearly its financial and operating objectives at least annually	
The Council of Governors should take the lead in agreeing with the audit committee the criteria for appointing, reappointing and removing auditors		The Audit Committee should make recommendations to the Council of Governors, in relation to the appointment, reappointment, removal of the external auditor and approve the remuneration of the external auditor
	The board of directors should appropriately consult and involve members, patients, clients and the local community. It is responsible for ensuring a satisfactory dialogue is in place with its stakeholders	The Chair (and SID and other directors as appropriate) should maintain sufficient contact with governors to understand their issues and concerns

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Council of Governors	Board of Directors	Non-Executive Directors[1]
	The board of directors is responsible for ensuring an effective mechanism for communication between governors and members. Contact procedures for members that wish to communicate with governors and directors should be available within the trust web-site and annual report	The Chair should ensure that the views of governors and members are communicated to the board of directors as a whole. The Chair should discuss the affairs of the trust with the governors. NEDs should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The SID should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors
Conflict of Interests		
Must disclose pecuniary interests in any contract etc which is under consideration by the board	Must disclose pecuniary interests in any contract etc which is under consideration by the board	Must disclose pecuniary interests in any contract etc which is under consideration by the board

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Agenda item 21

Title:	Review of Standing Financial Instructions and Scheme of Delegation

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	26 November 2020		Discussion	✓
Exec Sponsor	Annette Walker		Decision	✓

Summary:	The Standing Financial Instructions are the financial rules and regulations by which the organisation is governed in order to ensure compliance with the law, probity, transparency and value for money. The Financial Scheme of Delegation sits sets out the powers and financial levels of authority or the Board, its Committees and the Executive. The Standing Financial Instructions and Financial Scheme of Delegation combine to form part of the Standing Orders of the organisation and are reviewed periodically. Both of these documents have been significantly redrafted to improve usability. Included in this agenda item is a covering paper to summarise the changes made along with the current versions to aid comparison. It should be noted that minor changes may continue to be made following the publication of committee papers.
Previously considered by:	The Executive reviewed 9 November. The documents are scheduled for consideration by the Finance Committee and the Audit Committee, any further significant changes will be updated when the Board meets
Proposed Resolution	Subject to noting any further changes the Board are asked to approve the Standing Financial Instructions and Scheme of Delegation

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*		*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*		*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	
*To continue to use our **resources** wisely so that we can invest in and improve our services*	✓	*To develop **partnerships** that will improve services and support education, research and innovation*	

Prepared by:	Annette Walker	**Presented by:**	Annette Walker

2020 Review of Standing Financial Instructions and Scheme of Delegation

The Standing Financial Instructions and Financial Scheme of Delegation form part of the Standing Orders of the Trust and are reviewed periodically. These have been significantly re-drafted to improve usability.

IFM Bolton is currently reviewing their Standing Financial Instructions.

The Charity is covered by the Trust Standing Financial Instructions but has a separate Financial Scheme of Delegation approved by the Charity Committee.

Summary of Changes from the Previous Version

Financial Scheme of Delegation
• Improved formatting • Inclusion of narrative in the Board section that clarifies all powers emanate from the Board and can be amended by the Board. • Removal of references to powers that are not financially related • Removal of references to non-financial powers that are elsewhere covered within the Standing Orders and Matters reserved to avoid duplication. • Inclusion of verbs to ensure clarity on the power being delegated by the Board • Clarification that contract value is over the life of the contract. • Change to invoice/contract/revenue business case approval limit for the Board to > £2m (was £1m) and to Finance Committee <£2m (was £1m), this aligns to capital business cases. • Improved alignment to Standing Financial Instructions with powers listed in the Financial Scheme of Delegation for ease of reference. • Work to ensure that there are no gaps in powers or limits e.g. the current Financial Scheme of Delegation gives powers to the Director of Finance for contract and invoices up to £1m but is silent on what happens above £1m. • Formal power for the Director of Finance and the Chief Executive to approve capital business cases up to £100k – this happens in practice now under current limits for urgent capital spend. • Formal power for the Director of Finance and the Chief Executive to approve non recurrent revenue business cases up to £100k – this happens in practice now under current limits for urgent revenue spend. • Removal of the audit committee as the approving committee of the SFIs – this is a matter reserved to the Board as they form part of the Standing Orders. Audit can review but not approve. • Includes narrative to confirm that in the absence of the Chief Executive or Director of Finance, powers and limits are assumed by their Deputies. • Removal of unlimited power of the Director of Finance to dispose of capital equipment, currently no upper value • Section 2 shows powers cascading down. • Inclusion of a third table which shows the for each type of approval, the various limits from board to ward – a different presentation for ease of reference.
Standing Financial Instructions
• Improved formatting and ordering of sections. • Reduction in pages from 40 to 23.

- Removal of superfluous and duplicating language, gender references and legal ease.
- Attempt to simplify language.
- Removal of acronyms.
- Removal of detail which is duplicated elsewhere e.g. in terms of reference of committees.
- Removal of some extracts from guidance, acts etc. which can date – instead the reader can separately access these.
- Removal of procedural content – these are subject to rather than 'standing'.
- Changes and corrections to numbering.
- Significant reduction in detail in section 7 – Tendering – to removed detailed procedural advice.
- Updating of job titles

Standing Financial Instructions are for reference purposes. It is not expected or reasonable for every member of staff to know the details intricately. A list of Key SFIs has been drawn up with a corresponding description in simple language. It is reasonable that all staff should know these.

Key SFIs

SFI	Description
3.2.4	Do not use non recurrent monies to fund recurring expenditure
5.1.2	Do not open a bank account in the name of Trust, only the Director of Finance can open bank accounts in the name of the Trust
5.2.1	Only deposit Trust money, cheques or cash through the cashiers' department and into official bank accounts. Do not use unofficial bank accounts
6.3.2	Sponsorship is acceptable provided the Standards of Business Conduct policy is followed
6.5.1	If you have a safe it must be regularly authorised for use and be designated as official by the Director of Finance
6.5.1	You must seek permission from the Director of Finance to set up charitable giving platforms in the name of the Trust
6.5.3	If you receive cash or cheques on behalf of the Trust or its Charity, this must be banked intact. Do not use the cash to buy goods or services.
6.5.4	Do not use an official safe to store unofficial funds or valuables
7.	You must follow the guidance from the procurement team on tendering and waivers. Seek their advice if unsure.
7.3.1	The tendering limits apply to the total expected cumulative spend with the supplier.
9.6.1	Use official orders for non-pay unless there is an agreed exception. Seek advice from the procurement team.
9.7.3	Do not place an order if there is no budget or insufficient budget, unless the Chief Executive or the Director of Finance has given approval
9.7.5	Do not split order values to circumvent financial thresholds
11.1.8	Do not incur capital expenditure without the necessary approval
11.3.5	Any theft must be reported to the Director of Finance

13.2.1	Suspected fraud must be reported to line management, Local Counter Fraud lead or the Director of Finance
15.1.2	Patients property should be stored using official receipts and safes.
17.2.1	Staff should declare their interests and provide updates when there are changes – refer to the Trust policy on Standards of Business Conduct
17.3.1	Follow the guidance when receiving gifts and make sure they are declared.
17.3.5	Do not accept personal gifts of cash or vouchers

Further work will be undertaken to ensure that the key SFIs are understood throughout the organisation.

Recommendation

The Committee is asked to review the revised Standing Financial Instructions and Financial Scheme of Delegation and recommend approval to the Board.

NHS
Bolton
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

November 2020

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CONTENTS

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1.1 Use and Application

1.1.2 These Standing Financial Instructions are issued by the Board of Bolton NHS Foundation Trust (the Trust). They will have effect as if incorporated in the Standing Orders.

1.1.3 These Standing Financial Instructions detail the financial regulations adopted by the Trust. They are designed to ensure that financial matters are carried out in accordance with the law and relevant Government policy in order to achieve probity, accuracy, and value for money. The Standing Financial Instructions should be used in conjunction with the Financial Scheme of Delegation which sets out powers and financial limits of the Board, its Committees and the Executive.

1.1.4 These Standing Financial Instructions apply to all employees, agency, locum or temporary staff working for the Trust. They also apply to wholly owned subsidiaries, hosted functions and organisations and the Trust Charity unless separate arrangements have been agreed by the Board. Standing Financial Instructions do not provide detailed advice or policies and should therefore be used in conjunction with financial procedure notes.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought.

1.1.6 Wherever the title Chief Executive or Director of Finance is used in these instructions, it shall be deemed to include such other directors or employees as have been duly authorised to represent them.

1.2 Failure to Comply

1.2.1 Failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter.

1.2.2 Deliberate failure to comply with Standing Financial Instructions could constitute fraud or theft and result in criminal action being taken.

1.2.3 If for any reason these Standing Financial Instructions are not complied with, full details should be reported to the Director of Finance who will advise on the appropriate course of action. This will include deciding whether to report to the Audit Committee and/or the Board if the breach is significant.

1.2.4 All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.3 The Role of the Board

1.3.1 The Board exercises financial supervision and control by:-

(a) approving the financial strategy;

(b) approving of budgets within overall income;

(c) approving important financial policies and systems;

(d) approving the Financial Scheme of Delegation; and

(e) receiving regular assurance on financial strategy and performance.

1.4 The Role of the Chief Executive

1.4.1 The Chief Executive may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.4.2 By law, the Chief Executive of an NHS Foundation Trust is the Accounting Officer. The responsibilities of the Accounting Officer are contained in guidance issued by the Regulator and include the requirement to ensure that:-

(a) there is a high standard of financial management in the NHS Foundation Trust as a whole;

(b) there is efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation; and

(c) financial considerations are fully taken into account in decisions by the NHS Foundation Trust.

1.4.3 It is a duty of the Chief Executive to ensure that the Board and all employees understand their responsibilities within these Standing Financial Instructions.

1.5 The Role of the Director of Finance

1.5.1 The Director of Finance will carry out duties and responsibilities where delegated by the Chief Executive under these Standing Financial Instructions.

1.5.2 The Director of Finance may delegate their detailed duties and responsibilities, but retain accountability under these Standing Financial Instructions.

1.5.3 The Director of Finance is accountable for:-

(a) design and implementation of financial policies;

(b) maintaining an effective system of internal financial control;

(c) ensuring that sufficient financial records are maintained;

(d) the provision of strategic financial advice to the Board and employees; and

(f) the preparation and maintenance of accounts, certificates, estimates, records and reports as required.

1.6 The Role of the Board and Employees

1.6.1 The Board and employees must act in the interests of the Trust by:-

(a) avoiding loss of property and valuables;

(b) exercising economy and efficiency in the use of resources; and

(c) conforming with the requirements of these Standing Financial Instructions and the Financial Scheme of Delegation.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with the NHS Foundation Trust Code of Governance, the Board will formally establish an Audit Committee of non-executive directors.

2.1.2 The Board will satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 The Audit Committee will have clearly defined terms of reference and follow guidance from the NHS Audit Committee Handbook.

2.1.4 The Audit Committee will meet a minimum of four times a year.

2.2 Internal Audit

2.2.1 The Audit Committee will ensure that there is an effective internal audit function established by management that meets mandatory audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

2.2.2 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(a) an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives; and

(b) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.2.3 The Head of Internal Audit will provide to the Audit Committee:-

(a) a risk-based plan of internal audit work, agreed with management and approved by the Audit Committee;

(b) regular updates on the progress against plan;

(c) reports of management's progress on the implementation of actions agreed as a result of internal audit findings;

(d) an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This opinion is used by the Board to inform the Annual Governance Statement; and

(e) additional reports as requested by the Audit Committee.

2.2.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.2.5 The Head of Internal Audit will be accountable to the Director of Finance.

2.2.6 The Director of Finance is responsible for ensuring that:-

(a) there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) the Internal Audit is adequate and meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit Committee and the accountable officer;

(c) an annual Internal Audit report is prepared for the consideration of the Audit Committee;

(d) an annual Internal Audit Plan is produced for consideration by the Audit Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year; and

(e) ensuring that a medium-term Internal Audit Plan (usually three years) is prepared for the consideration of the Audit Committee and the Board.

2.3 External Audit

2.3.1 The Audit Committee will review the findings of the external auditor and consider the implications and management responses.

2.3.2 In accordance with the relevant legal requirements the governors of the Trust appoint the External Auditor. The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. The Council of Governors will need to ensure they have the skills and knowledge to choose the right External Auditor and monitor their performance. However, they should be supported in this task by the Audit Committee, which provides information to the governors on the External Auditor's performance as well as overseeing the Trust's internal financial reporting and internal auditing.

2.3.3 The Audit Committee should make recommendations to the council of Governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.

2.3.4 The Trust and the Council of Governors must ensure compliance with requirements of the relevant Acts as to who may be an auditor for an NHS Foundation Trust.

2.3.5 While the Council of Governors may be supported by the Audit Committee in running the process to appoint the external auditor, the Council of Governors must have ultimate oversight of the appointment process.

2.3.6 In appointing and monitoring the External Auditor, the Council of Governors should ensure that the audit firm and audit engagement leader have an established and demonstrable standing within the healthcare sector and are able to show a high level of experience and expertise.

2.3.7 The responsibilities of the External Auditor are prescribed in National Audit Office Code of Audit Practice.

2.4 Counter Fraud and Security Management

2.4.1 The Audit Committee will satisfy itself that the organisation has adequate arrangements in place for countering fraud. NHS organisations must have appropriate counter fraud arrangements.

2.4.2 The Director of Finance will monitor and ensure compliance with the conditions of the NHS Contract Fraud Standards.

2.4.3 The Director of Finance is responsible for deciding at what stage to involve the police in cases of theft, fraud, misappropriation and any other irregularities.

2.4.4 The Director of Finance will appoint a suitable person to carry out the duties of the Local Anti-Fraud Specialist as specified by the NHS Fraud, Corruption and Bribery Manual and guidance.

2.4.5 The Local Anti-Fraud Specialist will report to the Director of Finance and will work with staff in NHS Protect in accordance with the NHS Fraud, Corruption and Bribery Manual.

2.4.6 The Local Anti-Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. A Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

2.4.7 The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

2.4.8 The Act:-

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

2.4.9 The Trust will produce an annual statement to satisfy the compliance requirements of the Bribery Act.

2.4.10 The Chief Executive will ensure compliance with the conditions of the NHS Standard Contract on NHS security management.

2.4.11 The Trust will nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the conditions of the NHS Standard Contract guidance on NHS security management.

2.5 Financial Reporting

2.5.1 The Audit Committee will assure the integrity of the annual financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

2.6 Scrutiny of Waivers and Registers

2.6.1 The Audit Committee will be responsible for:-

(a) scrutinising waivers approved by Chief Executive and/or Director of Finance and approving waivers above £1m;

(b) scrutinising regular reports on losses and compensations; and

(c) scrutinising the registers of interests.

2.7 Raising Concerns

2.7.1 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, non-compliance with Standing Financial Instructions, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

2.7.2 The Audit Committee should review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Audit Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action.

2.8 Access to Records and Information

2.8.1 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:-

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust; and

(d) explanations concerning any matter under investigation.

3. FINANCIAL PLANNING AND MANAGEMENT

3.1 Annual Financial Plans

3.1.1 Prior to the start of the financial year the Director of Finance will prepare and submit an annual financial plan for approval by the Board. The financial plan will:-

(a) reflect the Trust's annual plan in terms of developments, workforce, performance etc.;

(b) be produced following discussion with appropriate budget holders;

(c) be prepared within the context of available income;

(d) identify potential financial risks;

(e) include a cash flow forecast;

(f) identify an opening capital plan; and

(g) include details of the required level of cost improvement.

3.1.2 The financial plan will be submitted to the Regulator in the required format.

3.1.3 The Director of Finance will monitor financial performance against the plan and report to the Finance Committee and/or Board and the Regulator.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Delegation to Budget Holders

3.2.1 Budgets will be delegated in accordance with the Financial Scheme of Delegation.

3.2.2 Budget holders must ensure that plans are in place to prevent expenditure budgets from being exceeded.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the control of the Director of Finance unless virement is agreed.

3.2.4 Non-recurrent budgets should not be used to finance recurrent expenditure without the authority in writing of the Director of Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:-

(a) monthly financial reports to the Board and/or Finance Committee;

(b) timely and accurate financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from the budget or plan;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers;

(f) determination of budget control totals prior to the start of the financial year; and

(g) a requirement for a monthly report from Divisional Directors to provide an account of their financial performance and forecast outturn.

3.3.2 Budget Holders are responsible for ensuring that:-

(a) any overspending or reduction of income which cannot be met by an approved virement is not incurred;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised;

(c) no permanent employees are appointed without the approval of the Director of Finance other than those provided for within the available resources and manpower establishment as approved by the Board; and

(d) they take responsibility for the delivery of savings targets in accordance with the requirements of the annual plan.

3.4 Capital Planning

3.4.1 The Board will approve the capital plan as part of the overall financial plan prior to the start of the financial year.

3.4.2 The Board may delegate decision making to the Finance Committee and the Capital Revenue & Investment Group (CRIG) in line with the Financial Scheme of Delegation.

3.4.3 The Director of Finance will provide monthly reports to the Finance Committee monitoring progress against the capital plan.

4. ANNUAL ACCOUNTS AND REPORTS

4.1.1 The Trust must prepare annual accounts in accordance with the requirements of the Regulator. The Director of Finance will make arrangements to:-

(a) prepare and submit annual accounts in accordance with the Regulator's requirements, accounting policies and generally accepted accounting practice;

(b) prepare and submit annual accounts to the Board and an audited summary to an annual members meeting convened by the Council of Governors; and

(c) lay a copy of the annual accounts before Parliament.

4.1.2 The annual report should include an Annual Governance Statement in accordance with the relevant requirements.

4.1.3 The annual accounts must be audited by the external auditor and be presented at the annual members' meeting.

4.1.4 The Trust will prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's requirements.

5. BANK AND GBS ACCOUNTS

5.1 Operation of Accounts

5.1.1 The Director of Finance is responsible for:-

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) ensuring separate bank accounts for charitable funds;

(c) ensuring accounts are not overdrawn except where arrangements have been made; and

(d) making arrangements for overdrafts if required.

5.1.2 All accounts will be held in the name of the Trust. No officer other than the Director of Finance will open any account in the name of the Trust or for the purpose of furthering Trust activities.

5.2 Banking Procedures

5.2.1 Monies belonging to the Trust or its Charity must only be deposited in bank accounts authorised by the Director of Finance. All bank accounts must be in the name of the Trust or its Charity.

5.2.2 The Director of Finance will ensure that detailed procedures are in place for the operation of bank and GBS accounts.

5.2.3 The Director of Finance will advise the Trust bankers in writing of the conditions under which each account will be operated.

5.3 Tendering and Review

5.3.1 The Director of Finance will ensure that banking arrangements are reviewed at regular intervals to ensure they reflect best practice and represent best value for money. This will be through local or national competitive tendering exercises.

6. CONTRACTING AND INCOME

6.1 Contracting for Income

6.1.1 The Director of Finance is responsible for negotiating, approving and signing contracts with CCGs and other NHS bodies.

6.1.2 The Trust will contract its services in line with either national tariff arrangements or local price agreements.

6.1.3 The Director of Finance will ensure that the appropriate contractual arrangements and documentation are in place for all services provided.

6.1.4 The Director of Finance will ensure that reports are produced detailing contract performance and income levels.

6.1.5 The Director of Finance will ensure the production of reports to show the profitability of services compared to income generated.

6.2 Income

6.2.1 The Director of Finance is responsible for designing and maintaining systems for recording, invoicing, collection and coding of income due.

6.2.2 Private patient and overseas visitors paying for their treatment, are required as far as possible, to make a pre-payment equal to the estimated cost of treatment prior to admission.

6.3 Fees and Charges

6.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of fees and charges.

6.3.2 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is received, the Trust's policy on Standards of Business Conduct and Conflict of Interest must be followed.

6.3.3 All employees must inform the Director of Finance promptly of money due from agreements, including provision of services, leases, private patient undertakings and other transactions.

6.4 Debt Recovery

6.4.1 The Director of Finance is responsible for ensuring arrangements are in place to recover outstanding debt.

6.4.2 Where income is written off, this should be dealt with in accordance with losses procedures and reported to the Audit Committee.

6.4.3 All overpayments (including salary) should be recovered wherever possible.

6.5 Security of Cash, Cheques, Payable Orders

6.5.1 The Director of Finance is responsible for:-

(a) approving all means of officially acknowledging or recording cash, cheques and payable orders received;

(b) controlling stationery used for receipting funds;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash;

(d) authorisation and provision of safes or lockable cash boxes;

(e) ensuring that policies are in place for the operation of safes including key holding;

(f) systems and procedures for handling cash, postal orders and cheques; and

(g) authorising the use of charitable giving platforms such as Just Giving, Amazon Wish Lists etc and ensuring that there is appropriate oversight and monitoring.

6.5.2 Trust cash will not be used to cash private cheques or “I Owe You’s” (IOUs).

6.5.3 All cheques, postal orders, cash etc., will be banked promptly and intact. This means that disbursements (payments) will not be made from cash received prior to banking.

6.5.4 The holders of safe keys will not accept unofficial funds or items for depositing in their safes.

7. TENDERING PROCEDURES

7.1 Compliance

7.1.1 The Trust will comply with the requirements of the law and relevant national guidance and European law as applicable. Advice should be taken from the procurement team as needed to ensure compliance with these Standing Financial Instructions.

7.2 Formal Tendering

7.2.1 The Trust will ensure that a minimum of three competitive tenders are invited for:-

(a) the supply of goods, materials and manufactured articles;

(b) the receipt of services;

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) health care services supplied by non NHS providers.

7.3 Exceptions Where Formal Tendering Need Not Be Applied

7.3.1 Formal tendering procedures need not be applied:-

(a) where total estimated cumulative expenditure with a supplier is expected to be below £10k, at least one written quote is needed;

(b) where total estimated cumulative expenditure with a supplier is not expected to exceed £50k but is above £10k, a minimum of three written or electronic quotations must be obtained; or

(c) where a competitive process or direct award (where permissible) has been undertaken through a public sector framework agreement co-ordinated by the procurement team.

7.3.2 Formal tendering procedures **may be waived** in the following circumstances:-

(a) in very exceptional circumstances formal tendering procedures would not be practical;

(b) where the timescale genuinely precludes a competitive process; or

(c) where specialist goods/services are required and available from only one source.

7.3.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a supplier originally appointed through a competitive procedure.

7.3.4 All waivers with supporting reasons should be fully documented and approved by the Director of Finance or the Chief Executive and reviewed by the Audit Committee at each meeting.

7.3.5 Where contract expenditure subsequently breaches a tender threshold, advice from the procurement team will need to be sought and the matter reported to the Audit Committee.

7.4 Tendering Procedures

7.4.1 All invitations to tender will be compliant with the Trust procurement policies and procedures which ensure a full audit trail is maintained.

7.4.2 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender. Clarifications may be made regarding qualitative aspects of the tender prior to the award of a contract providing there is a full audit trail of communications and information relevant to all bidders and shared.

7.4.3 Contracts should be awarded based on achieving the best value for money, from both quality and cost perspectives.

7.4.4 Contracts should not be awarded if they exceed the budget allocated.

7.4.5 All tenders should be treated as confidential and should be retained for inspection.

7.4.6 The Director of Finance will ensure that a register of tenders is maintained.

7.5 Financial Standing and Technical Competence

7.5.1 The Director of Finance will ensure that procurement processes include the necessary checks on the financial standing, technical competence, legal and regulatory compliance and suitability of contractors/suppliers.

8. PAY EXPENDITURE

8.1 Remuneration and Nomination Committee

8.1.1 The Board will establish a Remuneration and Nomination Committee, with clearly defined terms of reference, specifying which posts and issues fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will report in writing to the Board the basis for its recommendations. The Board will use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

8.1.3 The Trust will remunerate the Chair and non-executive directors of the Board in accordance with resolutions of the Council of Governors.

8.2 Funded Establishment

8.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2 Remuneration in terms and conditions of other employees will follow nationally negotiated settlements unless otherwise agreed by the Remuneration Committee.

8.2.3 The funded establishment of any department may not be varied except in accordance with the Financial Scheme of Delegation.

8.3 Staff Appointments

8.3.1 No employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration beyond the limit of their approved budget and funded establishment.

8.4 Payroll

8.4.1 The Director of Finance will arrange the provision of a payroll service and will be responsible for:-

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment;

(e) ensuring internal controls and audit review; and

(f) ensuring separation of duties.

8.4.2 Managers have responsibility for:-

(a) completing and submitting time records, termination forms and other notifications in accordance with agreed timetables; and

(b) notifying payroll if an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice.

8.5 Contracts of Employment

8.5.1 The Director of People will have responsibility for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) making arrangements to deal with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis as part of the annual financial plan.

9.1.2 Authority to incur spend and enter into expenditure contracts will be set in accordance with the Financial Scheme of Delegation.

9.2 Requisitioning of Goods and Services

9.2.1 The requisitioner should use electronic catalogues for the procurement of goods or services. Where this is not possible the procurement team should be consulted to advise on the appropriate route to market.

9.3 Payment of Invoices

9.3.1 The Director of Finance will ensure arrangements are in place for prompt payment of invoices and claims. Payment of invoices will be in accordance with contract terms.

9.4 Expenditure contracts

9.4.1 Advice should be sought from the procurement team before signing expenditure contracts of any value. The 'value' of the contract is over its duration rather than per annum. Authority to sign contracts is set out in the Financial Scheme of Delegation.

9.5 Prepayments

9.5.1 Prepayments will only be permitted where this is normal commercial practice or provides a financial advantage to the Trust and the financial standing of the company has been assessed along with the associated financial risk.

9.5.2 In all cases the budget holder is responsible for ensuring that goods and services due under a prepayment contract are received.

9.6 Official Orders

9.6.1 Official orders must be used for all non pay expenditure and contracts unless there is an agreed exception approved by the procurement team. The Trust operates a no purchase order no pay policy. This means that there is no obligation to pay for supplies delivered or work carried out without a purchase order.

9.7 Budget Holders

9.7.1 Budget holders must adhere to the delegated limits specified in the Financial Scheme of Delegation.

9.7.2 Orders should not be issued to any supplier that has made an offer of gifts, reward or benefit to directors or employees, or has in any other way breached the Bribery Act (2010).

9.7.3 Requisitions/orders must not be placed where there is no budget or insufficient budget, unless authorised by the Director of Finance or the Chief Executive.

9.7.4 Verbal orders must only be issued very exceptionally and an official order must be obtained as soon as practically possible.

9.7.5 Orders must not be split to circumvent financial thresholds.

9.7.6 Goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

9.7.7 Changes to the list of employees and officers authorised to certify invoices will be notified to the Director of Finance.

9.7.8 Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by Director of Finance.

9.7.9 Petty cash records will be maintained in a form as determined by the Director of Finance.

10. EXTERNAL BORROWING AND INVESTMENTS

10.1 Borrowing and Public Dividend Capital

10.1.1 All loans and overdrafts must be approved by the Board. Any draw-down against working capital facilities must be authorised by the Director of Finance and reported to the Board.

10.1.2 Draw down of Public Dividend Capital should be authorised in accordance with the Financial Scheme of Delegation.

10.1.3 The Trust will pay a dividend on its Public Dividend Capital at a rate determined by the Secretary of State.

10.1.4 The Director of Finance will report on loans, overdrafts and Public Dividend Capital to the Finance Committee.

10.1.5 The Director of Finance will prepare applications for loans and overdrafts for approval by the Finance Committee in accordance with the Regulator's requirements.

10.2 Investments

10.2.1 The Director of Finance will prepare a Treasury Management Policy which sets out the Trust's approach to cash management including investments for approval by the Board.

10.2.2 The Treasury Management Policy will seek to obtain competitive rates of interest with minimal exposure to risk.

10.2.3 Cash balances and investments must only be held by banking institutions approved by the Board as part of the Treasury Management Policy.

10.2.4 The Director of Finance is responsible for advising and reporting to the Finance Committee on any Treasury Management activities.

10.2.5 The Director of Finance will prepare detailed procedural instructions on the operation of Treasury Management activities.

11. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital Investment

11.1.1 The Director of Finance:-

(a) will ensure that there is an adequate process in place for determining capital expenditure priorities;

(b) is responsible for ensuring that monitoring arrangements are in place for capital schemes and that budgets are adhered to;

(c) will put arrangements in place to manage the capital programme within the overall budget available; and

(d) will ensure that the capital investment is not undertaken without the necessary capital financing and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For all capital expenditure the Director of Finance will ensure that that a business case has been produced and approved in accordance with the Financial Scheme of Delegation.

11.1.3 The Director of Finance will assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

11.1.4 The approval of a capital plan will not constitute approval for expenditure on any scheme unless:

(a) the funding has been confirmed in the annual capital budget for the year;

(b) the cost of the scheme remains within the sum allocated whilst still delivering the benefits identified in the business case; and

(c) the supporting Business Case has been approved.

11.1.5 Where the forecast of costs of any scheme rises above the sum allocated in the capital budget, the Director of Finance must immediately be notified and an updated business case prepared for the Capital, Revenue and Investment Group approval.

11.1.6 Contractual commitments should not be entered into unless the scheme is approved.

11.1.7 Business cases requiring Board approval under the Financial Scheme of Delegation will be considered and scrutinised by the Finance Committee.

11.1.8 All business cases will be considered by the Capital, Revenue and Investment Group irrespective of the value and either approved or recommended for approval by the Finance Committee or Board according to the Financial Scheme of Delegation.

11.1.9 The Director of Finance will approve procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 Capital Asset Registers

11.2.1 The Chief Executive is responsible for the maintenance of registers of capital assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.2.2 The Chief Executive is also responsible for the maintenance of a register identifying land and/or buildings owned or leased by the Trust.

11.2.3 Capital assets must not be sold, scrapped, or otherwise disposed of without prior approval of the Director of Finance. Their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.4 The Director of Finance will approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.2.5 Capital assets will be valued and depreciated in accordance with current accounting and reporting standards.

11.3 Security of Capital Assets

11.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.3.2 Capital asset control procedures must be approved by the Director of Finance. This procedure will make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical location of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded; and

(f) identification and reporting of all costs associated with the retention of an asset.

11.3.3 All discrepancies revealed by verification of physical assets to fixed asset register will be notified to the Director of Finance.

11.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and employees in all disciplines to apply appropriate routine security practices in relation to NHS property. Any breach of security practices must be reported in accordance with agreed procedures.

11.3.5 Any theft, loss or damage to premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported to the Director of Finance.

11.3.6 Where practical, assets should be marked as Trust property.

11.3.7 Assets must not be used for private purposes unless agreed in advance by the Director of Finance.

12. STORES AND RECEIPT OF GOODS

12.1 General Position

12.1.1 Stores, defined in terms of controlled stores and departmental stores should be:

(a) kept to a minimum;

(b) subjected to annual stock take or a program of rolling stock takes and

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, Condemnations and Disposal

12.2.1 The day-to-day responsibility for stock control is delegated to departmental employees and stores managers/keepers. The control of Pharmaceutical stocks is the responsibility of the Chief Pharmacist.

12.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations will be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

12.2.3 The Director of Finance will ensure systems are in place to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 The Director of Finance will ensure there are adequate checks on items in stores at least once a year.

12.3 Goods Supplied by NHS Supply Chain

12.3.1 The Director of Finance will identify those authorised to requisition and accept goods from the store. The authorised person will check receipt against the delivery note and notify any discrepancies to Procurement who will pursue correction of delivery or a credit note.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations

13.1.1 Land and buildings may not be sold or otherwise disposed of without the approval of the Board.

13.1.2 The Director of Finance must ensure procedures are in place for the disposal of assets.

13.1.3 When it is proposed to dispose of a Trust asset, the Head of Department or Divisional Director of Operations will liaise with Procurement and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.4 The method of all asset disposals will be recorded and confirmed by a countersignature authorised by the Director of Finance.

13.2 Losses and Special Payments

13.2.1 Any employee discovering a suspected fraud should report the matter to their line manager, Local NHS Counter Fraud Specialist or Director of Finance in accordance with the Fraud, Corruption and Bribery Policy.

13.2.2 Any employee discovering or suspecting any other loss or theft must immediately inform their head of department, security team and the Director of Finance.

13.2.3 Special payments e.g. payments not under legal obligation (or ex gratia) may only be made in line with the Financial Scheme of Delegation.

13.2.4 The Director of Finance will be authorised to take any necessary steps to safeguard against the impact of bankruptcies and company liquidations.

13.2.5 For any loss, the Director of Finance should consider whether any insurance claim can be made.

13.2.6 The Director of Finance will maintain a Losses and Special Payments Register.

13.2.7 All losses and special payments must be reported to the Audit Committee on a regular basis.

14. INFORMATION TECHNOLOGY

14.1.1 The Trust must comply with relevant legal and regulatory requirements in relation to IT and information.

14.1.2 The Trust will nominate one of the Executive Directors to act as the Senior Information Risk Officer (SIRO) to ensure controls over data entry, processing, storage, transmission and output to achieve security, privacy, accuracy, completeness, and timeliness.

14.1.3 The Senior Information Risk Officer (SIRO) will ensure that risks arising from the use of IT are identified and mitigated. This will include the preparation and testing of disaster recovery plans.

14.1.4 The Director of Finance will ensure that financial systems are implemented, developed and maintained to achieve accuracy and timeliness of data.

14.1.5 The Trust will publish and maintain a Freedom of Information (FOI) Publication Scheme.

14.1.6 The Trust IT strategy will be approved by the Board.

15. PATIENTS' PROPERTY

15.1.1 The Trust has a duty to provide safe keeping of money and other personal property belonging to patients.

15.1.2 The Trust will not accept responsibility or liability for patients' property unless it is handed in for safe keeping and a copy of an official patients' property record is obtained as a receipt.

15.1.3 The Director of Finance will ensure that procedures are in operation for the collection, recording, safekeeping and disposal of patients' property.

15.1.4 Where property of a deceased patient exceeds £5,000, the production of Probate or Letters of Administration will be required before release. Where the total value of the property is less than £5,000, this will be released to the next of kin provided forms of indemnity are obtained.

16. CHARITABLE FUNDS (FUNDS HELD ON TRUST)

16.1 Corporate Trustee Arrangements

16.1.1 The Board is the Corporate Trustee of the Trust Charity which is responsible for the management of funds held on trust.

16.1.2 The Board's discharge of Corporate Trustee responsibilities is distinct from its responsibilities for exchequer funds. There must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

16.1.3 The Corporate Trustee may delegate functions as it determines to a Charitable Funds Committee subject to approved written terms of reference. The Board must receive and adopt the annual accounts of the Charity.

16.1.4 The Corporate Trustee will authorise the Chief Executive to make arrangements for the executive leadership and day to day running of the Charity.

16.1.5 The Director of Finance will approve the financial governance arrangements of the Charity.

16.2 Administration of Charitable Funds

16.2.1 The Director of Finance will oversee the preparation of the annual accounts and the annual audit.

16.3 Accountability to Charity Commission

16.3.1 The Corporate Trustee responsibilities must be discharged separately from the Board and full recognition given accountability to the Charity Commission for charitable funds.

16.4 Applicability of Standing Financial Instructions to Funds Held on Trust

16.4.1 The Charity will apply these Standing Financial Instructions where relevant. Any breaches will be notified to the Director of Finance and reported to the Charity Committee.

17. DECLARATION OF INTERESTS AND STANDARDS OF BUSINESS CONDUCT

17.1 Policy

17.1.1 The Director of Finance will ensure that all staff are made aware of the Trust policy on Standards of Business Conduct which includes guidance on a range of issues including gifts, outside employment and managing conflicts of interest. This policy will incorporate best practice guidance issued by the Regulator and will take effect as if incorporated into these Standing Financial Instructions.

17.2 Declaration of Interests

17.2.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes. Staff members will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

17.2.2 If a staff member comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any interest, direct or indirect, they must make a declaration.

17.2.3 If a staff member has any doubt about the relevance of an interest, this should be discussed with their line manager or the Director of Corporate Governance.

17.2.4 Staff should be asked to declare interests at the start of meetings and recorded in the minutes.

17.2.5 During the course of a meeting, if a conflict of interest arises, the staff member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

17.3 Register of Interests

17.3.1 The Director of Corporate Governance will ensure that all staff and governors are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.

17.3.2 The Director of Corporate Governance will ensure that a Register of Interests is maintained to record formal declarations of interests of staff in accordance with the Trust policy.

17.3.3 The Register will be available to the public on request.

17.3.4 The Trust operates a zero tolerance approach to any form of bribery, fraud or corruption. Any such concerns in these areas should be reported to the Local Counter Fraud Specialist and/or the Director of Finance.

17.3.5 Gifts of cash and vouchers to staff should always be declined.

18. RETENTION OF RECORDS

18.1.1 The Chief Executive will be responsible for maintaining archives for all paper and digital records required to be retained in accordance with guidelines and the Trust's Record Management Policy.

19. RISK MANAGEMENT AND INSURANCE

19.1 Risk Management

19.1.1 The Chief Executive will ensure that risk management arrangements are in place in accordance with relevant requirements, which must be approved and monitored by the Board.

19.1.2 Risk management arrangements will be reported in the Annual Governance Statement within the Annual Report and Accounts.

19.2 Insurance

19.2.1 The Chief Executive will be responsible for ensuring adequate insurance cover is in place in accordance with risk management policy approved by the Board.

19.2.2 The Director of Finance should be notified of any changes to risks or property which require insurance.

19.2.3 The Director of Finance will ensure that insurance arrangements are regularly reviewed and provide the necessary assurances to the Finance Committee and / or Board.

19.2.4 The Director of Finance will authorise claims to be made and these will be reported to the Finance Committee and / or Board.

19.2.5 The Trust will insure for clinical negligence, employers' and public liability claims through the risk pooling schemes administered by the NHS Resolution.

FINANCIAL SCHEME OF DELEGATION

1. Financial Scheme of Delegation – Reservation of Financial Powers and Limits to Board, Committees and Directors

includes non recoverable VAT

Trust Board The Board reserves to itself the following powers:-	**Committees** Powers reserved to specific Committees unless delegated:-	**Directors** Powers reserved to specific Directors:-
All financial powers emanate from the Board and are delegated according to this Scheme which is incorporated as part of the Trust's Standing Financial Instructions. This scheme can be amended by the Board as required. Powers Approval of the Standing Financial Instructions and Financial Scheme of Delegation Approval of business cases for capital schemes above **£2m** Approval of business cases for revenue expenditure and income impact above **£2m** per annum Approval of invoices and contract values (total life over the contract) above **£2m** Approval of working capital facilities and loans Approval of Annual Financial Plan Approval of Capital Programme and Annual Capital Budget Approval of sale or acquisition of land or buildings Approval of sale or disposal of items on the capital asset register above **£1m** Approval of demolition of buildings Approval of waiver of competition requirements over **£1m** Approval of ex gratia payments above **£100k** The Board will authorise the appropriate Executive Director as signatories to execute its decisions e.g. contracts, invoices, requisitions. The Deputy Director of Finance transacts items on behalf of the Board in the ledger system.	Audit Committee Approval of the appointment of Internal Auditor Approval of Internal & External Audit Plans Recommending the External Auditor appointment to the governors Approval of Annual Accounts/ Annual Report Review of waivers of competition Review and scrutiny of losses and ex gratia payment registers Review of SFI breaches Finance Committee Approval of business cases for capital schemes up to **£2m** Approval of business cases for revenue expenditure or income impact up to **£2m** per annum Approval of invoices and contract values (total life over the contract) up to **£2m** Approval of the appointment of Measured Term Contractors Approval of the Treasury Management Policy Approval of ex gratia payments up to **£100k** Approval of waivers of competition requirements above **£250k and up to £1m** The Finance Committee will authorise the Director of Finance or other relevant officer as signatory to execute its decisions as appropriate Executive Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** per annum Approval of sale or disposal of equipment on the capital asset register up to **£1m** Approval of requisitions, invoices and contract values (total life over the contract) up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events e.g. alcohol Remuneration Committee Approval of Executive Directors' Pay Awards and other variations to their terms and conditions of employment Approval non-contractual severance payments Approval of Pay and Terms and Conditions of senior managers on local pay arrangements Approval of significant variations to national Terms & Conditions	Chairman Approval of Chief Executive travel expenses and study leave Chief Executive/Deputy Chief Executive Approval of travel expenses and study leave of Directors Chief Executive or Director of Finance Approval of business cases for capital schemes or non recurrent revenue up to **£100k** Approval of requisitions, invoices and contract values (total life over the contract) within approved budget up to **£1m** Approval of ex gratia payments up to **£50k** Approval of waivers of competition requirements up to **£250k** Approval of lottery licenses or other licences needed for events Director of Finance Final interpretation of Standing Financial Instructions Authorising the opening/closing bank accounts Approval of financial procedures and financial signatories Authorisation of the use of charitable giving platforms, wish lists etc. Authorisation of the use of safes Approval of pricing strategies, fees and charges in relation to income Deciding when to involve the police in matters of fraud or theft Approval of financial systems and controls including cash handling Approval of sale or disposal of equipment on the capital asset register up to **£100k** Approval of financial governance arrangements of charitable funds Approval of changes to the Financial Scheme of Delegation below **£50k** Approval of budget increases/virement over **£50k.** Approval of PDC draw down signatories Approval of insurance claims Access to records to progress financial investigations Deputy Chief Executive Assumes powers and limits in the absence of the Chief Executive Deputy Director of Finance Assumes powers and limits in the absence of the Director of Finance Capital Revenue & Investment Group - sub group of Executive Approval of business cases for capital schemes up to **£1m** Approval of business cases for revenue expenditure or income impact up to **£1m** per annum Review of all capital business cases and capital expenditure

2. Financial Scheme of Delegation – Authorised Powers and Limits to the Executive including non recoverable VAT

Executive Directors Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Deputy Director of Operations** **Divisional Directors of Operations** **Deputy Director of Finance** Powers and Approval Limits within Directorate/ Divisional Approved Budget:	**Other Deputy Directors** **General Managers** **Professional Leads** Powers and Approval Limits within Departmental Approved Budget:	**Departmental Managers** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**Matrons** Powers and Approval Limits within Ward/Department/Unit Approved Budget:	**"Ward / Unit Managers" or equivalent** Powers and Approval Limits within Ward/Departmental/Unit Approved Budget:	**Managers within Ward / Unit** Powers and Approval Limits within Ward/Department/Unit Approved Budget:
Revenue or capital requisitions, orders, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£250k**	Revenue or capital requisitions, orders, invoices and contracts for income or expenditure (total value over the life of the contract) up to **£50k**	Revenue or capital requisitions, orders or invoices up to a limit which will be agreed by DDOs but not exceeding **£10k**	Revenue requisitions or orders up to a limit which will be agreed by DDOs but not exceeding **£5k**	Revenue requisitions or orders up to a limit which will be agreed by DDOs but not exceeding **£2.5k**	Revenue requisitions or orders up to a limit which will be agreed by DDOs but not exceeding **£1k.**	Revenue requisitions or orders up to a limit which will be agreed by DDOs but not exceeding **£1k.**
Recruitment to posts within budgeted establishment	Recruitment to posts within budgeted establishment	Recruitment to posts within budgeted establishment	Recruitment to posts within budgeted establishment	Recruitment to posts within budgeted establishment	Recruitment to posts within budgeted establishment	Recruitment to posts within budgeted establishment
Travel Expenses of staff at bands of the same or below.	Travel Expenses of staff at bands of the same or below.	Travel Expenses of staff at bands of the same or below.	Travel Expenses of staff at bands of the same or below.	Travel Expenses of staff at bands of the same or below.	Travel Expenses of staff at bands of the same or below.	Travel Expenses of staff at bands of the same or below.
Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave	Timesheets including overtime and internal bank hours, special duty claims and scheduling of annual leave
Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)	Disposal of obsolete revenue funded furniture and equipment (excludes capital)
Virement within pay and non-pay budget	Virement within pay and non-pay budget	Virement within pay and non-pay budget	Virement within pay and non-pay budget	Virement within pay and non-pay budget		
Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories	Delegation of budgets within the Directorate/ Division including authorisation of signatories		
Changes to budgeted establishment within pay budget	Changes to budgeted establishment within pay budget	Changes to budgeted establishment within pay budget				
Ex gratia payments up to **£5k**	Ex gratia payments up to **£5k**	Ex-gratia payments up to **£1k** <u>Chief Pharmacist</u> Drugs expenditure up to **£50k**				

3. Financial Scheme of Delegation – Financial Limits by Type of Approval (£) including non recoverable VAT

Type of Approval	Board	Finance Comm	Execs	CRIG	CEO	Dof	ED	DDOs	Other Deputy Directors	Dep't managers	Matrons	Ward managers Managers
Approval of business cases for capital schemes	>2m	<2m	<1m	<1m	<100k	<100k						
Approval of business cases for revenue expenditure and income impact per annum	>2m	<2m	<1m	<1m	<100k Non rec	<100k Non rec						
Approval of invoices and contract values (total life over the contract) within approved budget	>2m	<2m	<1m		<1m	<1m	<250k	<50k	<10k	<2.5k	<1k	<1k
Approval of requisitions or orders within approved budget	>2m	>2m	<1m		<1m	<1m	<250k	<50k	<10k	<2.5k	<1k	<1k
Approval of sale or disposal of items on the capital asset register	>1m		<1m			<100k						
Approval of ex gratia payments	>100k	<100k	<50k		<50k	<50k	<50k	<5k	<1k			
Approval of waiver of competition requirements	>1m	<1m	<250k		<250k	<250k						
Changes to Financial Scheme of Delegation	>50k					<50K						
Approval of budget increases/virement						>50k	<50k					

Key SFIs

1.2.4	If you become aware of a breach of SFIs, then seek advice from the Director of Finance
3.2.4	Do not use non recurrent monies to fund recurring expenditure
5.1.2	Do not open a bank account in the name of Trust, only the Director of Finance can open bank accounts in the name of the Trust
5.2.1	Only deposit Trust money, cheques or cash through the cashiers' department and into official bank accounts. Do not use unofficial bank accounts
6.3.2	Sponsorship is acceptable provided the Standards of Business Conduct policy is followed
6.5.1	If you have a safe it must be regularly authorised for use and be designated as official by the Director of Finance
6.5.1	You must seek permission from the Director of Finance to set up charitable giving platforms in the name of the Trust
6.5.3	If you receive cash or cheques on behalf of the Trust or its Charity, this must be banked intact. Do not use the cash to buy goods or services.
6.5.4	Do not use an official safe to store unofficial funds or valuables
7.	You must follow the guidance from the procurement team on tendering and waivers. Seek their advice if unsure.
7.3.1	The tendering limits apply to the total expected cumulative spend with the supplier.
9.6.1	Use official orders for non pay unless there is an agreed exception. Seek advice from the procurement team.
9.7.3	Do not place an order if there is no budget or insufficient budget, unless the Chief Executive or the Director of Finance has given approval
9.7.5	Do not split order values to circumvent financial thresholds
11.1.8	Do not incur capital expenditure without the necessary approval
11.3.5	Any theft must be reported to the Director of Finance
13.2.1	Suspected fraud must be reported to line management, Local Counter Fraud lead or the Director of Finance
15.1.2	Patients property should be stored using official receipts and safes.
17.2.1	Staff should declare their interests and provide updates when there are changes – refer to the Trust policy on Standards of Business Conduct
17.3.1	Follow the guidance when receiving gifts and make sure they are declared.
17.3.5	Do not accept personal gifts of cash or vouchers

Bolton NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Approved Audit Committee

(Date to be inserted)

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STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued by the Board of Bolton NHS Foundation Trust (BNHSFT). They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by BNHSFT. They are designed to ensure that BNHSFT's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, and value for money (economy, efficiency and effectiveness). They should be used in conjunction with the Schedule of Decisions/Powers Reserved to the Board/Committees and Scheme of Delegation to Directors and Managers.

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for BNHSFT and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of BNHSFT's Standing Orders.

1.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 Deliberate failure to comply with Standing Financial Instructions (SFIs) and Standing Orders (SOs) could constitute a breach of the Fraud Act 2006 or the Bribery Act 2010 and result in criminal action being taken against an individual or individuals.

1.1.7 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 Terminology

"Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

a. "Trust" means the Bolton NHS Foundation Trust

b. "Board" means the Board of Directors of BNHSFT as set out in the Constitution;

c. "Committee" means any committee established by the Council of Governors or the Board of Directors for the purposes of fulfilling its functions;

d. "Council of Governors" means the body of elected and appointed governors, authorised to be members of the Council of Governors and to act in accordance with the Constitution;

e. "Constitution" means the constitution, approved by the members of the Foundation Trust, and which describes the operation of BNHSFT;

f. "Chief Executive" means the chief officer of BNHSFT;

g. ""Director of Finance" means the chief financial officer of BNHSFT;

h. "2006 Act" refers to the National Health Service Act 2006;

i. "Authorisation agreement" refers to the document issued by the Regulator at the inception of BNHSFT authorising it to operate as a Foundation Trust in accordance with Chapter 5 of the National Health Service Act 2006.

j. "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of BNHSFT;

k. "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

l. "Funds held on trust" shall mean those funds which BNHSFT holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 2006, as amended. Such funds may or may not be charitable;

m. "Legal Adviser" means the properly qualified person appointed by BNHSFT to provide legal advice;

n. "Mandatory services" are those services which the Regulator has deemed it compulsory that BNHSFT provides, as listed in the Authorisation agreement;

o. "Protected assets" refers to those assets of BNHSFT deemed by the Regulator to be essential to the provision of mandatory services (see above) and listed as such in the Authorisation agreement;

p. "Regulator" means the Independent Regulator for the purposes of the 2006 Act;

q. "SFIs" means Standing Financial Instructions;

r. "SOs" means Standing Orders; and

s. "Virement" means the transfer of budgetary provision from one budget head to another."

1.3 Responsibilities and delegation

1.3.1 **BNHSFT Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Schedule of Decisions etc document referred to at SFI 1.1.2 above.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Decisions etc document referred to at SFI 1.1.2 above. All other powers have been delegated to such other committees as BNHSFT has established.

1.3.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

The National Health Service Act 2006 designates the Chief Executive of an NHS Foundation Trust as the Accounting Officer. The responsibilities of an NHS FT Accounting Officer are contained in guidance issued by NHSI (NHS Improvement) and include the overall organisation, management and staffing of the NHS Foundation Trust and its procedures in financial and other matters. The Accounting Officer must ensure that:

- there is a high standard of financial management in the NHS Foundation Trust as a whole;
- financial systems and procedures promote the efficient and economical conduct of business and safeguard financial property and regularity throughout the NHS Foundation Trust; and
- financial considerations are fully taken into account in decisions on NHS Foundation Trust policy proposals.

1.3.4 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.3.5 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing BNHSFT's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain BNHSFT's transactions, in order to disclose, with reasonable accuracy, the financial position of BNHSFT at any time;

and, without prejudice to any other functions of BNHSFT, and employees of BNHSFT, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as BNHSFT may require for the purpose of carrying out its statutory duties.

1.3.6 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of BNHSFT;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.7 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

1.3.8 Contractors and their employees

Any contractor or employee of a contractor who is empowered by BNHSFT to commit BNHSFT to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with paragraph 23, Schedule 7 of the NHS Act 2006, the Board shall formally establish an Audit Committee of non-executive directors to perform such monitoring, reviewing and other functions as are appropriate.

2.1.2 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 The Audit Committee will have clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2005).

2.1.4 The Audit Committees main responsibilities are to:

- provide the third line of assurance focusing on reviewing assurance and gaps in the control and scrutiny provided by other committees.
- review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.
- review the Board Assurance framework at least twice a year.
- use NHSI's quarterly risk rating to monitor and review the Trust's financial performance and any formal announcements relating to the Trust's financial performance, reviewing significant financial reports and the judgments contained in them.

In particular, the committee will review the adequacy of:-

- all risk and control related disclosure statements together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

- review and seek assurances on the work of other committees.

- in carrying out this work the committee will primarily utilise the work of the internal audit, external audit and other assurance functions, but will also seek reports and assurance from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

2.1.5 Relationship with Internal Audit

The Committee shall:-

- ensure that there is an effective internal audit function established by management, that meets mandatory Government audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board this will be achieved by:-

- consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

- review and approve the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance framework.

- consider the major findings of internal audit work (and managements response) and ensuring co-ordination between external and internal auditors to optimise audit resources.

- ensure that the internal audit function is adequately resourced and has appropriate standing within the Trust.

- review annually the effectiveness of internal audit.

2.1.6 Relationship with External Audit

The Committee shall:-

- review the work findings of the external auditor appointed by the Governors and consider the implications and management's responses to their work this will be achieved by:-

- consider the appointment and performance of the external auditors, as far as the rules governing the appointment permit.

- liaise with the Council of Governors regarding the appointment and performance of the external auditor.

- discuss and agree with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

- review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

2.1.7 Relationship with NHS Protect

The Audit Committee shall satisfy itself that:-

- the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work including but not limited to:-

- the policies and procedures for all work related to fraud and corruption as set out in under the NHS Standard Contract for 2017/2018, that all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements and Security Management Service In line with their responsibilities, The Trust Chief Executive and Director of Finance shall monitor and ensure compliance on fraud, corruption, and bribery as set out in the NHS Protect Standards for providers.

- .

- ensure the Trust has identified a Non Executive to undertake the whistleblowing role in line with the trust's policy and will review any issues raised in the Audit Committee.

2.1.8 Financial Reporting

- The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

- ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to completeness and accuracy of information provided to the Board.

- Review the Annual Report and financial statements before submission to the Board, focusing primarily on:-

- the wording of the Statement of Internal Control and other disclosures relevant to the terms of reference of the committee,

- changes in, and compliance with, accounting policies, practices and estimation techniques.

- unadjusted mis-statements in the financial statements.

- significant judgements in preparation of the financial statements.

- significant adjustments resulting from the audit.

- letter of representation.

- qualitative aspects of financial reporting.

2.1.9 Other Responsibilities

- The Audit Committee will also be responsible for:-
- scrutinising waivers approved by Chief Executive and Director Of Finance and approving waivers of £250,000 - £1m.

- approving changes to the Trust's standing financial instructions.

- receiving regular reports on losses and compensations and review the appropriateness thereof.

- receiving regular reports on variations to terms and conditions of service and review the appropriateness thereof.

2.1.10 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board.

2.1.11 The Audit Committee should review arrangements by which staff of BNHSFT may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Audit Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit Committee and the accountable officer

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control, risk management and governance;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of Internal Audit recommendations;
(iv) progress against plan over the previous year.

(e) ensuring that an annual Internal Audit Plan is produced for consideration by the Audit Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year; and

(f) ensuring that a medium-term internal audit plan (usually three years) is prepared for the consideration of the Audit Committee and the Board.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of BNHSFT;

(c) the production of any cash, stores or other property of BNHSFT under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(a) an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives;

(b) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.3.2 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which BNHSFT's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

2.3.3 The Head of Internal Audit will provide to the Audit Committee;

(a) A risk-based plan of internal audit work, agreed with management and approved by the Audit committee, based upon the management's Assurance Framework that will enable the Auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organization;

(b) Regular updates on the progress against plan;

(c) Reports of management's progress on the implementation of action agreed as a result of internal audit findings;

(d) An annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system on internal control). This opinion is used by the Board to inform the Annual Governance Statement.

(e) Additional reports as requested by the Audit Committee.

2.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of BNHSFT.

2.3.6 The Head of Internal Audit shall be accountable to the Director of Finance.

2.3.7 The reporting system shall be reviewed at least every three years.

2.4 External Audit

2.4.1 In accordance with paragraph 23, Schedule 7 of the 2006 Act, BNHSFT must appoint an External Auditor.

- It is for the board of governors to appoint or remove the auditor at a general meeting of the board.

- But a person may not be appointed as auditor unless they (or, in the case of a firm, each of its members) are a member of one or more of the following bodies
  (a) the bodies mentioned in section 3(7)(a) to (e) of the Audit Commission Act 1998 (c. 18),
  (b) any other body of accountants established in the United Kingdom and approved by NHSI for the purposes of this paragraph.

2.4.2 The responsibilities of the External Auditor are prescribed in Schedule 10 of the Act; in particular:

- To be satisfied that the accounts comply with the directions provided, i.e. that the accounts comply with *The NHS Foundation Trust Financial Reporting Manual*.

- To be satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which are applicable to the accounts.

- To be satisfied that proper practices have been observed in compiling the accounts.

- To be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources.

- To comply with any directions given by NHSI as to the standards, procedures and techniques to be adopted, i.e. to comply with the code.

- To consider the issue of a public interest report.

- To certify the completion of the audit.

- To express an opinion on the accounts.

- To refer the matter to NHSI when an NHS Foundation Trust, or an officer or director of an NHS Foundation Trust, makes or is about to make decisions

involving potentially unlawful expenditure or takes or is about to take potentially unlawful action likely to cause a loss or deficiency.

2.5 Fraud, Corruption and Bribery

2.5.1 In line with their responsibilities as set out in HSG (96) 12, BNHSFT Chief Executive and Director of Finance shall monitor and ensure compliance with the conditions of the NHS Standard Contract on fraud, corruption and bribery.

2.5.2 BNHSFT shall nominate a suitable person to carry out the duties of the Local Anti-Fraud Specialist as specified by the NHS Fraud, Corruption and Bribery Manual and guidance.

2.5.3 The Local Anti-Fraud Specialist shall report to BNHSFT Director of Finance and shall work with staff in NHS Protect in accordance with the NHS Fraud, Corruption and Bribery Manual

2.5.4 The Local Anti-Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. In addition, a Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

2.5.5 The Bribery Act (2010) came into force on 1st July 2011. The Act made it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid (or at least minimise) the Bolton NHS Foundation Trust – Standing Financial Instructions (SFIs) risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

The Act covers the following areas:

- make it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);
- make it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and
- introduce a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

However, organisations will have a defence against prosecution if they can show that they have adequate procedures in place to prevent bribery. The Trust will produce an annual statement to satisfy the compliance requirements of the Bribery Act

2.6 Security Management

2.6.1 In line with their responsibilities, BNHSFT Chief Executive will monitor and ensure compliance with the conditions of the NHS Standard Contract on NHS security management.

2.6.2 BNHSFT shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the conditions of the NHS Standard Contract guidance on NHS security management.

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 In accordance with paragraph 27, Schedule 1, of the 2006 Act, the Compliance Framework and Annual Planning Guidance issued by Monitor, BNHSFT will prepare and submit to NHSI an Annual Plan for publication. This will be developed and approved by the Board and will set out, *inter alia,* its strategic plans and income and expenditure projections for the following three financial years.

3.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit an Annual Revenue Budget for approval by the Board. Such budget will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available income;

(e) identify all sources of income;

(f) identify potential risks;

(g) enable BNHSFT to comply with the requirements of the Prudential Borrowing Code set by the Independent Regulator

3.1.3 The plan must be submitted to NHSI in the required format.

3.1.4 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

3.1.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 Budgets will be delegated to Executive Directors and Managers in accordance with the Scheme of Delegation.

3.2.2 Budget holders must not allow expenditure budgets to be exceeded.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Director of Finance subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Director of Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board and Finance and Investment Committee in a form approved by the Board containing:

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(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash and capital and performance within the Prudential Borrowing Code;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

(f) arrangements for the issuing of Divisional and Directorate budget control totals prior to the start of the financial year as detailed in the Financial Management Framework

3.3.2. Divisions and Directorates will be required to certify prior to start of each quarter that they will live within their budget control total for the year. This certification will be signed off by the Divisional/Directorate Management Team and based on activity forecasts which will include:-

- month by month income, pay and non-pay forecast including recurrent/non-recurrent analysis
- month by month projection of savings schemes including recurrent/non recurrent analysis
- month by month projection of contract performance re penalties/CQUINs and best tariff practice adjustments
- month by month analysis of downside risks.

3.3.3 The control totals, at a divisional level, for income, pay and non pay can only be changed following agreement from the Capital and Revenue Investment Group (CRIG)

3.34 Within each Division/Directorate each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by an approved virement is not incurred;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised

(c) no permanent employees are appointed Director of Finance other than those provided for within the available resources and manpower establishment as approved by the Board.

3.3.5 The delivery of savings targets in accordance with the requirements of the Annual Plan and a balanced budget are the responsibility of each Division/Directorate and will be performance managed by the Executive Board.

3.4 Capital Expenditure (See also SFI 11)

3.4.1 The Board approves the overall capital programme as part of the annual plan (APR) and delegates to the Finance and Investment Committee decisions on variations/business cases between £1m and £2m. Capital Revenue & Investment Group (CRIG) approves any below those limits. (The particular applications relating to capital are contained in SFI 11

3.4.2 The Director of Finance will chair the CRIG will prepare a detailed annual and five year capital programme for approval by the Board prior to the start of the relevant financial year.

3.4.3 The Director of Finance will provide monthly reports to the Finance and Investment Committee monitoring progress against the capital budget and authority to approve cost increases/virements.

3.4.4 The CRIG will approve capital business cases within its delegated authority,

3.4.5 Delegation of the capital budget shall be in accordance with the Scheme of Delegation.

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 In accordance with Schedule 7 (paragraph 25) of the 2006 Act and BNHSFT's Constitution, BNHSFT must keep accounts, and in respect of each financial year must prepare annual accounts, in such form as the Regulator may, with the approval of the Treasury, direct. These responsibilities will be carried out by the Director of Finance who, on behalf of BNHSFT, will:-

(a) prepare annual accounts in accordance with the Regulator's Manual of Accounts and any other guidance from the same, BNHSFT's accounting policies and generally accepted accounting practice;

(b) prepare and submit annual accounts to the Board and an audited summary of the Main Financial Statements to an annual members meeting convened by the Council of Governors, certified in accordance with current guidelines;

(c) lay a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.

4.2 The annual accounts should, in accordance with the requirements set out in the Accounts Direction, include an Annual Governance Statement within the financial statements.

4.3 BNHSFT's annual accounts must be audited by the external (financial) auditor appointed by the Council of Governors and be presented at the annual members meeting referred to in 4.1 (b) above.

4.4 In accordance with Schedule 7 (paragraph 26) of the 2006 Act, BNHSFT will also prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's Annual Report Guidance for NHS Foundation Trusts and will include, inter alia:

(a) information on the steps taken by BNHSFT to ensure that the actual membership of the various constituencies (public ,patients and staff) is representative of those eligible for such membership;

(b) the Annual Accounts of BNHSFT in full or summary form;

(c) details of relevant directorships and other significant interests held by Board members;

(d) composition of the Audit Committee and of the Remuneration and Terms of Service Committee;

(e) remuneration of the Chair, the Non-Executive Directors and Executive Directors, on the same basis as those specified in the Companies Act;

(f) a statement of assurance by the Chief Executive in respect of organisational controls and risk management within BNHSFT (as per HSC 1999/123;

(g) any other information required by the Regulator.

4.5 BNHSFT is to comply with any decision that the Regulator may make as to the form of the annual report, the timing of its submission and the period to which it relates.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 Subject to approval by the Finance and Investment Committee, the Director of Finance is responsible for managing BNHSFT's banking arrangements and for advising BNHSFT on the provision of banking services and operation of accounts.

5.2 Bank and GBS Accounts

5.2.1 The Director of Finance is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for BNHSFT's charitable funds;

(c) ensuring payments made from bank or GBS aggregated accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with BNHSFT's bankers for accounts to be overdrawn.

5.2.2 All accounts shall be held in the name of BNHSFT. No officer other than the Director of Finance shall open any account in the name of BNHSFT or for the purpose of furthering Foundation Trust activities.

5.3 Banking Procedures

5.3.1 Funds belonging to BNHSFT (or the charitable fund) must only be deposited in those accounts authorised by the Director of Finance. All such accounts must be in BNHSFT's name (or the name of BNHSFT charitable fund).

5.3.2 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on BNHSFT's accounts;

(c) the limit to be applied to any overdraft

5.3.3 The Director of Finance must advise BNHSFT's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review

5.4.1 The Director of Finance will review the commercial banking arrangements of BNHSFT at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for BNHSFT's commercial banking business.

5.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Finance and Investment Committee. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Contracts

6.1.1 The Chief Executive and/or the Director of Finance are responsible for negotiating, approving and signing contracts with CCGs and any other NHS bodies. Contracts will take into account:-

- The NHS Standard Contract
- Everyone Counts (previously the Operating Framework)
- National Code of Conduct

6.1.2 BNHSFT will price its service contracts with NHS healthcare commissioners according to national tariffs published by the Department of Health. In areas where the national tariff arrangements do not apply, BNHSFT shall follow the Department of Health's Payment by Results Guidance.

6.2 NHS Contracts for Provision of Services

6.2.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Foundation Trust enters into suitable legally binding contracts with NHS Commissioners both for mandatory healthcare services specified in BNHSFT's authorisation agreement with the regulator, and also other healthcare services.

6.2.2 In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected;

(b) the relevant national service framework

(c) service priorities contained within BNHSFT's Business Plan and agreed with healthcare commissioners;

(d) national tariffs published by the Department of Health or other agreed local pricing mechanisms where national tariffs do not (yet) apply;

(e) the need to provide ancillary and other supporting services essential to the delivery of the healthcare involved;

(f) the need to ensure the provision of reliable and on-going information on service cost, volume and quality;

(g) previously agreed developments or investment plans

6.2.3 The Chief Executive as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the Contracts with NHS Commissioners and non NHS Commissioners. This analysis will particularly highlight the impact of differences between planned and actual numbers of service users treated and outline any action required to address such variances. Periodically, at intervals to be agreed with the Board, the Chief Executive will also provide information on the impact of differences between the actual cost to BNHSFT of treating service users in individual service lines and the relevant national tariff.

6.3 Income Systems

6.3.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.3.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.4 Fees and Charges

6.4.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.4.2 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.4.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.5 Debt Recovery

6.5.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.5.2 Income not received should be dealt with in accordance with losses procedures.

6.5.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.6 Security of Cash, Cheques and other Negotiable Instruments

6.6.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of BNHSFT.

6.6.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.6.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.6.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that BNHSFT is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving BNHSFT from responsibility for any loss.

7. COMPETITIVE TENDERING AND CONTRACTING PROCEDURE - EXPENDITURE

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of BNHSFT shall comply with these Standing Financial Instructions.

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Financial Instructions.

7.3 National Guidance

BNHSFT shall comply as far as is practicable with the guidance issued by NHSI also taking into account requirements of current accounting standards and “Estate code” in respect of capital investment and estate and property transactions.

7.4 Formal Competitive Tendering

7.4.1 **General Applicability**

BNHSFT shall ensure that a minimum of three competitive tenders dependant on the EU procedure used are invited for:

- the supply of goods, materials and manufactured articles,
- the receipt of services, and
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens).

- Health Care Service. Where the Trust elects to invite tenders for the supply of healthcare services, Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to tendering procedures.

One of the following methods must be used:

- electronic tenders using a system approved by the Director of Finance such as EU – Supply" which provides equivalent controls to those identified for written tenders and is administered by Procurement , and

  electronic auction – using the most appropriate procedure.

7.4.2 **Exceptions and instances where formal tendering need not be applied (provided they conform to EU directives governing public procurement)**

Formal tendering procedures **need not be applied** where the total estimated expenditure does not, or is not reasonably expected to exceed **£50k, however for procurements estimated to cost £10k to £50k a minimum of three competitive written or electronic quotations must be obtained (see 7.6 below).**

Or where specialist expertise is required and is available from only one source. However it must be noted that the Procurement Team will carry out all due diligence checks prior to the order being processed.

7.4.3 Formal tendering procedures **may be waived** in the following circumstances: **(provided they conform to EU directives governing public procurement)**

a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

b) where the requirement is covered by an existing contract be that national, regional or local;

c) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as ajustification for a single tender;

d) where specialist expertise is required and is available from only one source;

e) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

f) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

g) The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

h) Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.4.4 All waivers must be supported by a completed waiver form justifying the waiver and authorised in accordance with the scheme of delegation.

7.4.5 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.5 Contracting/Tendering Procedure

7.5.1 **Invitation to tender**

(i) All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal where practicable.

(ii) All tendering carried out through e-tendering will be compliant with the Trust policies and procedures. The issuing of all tender documentation should be undertaken electronically through a secure website with controlled access using secure login, authentication and viewing rules.

(iii) All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

(iv) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(v) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

7.5.2 **Receipt and safe custody of tenders**

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The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

Electronic- This is undertaken through the e-tendering system. All tenders that are received in an electronic format will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. The system records the date and time of receipt of each tender.

7.5.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the nominated Procurement officer with the appropriate permissions to do

(ii) An audit report detailing the names and details of all documents received in to the Electronic Vault is recorded.

(iii)

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v)

(vii) A full audit trail shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.
- any correspondence from the bidder

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (See SFI 7.5.5 below).

(ix) Any tenders issued electronically via the e-tendering system will be locked until the due date at which point they can be released by a designated officer

7.5.4 **Admissibility**

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are

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insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or Director of Finance.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for BNHSFT.

7.5.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. where the tenderer has encountered a technical issue via the e-tendering portal

(ii)

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and heldelectronically.

(ii) The e-tendering system will require the Trust authorised officers to approve the opening of Tenders received past the Tender Return date – until this is agreed /arranged they will be stored securely online. The option remains for such Tenders not to be opened at all and declared void.

7.5.6 **Acceptance of formal tenders**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by BNHSFT, or the highest, if payment is to be received by BNHSFT, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, and supported by a waiver form authorised in accordance with the Scheme of Delegation.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by BNHSFT and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

7.5.7 **Tender reports to BNHSFT Board**

A final report to BNHSFT Board will be made when a full tender is carried out.

7.5.8 **List of approved firms**

Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Health Building Note 00-08 Estatecode(2007)

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Single Equalities Act 2011 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.5.9 **Financial Standing and Technical Competence of Contractors and Suppliers**

The Director of Finance may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of contractors/suppliers. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

7.6 Quotations: Competitive and non-competitive

7.6.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10k but not exceed £50k, inclusive of VAT over the lifetime of the contract.

7.6.2 **Competitive quotations**

(i) Quotations should be obtained from at least three firms/individuals based on specifications prepared by, or on behalf of, BNHSFT.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be

obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by BNHSFT, or the highest if payment is to be received by BNHSFT, then the choice made and the reasons must be supported by a waiver form and authorised in accordance with the Scheme of Delegation.

7.6.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

All non-competitive quotations must be supported by a completed waiver form justifying competitive quotations have not been obtained, and authorised in accordance with the Scheme of Delegation.

7.6.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by BNHSFT and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.
(provided they conform to EU directives governing public procurement)

7.7 Authorisation of Tenders and Competitive Quotations

Providing that the goods/services have been authorised in accordance with the Scheme of Delegation (see SFI 1.1.2 above), and all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, including obtaining waiver authorisation if required, formal authorisation and awarding of a contract will be made by Procurement following authorisation from the appropriate budget.

7.8 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of BNHSFT within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) BNHSFT's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including, Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by BNHSFT, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of BNHSFT.

7.9 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.10 Disposals (See also SFI 12)

Competitive Tendering or Quotation procedures shall similarly apply to the disposal of assets except:-

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the disposals policy of BNHSFT;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

7.11 In-house Services

7.11.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. BNHSFT may also determine from time to time that in-house services should be market tested by competitive tendering.

7.11.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £1 million, a non-officer member should be a member of the evaluation team.

7.11.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.11.4 The evaluation team shall make recommendations to the Board.

7.11.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of BNHSFT.

7.12 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI 16)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from BNHSFT's trust funds and private resources.

8. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF BNHSFT BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

8.1 Remuneration and Terms of Service

8.1.1 The Board shall establish a Nomination and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to BNHSFT - having proper regard to BNHSFT's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors Minutes of the Board's meetings should record such decisions.

The Board will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employee not covered by the Committee.

8.1.3 BNHSFT will remunerate the Chairman and non-executive directors of the Board in accordance with resolutions of the Council of Governors.

8.2 **Funded Establishment**

8.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

8.2.2 Remuneration in terms and conditions of other employees will follow nationally negotiated settlements unless otherwise agreed by the Board.

8.2.3 The funded establishment of any department may not be varied except in accordance with the Scheme of Delegation.

8.3 Staff Appointments

8.3.1 No officer or Member of BNHSFT Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Director of Human Resources;

(b) and within the limit of their approved budget and funded establishment.

8.4 Processing Payroll

8.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

8.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by bank credit or cheque to employees and officers;

(I) procedures for the recall of bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records

(m) a system to ensure the recovery from those leaving the employment of BNHSFT of sums of money and property due by them to BNHSFT.

8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance and appropriate Payroll Officer must be informed immediately.

8.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of Employment

8.5.1 The Director of Human Resources will have responsibility for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

9. NON-PAY EXPENDITURE

9.1 Delegation of Authority

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis as part of the Annual Revenue Budget.

9.1.2 Authority to place requisitions will be in accordance with the Scheme of Delegation

9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with SFI 7)

9.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always utilise the electronic catalogues available where possible, or consult with the Procurement Department to ensure that best value for money is achieved. Where this is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

9.2.2 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

9.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Financial Instructions and regularly reviewed;

(b) be responsible for the prompt payment of all properly authorised accounts and claims;

(c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of officers authorised to certify invoices.

(ii) Certification that:

- goods and services have been requisitioned via an official order of BNHSFT unless specifically exempted by the Director of Finance

- goods have been duly received, examined and are in accordance with specification and the prices are correct

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 9.2.4 below.

9.2.4 **Prepayments**

Prepayments will only be permitted where prepayment is the normal commercial practice for the service concerned, e.g. leases and maintenance agreements, in which case the service should be competitively tendered to ensure that the financial advantages of prepayment outweigh the disadvantage in terms of loss of interest and taking into account the financial standing of the company concerned and the associated financial risk.

9.2.5 No other prepayments should be made without the agreement of the Director of Finance following a written report justifying the need for prepayment, the financial advantages, disadvantages and risks.

9.2.6 In all cases the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.7 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state BNHSFT's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive or the Director of Finance.

9.2.8 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, or has in any other way breached the Bribery Act (2010) other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Orders and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff"); and the Bribery Act

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by a departmental manager, divisional manager, divisional nurse or executive director and only in cases of emergency or urgent necessity. An official order number must be obtained in advance from Procurement.

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit BNHSFT to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

9.2.9 The Chief Executive and the Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Health Building Note 00-08 Estatecode. (The technical audit of these contracts shall be the responsibility of the relevant Director.

10. EXTERNAL BORROWING AND INVESTMENTS

10.1 Borrowing

10.1.1 All new loans must be approved by the Board. Any draw-down against working capital facilities must be reported to the next meeting of the Board.

10.1.2 The Director of Finance is responsible for ensuring that BNHSFT does not break its Prudential Borrowing Limit as determined by Monitor, and for reporting periodically to the Board BNHSFT's position against this limit and any associated risks.

10.1.3 The Director of Finance will advise the Board concerning BNHSFT's ability to pay dividend and/or interest on, and repay, Public Dividend Capital and any proposed new borrowing. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

10.1.4 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts, including authorised signatories, for approval by the Finance and Investment Committee. These must comply with instructions issued by Monitor.

10.2 Investments

10.2.1 The Director of Finance will prepare a Treasury Management Policy and procedures for approval by the Finance and Investment Committee. This will, *inter alia*, seek to obtain competitive rates of interest with minimum exposure to risk. The Director of

Finance will report periodically to the Finance and Investment Committee in relation to investments and performance.

11. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital Investment

11.1.1 The Director of Finance, as Chair of the CRIG:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without the necessary capital financing and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For every capital expenditure proposal the Director of Finance shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that where applicable Monitor's guidance e.g. "Risk Evaluation for Investment Decisions by NHS FTs" is follows.

(c) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Finance will issue procedures for their management, incorporating the recommendations of "Estatecode".

11.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

11.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme unless:

(a) the funding has been confirmed in the annual capital budget for the year, and
(b) the cost of the scheme remains within the sum allocated whilst still delivering the benefits identified in the business case.
(c) the supporting Business Case has been approved by the CRIG.

11.1.7 Where the forecast of costs of any scheme rises above the sum allocated in the capital budget, the Director of Finance must immediately be notified. Cost increases/virements of up to £50k may be approved by the Chief Executive or the Director of Finance between meetings and reported to the next meeting of the CRIG . Cost increases/virements of greater than £50k will require prior approval of the Executive Board and no contractual commitment should be entered into unless approved by the Executive Board (or the Board).

11.1.8 For schemes estimated to cost over £1m the approval of the Finance and Investment Committee should additionally be sought prior to tender.

11.1.9 For schemes estimated to cost over £2m the approval of the Finance and Investment Committee and Board should additionally be sought prior to tender.

11.1.10 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and BNHSFT's Standing Orders.

11.1.11 The Director of Finance shall approve procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 Asset Registers

11.2.1 The Chief Executive is responsible for the maintenance of registers of capital assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.2.2 The Chief Executive is also responsible for the maintenance of a publicly available extract of the capital asset register identifying land and/or buildings owned or leased by BNHSFT. This public register must identify separately

(a) any land and buildings which are not required for the provision of mandatory goods and services and are thus not protected, and
(b) any land and buildings which are currently required for the provision of mandatory goods and services, but are planned for disposals in the current financial year.

11.2.3 Capital assets must not be sold, scrapped, or otherwise disposed of without prior approval of the Director of Finance. Their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.2.4 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.2.5 Capital assets will be valued and depreciated in accordance with current accounting and reporting standards and guidance issued by Monitor.

11.3 Security of Assets

11.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

11.3.4 Whilst each employee and officer has a responsibility for the security of property of BNHSFT, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

11.3.5 Any damage to BNHSFT's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

11.3.6 Where practical, assets should be marked as Trust property.

12. STORES AND RECEIPT OF GOODS

12.1 General position

12.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, condemnations and disposal

12.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil, coal, printing and stationery of a designated manager.

12.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

12.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

12.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

12.2.6 The designated Manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.3 Goods supplied by NHS Supply Chain

12.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Director of Finance shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and notify any discrepancies to Procurement who will pursue correction of delivery or a credit note.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations (See also SFI 7.1)

13.1.1 Protected land and buildings must not be sold or otherwise disposed of. No land or buildings may be sold or otherwise disposed of without the approval of the Board.

13.1.2 The Director of Finance must prepare detailed procedures for the disposal of other assets including condemnations, and ensure that these are notified to managers.

13.1.3 When it is proposed to dispose of a Trust asset, the Head of Department or Divisional General Manager will liaise with Procurement and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.4 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

13.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

13.2 Losses and Special Payments

13.2.1 **Procedures**

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

13.2.2 Any employee discovering a suspected fraud must report the matter to the Local Anti-Fraud Specialist (LAFS) in accordance with the Fraud, Corruption and Bribery Policy.

13.2.3 Any employee discovering or suspecting any other loss must either immediately inform their head of department or the Security Department who will then appropriately inform the Director of Finance .
The Director of Finance must notify the NHS Protect Services and the External Auditor of all frauds.

13.2.4 Special payments e.g. payments not under legal obligation (or ex gratia) may only be made with the approval of the Finance and Investment Committee unless authorised under the Scheme of Delegation.

13.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard BNHSFT's interests in bankruptcies and company liquidations.

13.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

13.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

13.2.8 All losses and special payments must be reported to the Audit Committee.

14. INFORMATION TECHNOLOGY

14.1 **Responsibilities and duties of the Director of Finance**

14.1.1 **BNHSFT**, under the terms of its Authorisation agreement, is required to participate in mandatory initiatives defined by Director of Finance the Health and Care Information Centre and NHS England having due regard for the Data Protection Act 1998;

(b) to ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) to ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) to ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

14.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

14.1.3 BNHSFT shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information

routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

14.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

14.2.1 The Chief Operating Officer and the Director of Finance will similarly be jointly responsible for ensuring the accuracy and security of other computerised information e.g. patient related data of BNHSFT.

14.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

14.4 Risk Assessment

BNHSFT's Senior Information Risk Officer (SIRO), shall ensure that risks to BNHSFT arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

14.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

15. PATIENTS' PROPERTY

BNHSFT has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that BNHSFT will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.
Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16. CHARITABLE FUNDS (FUNDS HELD ON TRUST)

16.1 **Corporate Trustee**

(1) BNHSFT Board is the corporate trustee of the Charitable Fund(s).

(2) The discharge of BNHSFT's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

The Board may delegate such trustee functions as it determines to the Charitable Funds Committee subject to written terms of reference approved by the Board. The Board must receive and adopt the annual accounts of the Charitable Fund(s).

16.2 **Accountability to Charity Commission**

BNHSFT responsibilities must be discharged separately and full recognition given to BNHSFT's accountability to the Charity Commission for charitable funds held on trust.

16.3 **Applicability of Standing Financial Instructions to funds held on trust**

(1) In so far as it is possible to do so, these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI 7.12).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17. DECLARATION OF INTERESTS AND STANDARDS OF BUSINESS CONDUCT

The Director of Finance shall ensure that all staff are made aware of BNHSFT policy on Standards of Business Conduct which includes guidance on the acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

17.1 DECLARATION OF INTERESTS

The Code of Accountability requires board directors to declare interests which are relevant and material to the NHS board of which they are a director. All existing board directors should declare such interests. Any board directors appointed subsequently should do so on appointment. Detailed guidance is included in the "Fit and Proper Person Policy"

Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable**.**

If board directors have any doubt about the relevance of an interest, this should be discussed with the Trust Secretary.

At the time board directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring and recorded in the minutes of that meeting.

During the course of a board meeting, if a conflict of interest is established, the board director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

17.2 REGISTER OF INTERESTS

The Trust Secretary will ensure that a Register of Interests is maintained to record formal declarations of interests of directors.

The Register will be available to the public on request.

18. RETENTION OF RECORDS

18.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines and BNHSFT's Record Management Policy.

18.2 The records held in archives shall be capable of retrieval by authorised persons. The access restrictions applies to both paper and digital records.

18.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

19. RISK MANAGEMENT AND INSURANCE

19.1 Programme of Risk Management

The Chief Executive shall ensure that BNHSFT has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis for the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

19.2 Insurance

19.2.1 The Chief Executive in consultation with his designated officer(s) shall be responsible for ensuring adequate insurance cover is effected in accordance with risk management policy approved by the Board.

19.2.2 Each officer shall promptly notify the designated officer of all new risks or property under his control, which require to be insured, and of any alterations affecting existing risks or insurances.

19.2.3 The designated officer shall ascertain the amount of cover required and shall affect such insurances ar are necessary to protect the interests of BNHSFT.

19.2.4 The Chief Executive or his designated officer shall make all claims arising out of policies of insurance and each officer shall furnish the Director of Finance immediately with full particulars of any occurrence involving actual or potential loss to BNHSFT and shall furnish an estimate of the probable cost involved.

19.2.5 The Director of Finance shall ensure that all engineering plant under BNHSFT's control is inspected by the relevant insurance companies within the periods prescribed by legislation.

19.2.6 The value of all assets and risks insured shall be reviewed or index-linked on an annual basis by the designated officer.

19.2.7 The relevant Directors shall decide if BNHSFT will insure through the risk pooling schemes administered by the NHS Litigation Authority or enter into arrangements with commercial insurers.

19.2.8 Where the risk pooling schemes are used the relevant Directors shall ensure the arrangements entered into are appropriate and complementary to the risk management programme. The relevant Directors shall ensure that documented procedures cover these arrangements.

19.2.9 The risk pooling schemes for Trusts requires members to contribute to the settlement of claims (the 'deductible'). The relevant Directors shall ensure that

documented procedures also cover the management of claims and payments below the deductible in each case.

19.2.10 The relevant Directors shall ensure documented procedures cover the management of claims and payments in respect of the arrangements with commercial insurers.

19.2.11 BNHSFT may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the council and the Board and the Secretary.

SCHEDULE OF DECISIONS/POWERS RESERVED TO THE BOARD/ COMMITTEES AND SCHEME OF DELEGATION TO DIRECTORS AND MANAGERS

RESERVATION OF POWERS

Trust Board The Board reserves to itself approval of the following:	Committees Approval of the items below is reserved to specific Committees	Director / Governor Specific Approval of the items below is reserved to specific Directors
Vision and Overall Strategic Direction Approval of Business Cases or major service changes e.g. Introduction of new Services or Discontinuation/ Transfer of Services involving income or expenditure > £1m Revenue or Capital and any associated loans ➢ £2m capital expenditure and associated loans Board level (Risk) Assurance Framework Annual Revenue (I&E) Budget Capital Programme and Annual Capital Budget Sale and/or acquisition of Land Demolition of buildings Waiver of competition requirements/acceptance of other than lowest price for goods/services/works over £1m Standing Orders Treasury Management Policy This schedule of decisions/powers reserved to the Board/ Committees and Scheme of Delegation to Directors and Managers <u>Corporate Strategies</u> e.g. Workforce Strategy IT Strategy	<u>Audit Committee</u> Appointment of Internal Audit Internal & External Audit Plans Annual Accounts Standing Financial Instructions Approval of the Annual Governance Statement having overseen risk management and assurances process during the year Waiver of competition requirements/acceptance of other than lowest price for goods/services/works over £250k up to £1m <u>Remuneration Committee</u> Approval of Executive Directors' Pay Awards and any other variations to Executive Director terms and conditions of employment Severance settlements for senior managers and any settlements outside of normal rules Approval of Pay and Terms and Conditions of senior managers on local pay arrangements <u>Executive Board</u> Approval of Trust-wide Clinical and Non-Clinical Policies and Procedures Approval of Business Cases or significant service changes whether investment or disinvestment/discontinuation of services up to £1m revenue or capital. <u>Finance Committee</u> Approval of Business Cases for Capital Schemes up to £2m. Approval of budget increases/virements over £50k. Approval of the use of Measured Term Contracts for capital schemes over £50k. Approval to progress to tender for schemes costing over £1 million. Approval of the Treasury Management Policy and Banking arrangements. Approval of arrangements for loans approved by the Board. Approval of any special payments/ex gratia payments over £50k (excluding those delegated to the Remuneration Committee above).	<u>Director of Human Resources</u> Salary banding of new posts and changed posts Variations to Terms & Conditions Issue of Contracts of Employment <u>Director of Finance</u> Opening Bank Accounts Income generation contracts over £250k Pricing strategies, fees and charges in relation to income Prepayments and/or contracts which commit the Trust to pay in advance of services received Long term financial commitments including leases Financial systems and controls Disposal or sale of capital equipment Changes to the Scheme of Delegation below £50k <u>Chairman</u> Approval of Chief Executive travel/ other expenses / study leave <u>Chief Executive/Deputy Chief Executive</u> Introduction of new services, or discontinuation/transfer of services up to £1m pa. Delegation of budgets to Directorates/Divisions Travel expenses/study leave of Directors <u>Chief Executive or Director of Finance</u> Requisitions/contracts (revenue or capital) over £250k up to £1m Changes to budgeted establishment financed from income or virement from non-pay budgets Approval of Capital Scheme budget increases up to £50k Authorisation of sponsorship (e.g. of new posts) by external bodies (Drug companies, suppliers, Macmillan etc.) including bids to secure sponsorship Ex gratia payments over £5k up to £50k. Waiver of competition requirements and/or acceptance of other than lowest tender for

Estates Strategy Deputy Director of Finance Transacts in the system expenditure over £1m as approved by the Board	CRIG (Capital Revenue and Investment Group) Approval of Business Cases for Capital Schemes up to £1m. Approval of business cases for revenue (expenditure or income) up to £1m per annum.	goods/services/works over £10k up to £250k (retrospectively reported to Audit Committee for scrutiny). Authorisation of disposal of all items on the capital asset register up to £1m. Governors The Trust Governors to appoint the external auditors from recommendations from the Trust.

SCHEME OF DELEGATION

Executive Directors Approval of Expenditure within Directorate/ Divisional Expenditure Budget including:	**Deputy Directors of Operations, Divisional Director of Operations(DDOs), Deputy Director of Finance and direct reports to Board** Approval of Expenditure within Directorate/ Divisional Expenditure Budget including:	**Deputy Directors/General Managers/ Professional Leads** Approval of Expenditure within Departmental Budget including authorisation of:	**Departmental Managers** Approval of Expenditure within Ward/Department/Unit Budget including authorisation of:	**Matrons** Approval of Expenditure within Ward/Department/Unit Budget including authorisation of:	**"Ward / Unit Managers" or equivalent** Approval of Expenditure within Ward/Departmental /Unit Budget including authorisation of:	**Managers within Ward / Unit** Authorisation within Ward/Department/Unit Budget of:
Non-stock revenue requisitions up to £250k Delegation of budgets within the Directorate/ Division including authorisation of signatories Travel expenses/study leave of DDOs	Non-stock revenue requisitions up to £50k Changes to budgeted establishment within pay budget Virement within non-pay budget Delegation of budgets within the Directorate/ Division including authorisation of signatories Travel expenses/study leave of Heads of Division/General Managers/Professional Leads Waiver of competition requirements and/or acceptance of other than lowest price for goods/services/works up to £10k (retrospectively reported to Audit Committee for scrutiny) Ex-gratia payments over £1k to £5k (reported to the Audit Committee)	Agency temps/locums Revenue or capital requisitions up to a limit which will be agreed by DDOs but not exceeding £10k Advertisement of vacant posts (within budgeted establishment) Travel expenses/study leave of Departmental Managers Disposal of obsolete furniture and equipment but excluding capital items Ex-gratia payments to patients or staff for loss of personal effects up to £1k (request for payment to be clearly identified as "ex gratia" and reported to the Audit Committee). <u>Chief Pharmacist</u> Drugs expenditure up to £50k <u>Head of Payroll</u> Processing expenditure for 24/7 doctors	Revenue requisitions up to a limit which will be agreed by DDOs but not exceeding £5k Travel expenses/study leave of Ward Managers/equivalent	Revenue requisitions up to a limit which will be agreed by DDOs but not exceeding £2.5k Travel expenses/study leave of Ward Managers/equivalent Timesheets including overtime and internal bank hours and scheduling of annual leave	Timesheets including overtime and internal bank hours and scheduling of annual leave Special Duty Claims Travel Expenses of Managers Revenue requisitions up to a limit which will be agreed by DDOs but not exceeding £1k.	Timesheets including overtime and internal bank hours and scheduling of annual leave Special Duty Claims Travel Expenses of staff at bands of the same or below their own band.
One per cost centre	One per cost centre	One per cost centre	One per cost centre		One per cost centre	Multiple per cost centre

Agenda Item

Title:	IPC Annual Report 2019/20

Meeting:	Trust Board	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	
Exec Sponsor	Director of Nursing		Decision	

Summary:	▪ HCAI performance has largely remained unchanged from year-to-year ▪ There was a significant spike in CDT cases in the summer of 2019 which has been extensively reviewed and performance has improved to baseline ▪ The Trust achieved 81.9% frontline staff seasonal flu uptake in 19/20 – the joint highest in Greater Manchester ▪ The activities of the Trust were significantly affected at the end of the year and into 2020/21 by the emergence of a global pandemic caused by SARS-CoV-2 ▪ No national objectives for HCAI have been set by NHS England due to the impact of COVID-19

Previously considered by:	Infection Prevention and Control Committee
Proposed Resolution	Continued surveillance

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*		*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	✓
*To continue to use our **resources** wisely so that we can invest in and improve our services*		*To develop **partnerships** that will improve services and support education, research and innovation*	

Prepared by:	Richard Catlin, Assistant Director of IPC	**Presented by:**	Marie Forshaw, Director of Nursing

Infection Prevention and Control Annual Report

April 2019-March 2020

Our Bolton NHS FT Values

1. EXECUTIVE SUMMARY

This report is intended to give a concise overview of key activities in the Trust related to infection prevention and control (IPC), healthcare associated infections (HCAI) and antibiotic stewardship. IPC remains critical to the Trust as it is a core component in the delivery of clean, safe care; failures in IPC can lead to adverse outcomes for patients and a poor patient experience. Antimicrobial stewardship has increasingly been identified as a challenge for the UK and presents a legitimate risk of the widespread dissemination of multi-drug resistant organisms and is therefore reflected in this report and future plans.

The Trust has IPC and HCAI objectives set by NHS England related to *Clostridium difficile*[1] and meticillin resistant *Staphylococcus aureus* (MRSA)[2].

For 2019/20 NHS England introduced new nomenclature for HCAI which are used here, definitions for these are included in

Table 1: Summary table of performance of 2019/20 HCAI cases as reported as part of the mandatory surveillance scheme

Organism	Cases Reported			
	All Cases	Hospital Onset Cases		
Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias	6	2		
***Clostridium difficile* toxin cases**	67	**HOHA**	**COHA**	**Total**
		38	19	57
Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias	101	14		
***Escherichia coli* (*E. coli*) bacteraemias**	258	41		
***Pseudomonas aeruginosa* bacteraemias**	11	2		
***Klebsiella spp.* bacteraemias**	68	14		

MRSA Bacteraemia

NHS England adopts a zero tolerance to MRSA bacteraemias with an expectation that acute providers will have no avoidable MRSA cases as determined by root cause analysis of the case.

There were two Hospital Onset MRSA cases in 2019/20 compared with one case in the previous year.

[1] https://improvement.nhs.uk/documents/808/CDI_objectives_for_NHS_organisations_in_2019_12March.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2018/12/8-contract-technical-guidance-2019-20.pdf

Clostridium difficile

NHS England sets the annual *Clostridium difficile* objectives. The objective for 2019/20 was no more than 32 combined HOHA and COHA cases (see **Appendix 1** for definitions). There were 57 cases in total (38 HOHA cases and 19 COHA cases). There was a mid-year spike in cases and the Trust invited in the NHSi NW lead for Infection Prevention and Control (IPC) to review policy and processes. No clear issues were identified and the rate of cases has reverted to the baseline prior to this spike. All HOHA samples for a four-month period were sent for ribotyping by Public Health England (PHE) and there was no evidence of identifiable persistent transmissions between patients. The systems for cleaning and cleaning assurance were reviewed in conjunction with iFM Bolton.

Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

There are no national objectives for MSSA cases but these are a good proxy for the delivery of safe care, in particular related to line and wound care which are frequently the root cause of these infections. In 2019/20 there was a reduction to 15 Hospital Onset cases compared with were 22 cases in the previous year.

Gram Negatives

In November 2016, the government announced an intention to reduce all Gram negative bloodstream infections by 50% by the end of 2020/21. As a consequence, two new organisms were added to the mandatory surveillance list: all species of *Klebsiella* (described as *Klebsiella spp.*) and *Pseudomonas aeruginosa*.

Escherichia coli (*E. coli*) Bacteraemia

There were 41 Hospital Onset *E. coli* bacteraemias in 2019/20 compared with 39 cases in the previous year.

Pseudomonas aeruginosa Bacteraemia

There were two Hospital Onset *Pseudomonas aeruginosa* bacteraemias in 2019/20 in comparison with two cases in the previous year.

Klebsiella spp. Bacteraemia

This surveillance includes all species of *Klebsiella* – referred to as *Klebsiella spp.* There were 14 Hospital Onset *Klebsiella spp.* bacteraemias in 2019/20 in comparison with 12 cases in the previous year.

Carbapenemase Producing Enterobactericae (CPE)

CPE has been a concern in 2019/20 with two unrelated outbreaks on two wards. It has been reassuring to note that since the resolution of thee outbreaks, the number of cases has reverted to the baseline seen before these incidents.

In total there were 28 CPE cases identified at Bolton FT in 2019/20 compared with 34 cases in the preceding year. Of these, 20 cases were from screening samples – indicating CPE

colonisation rather than infection – and eight samples compared with 30 and six respectively in the previous year.

2. SYSTEMS TO MANAGE AND MONITOR THE PREVENTION AND CONTROL OF INFECTION PREVENTION AND CONTROL (IPC)

2.1 IPC Service Delivery

The IPCT remains unchanged from the structure in the previous year. The IPC functions continue to be split between the acute team who serve the Trust's acute services and the community team who serve the Trust's community functions as well as the Bolton Council. Bolton Council continues to commission Bolton Foundation Trust to provide community IPC services for their areas of accountability and the community services provided by Bolton FT.

The Director of Infection Prevention and Control (DIPC) retains overarching responsibility for IPC and reports directly to the Board. The Assistant DIPC (ADIPC) oversees the development and implementation of IPC strategy and policies for the acute and community teams, reporting directly to the DIPC. The ADIPC works in conjunction with the IPC doctor and the rest of the IPC team and key staff such as the antimicrobial pharmacist to develop strategy related to IPC and HCAI. The IPC matron has primary operational responsibility for day-to-day IPC management, management of the IPC team and oversight of key quality standards.

2.2 Microbiology Services

The provision of microbiology services also remains unchanged with three consultant microbiology posts (2.6 WTE).

The team continue to provide advice by phone; regular antimicrobial ward rounds for the review of patients with complex or prolonged antibiotic treatment and has recently established a weekly ward round to review *Clostridium difficile* toxin positive patients. The team also provide planned and prospective support for the critical care departments such as ICU and NICU.

Out of hours IPC advice continues to be provided by the microbiology service. The microbiology service also provides IPC advice Greater Manchester West Mental Health Trust under a service level agreement and a limited service for GPs.

The Trust has invested in an additional WTE antimicrobial pharmacy post to supplement the wider IPC service and to improve the scrutiny and awareness of safer antimicrobial prescribing. This increases this provision from 0.3 WTE to 1.3 WTE.

The microbiology laboratory continues to provide a seven-day service for the diagnosis of *Clostridium difficile* toxin, Meticillin resistant *Staphylococcus aureus* (MRSA), and Norovirus infections.

2.3 Healthcare Associated Infection (HCAI) System

The IPCT makes use of ICNet; a proprietary system for the management of HCAI. The system extracts data from the Trust laboratory system and Patient Administration System.

It uses this information to alert the IPCT to these results in real time and is also the electronic patient record (EPR) for the IPCT. The system allows epidemiological information to be used from historical data. The system also allows the acute and community team to function collaboratively and independently with each able to access each other's notes and to alert the opposing team to new information e.g. a patient of interest can be flagged prior to or on discharge for follow-up in the community.

Sunrise EPR is now used in conjunction with ICNet.

In the event that the lab reporting from ICNet is no longer functional the IPC team are able to get any relevant lab results directly from the microbiology laboratory. In the longer term, there will be reporting system which will allow the IPC team to retrieve microbiology information from the EPR system.

3. Healthcare Associated Infections (HCAI) performance

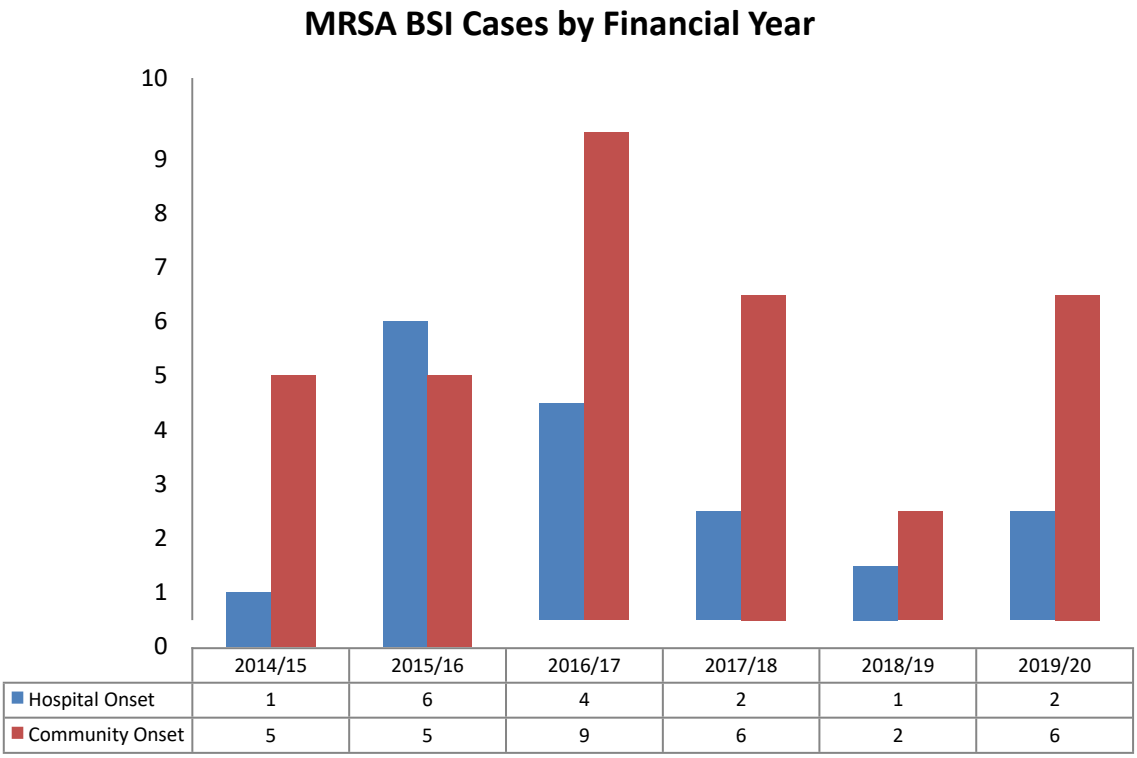
The Trust participates in the mandatory HCAI programmes. The following conditions are reported to the Department of Health (DH) via the Public Health England (PHE) Data Collection System (DCS):

1. MRSA positive blood cultures
2. *Clostridium difficile* toxin positive results
3. MSSA positive blood cultures
4. *E. coli* positive blood cultures
5. *Pseudomonas aeruginosa* blood cultures
6. *Klebsiella spp.* positive blood cultures

3.1 MRSA Bacteraemia

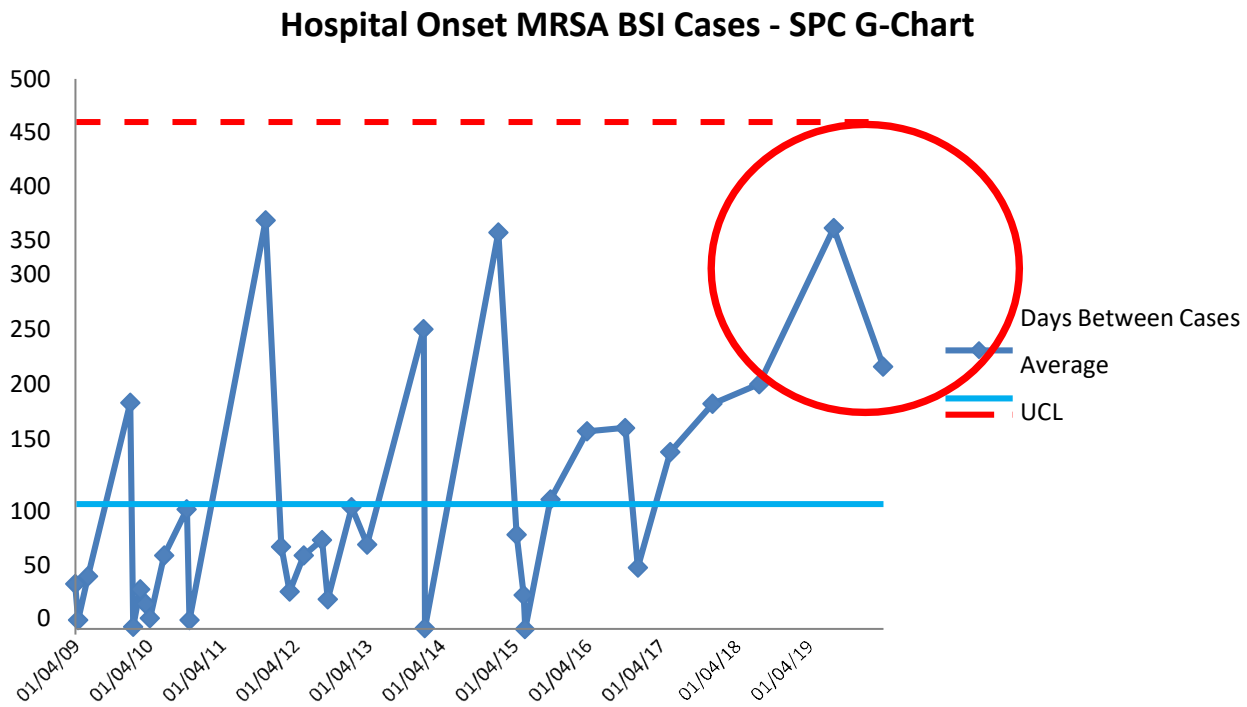
NHS England apportions cases to acute Trusts as outlined in **Appendix 1.**

Fig. 1: MRSA Cases



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Hospital Onset	1	6	4	2	1	2
Community Onset	5	5	9	6	2	6

Fig. 2: Hospital Onset MRSA Cases SPC Chart



This chart shows that the period of time between MRSA cases had been increasing for the past two years but the most recent case in 2020 reduce this time interval.

3.1.1 Trust Apportioned Cases

NHS England has set a zero tolerance policy for MRSA bacteraemias so every acute provider has a trajectory of zero cases every year. During 2019/20 there were two Hospital Onset cases.

Case 1: The source of the patient's infection was an ankle ulcer and old prosthesis and the post-infection review did not identify learning that would have mitigated the outcome. The patient was known to be MRSA positive and was managed in line with the Trust policy.

Case 2: The source of the patient's infection was an infected abscess formed from repeated injections of recreational drugs. The patient was screened for MRSA on admission and was screen negative. An initial set of blood cultures were negative but a second set of blood cultures collected on the third day of admission were positive. The post-infection review did not identify learning that would have mitigated the outcome.

An increasing proportion of resistant (MRSA) and sensitive (MSSA) *Staphylococcus aureus* bloodstream infections have been linked to recreational drug use. The community IPC team have worked proactively with the formal structures such as the Bolton drugs and alcohol teams. They have also worked with some of the less formal structures outside of health and social care like local hostels to increase awareness of clean injecting, general hygiene in an effort to reduce the risk of infections in this high-risk group.

3.1.2 Non-Trust Apportioned MRSA Cases

There were four Community Onset cases in 2019/20. These cases have been reviewed using post-infection review (PIR) methodology. In year, the support by Bolton FT for the CCG to undertake these reviews has been strengthened to improve shared learning.

3.1.3 MRSA Screening

The Trust has maintained a universal policy to MRSA screening with all elective and non-elective admissions being screened for MRSA on admission to the Trust. Additional screening is undertaken in the critical care departments of the Trust where patients are screened on admission to the relevant unit and on a weekly basis. Elective patients may also be screened as part of their pre-admission pathway to maximise safety prior to surgery or other invasive procedures.

Patients are re-screened for MRSA weekly once they have been an inpatient for 14 days or more.

Patients who have become colonised with MRSA after admission are now reviewed to determine measures to reduce future likelihood.

3.2 *Clostridium difficile*

NHS England apportions cases as outlined in **Appendix 1.** Every hospital onset hospital associated case is formally reviewed and managed by the Trust HCAI Harm Free Care Panel.

The Trust remains complaint follows the Department of Health guidelines for *C. difficile* testing[3]. These guidelines stipulate that all stool specimens type 5-7 on the Bristol Stool Chart (BSC) should be tested if there is no other clear cause of diarrhoea. All samples submitted to the lab from the acute services in patients older than two years that meet this definition should always be tested for CDT in the laboratory, additional to any other test request. Any sample in a patient over the age of 65 from community patients should be tested for CDT additional to any other tests requested.

The test should be undertaken using a two-step algorithm with a sensitive screening test; step one using glutamate dehydrogenase enzyme immunoassay (GDH EIA) or *Clostridium difficile* toxin polymerase chain reaction (CDT PCR). Step two using CDT EIA. It is only the CDT EIA positive cases that are mandated for reporting. Bolton FT uses GDH EIA followed by CDT EIA.

In 2019/20 an additional testing step has been introduced. Samples that are GDH EIA positive and CDT EIA negative are tested with CDT PCR. If this test is negative then we can confirm with a high level of certainty that the patient's stool sample does not contain a toxigenic *Clostridium difficile* which means that they cannot develop a *Clostridium difficile* infection (CDI) and are of no clinical risk to other patients. These patients may be taken out of isolation and managed as per their needs. Patients stool with CDT detected by PCR may have had a false negative CDT EIA test or have *Clostridium difficile* but they don't currently have active infection. CDT EIA can only be detected when the bacteria is producing the toxin that causes disease.

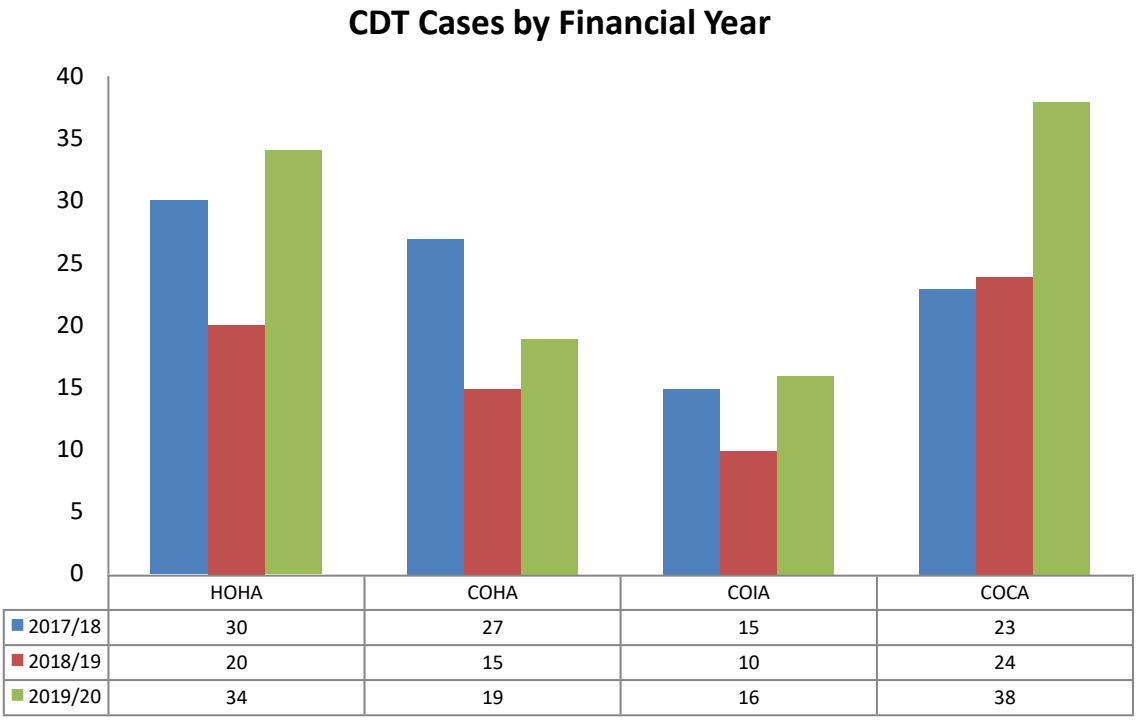
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215135/dh_133016.pdf

These patients are kept in isolation in line with the trust *Clostridium difficile* policy and may be treated for CDI following discussion with the microbiology team.

3.2.1 Trust Apportioned Cases

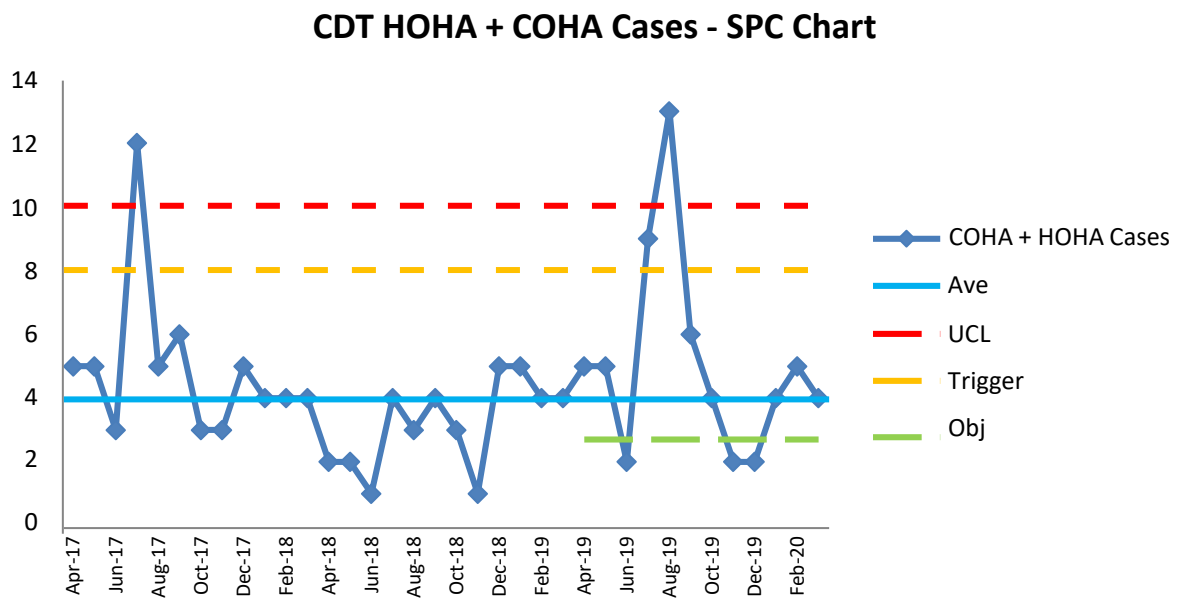
The objective for Bolton FT by NHS England was no more than 32 HOHA and COHA cases combined. The Trust ended the year with 57 cases in total (38 HOHA cases and 19 COHA cases).

Fig. 3: CDT cases



	HOHA	COHA	COIA	COCA
2017/18	30	27	15	23
2018/19	20	15	10	24
2019/20	34	19	16	38

Fig. 4: Hospital Onset CDT Cases SPC Chart



There has been a general sustained improvement in the number of HOHA & COHA cases over the past three years (the 2019/20 definitions have been applied to cases retrospectively for comparative review). However there was a mid-year spike in cases during July, August and September 2019 before the incidence of cases reverted to the pre- spike levels.

This period of increased incidence includes a small number of cases (three) connected to an outbreak one ward but the cause of the rest of this spike remains unknown. For four months all of the HOHA cases were sent for ribotyping to try and identify any otherwise unrecognised linked cases. None were determined using this process.

All CDT positive patients and their connections were reviewed going back to January 2019 but no new connections and opportunities for cross-transmission were identified.

The IPC service worked in liaison with iFM Bolton to review cleaning methods and audit standards. This has resulted in a redistribution of cleaning staff to support cleaning in clinical areas and a shared cleanliness audit programme between the two organisations.

The NHSi lead for IPC in the North-West was invited in to review the trust policies and processes to identify areas where Bolton would benefit from the shared learning from other organisations. The considered opinion from this independent review was that there were no serious concerns and this corresponded with a subsequent reduction in cases in September which has been maintained into 2020/21.

Trust apportioned cases are subject to a review which is undertaken using a guided root cause analysis approach. The purpose of these is to review the care provided and assess whether the care delivered was safe and appropriate. They are reviewed to establish whether care might have contributed to the risk of the patient developing a CDT infection and if this is the case, whether the corresponding policy was followed.

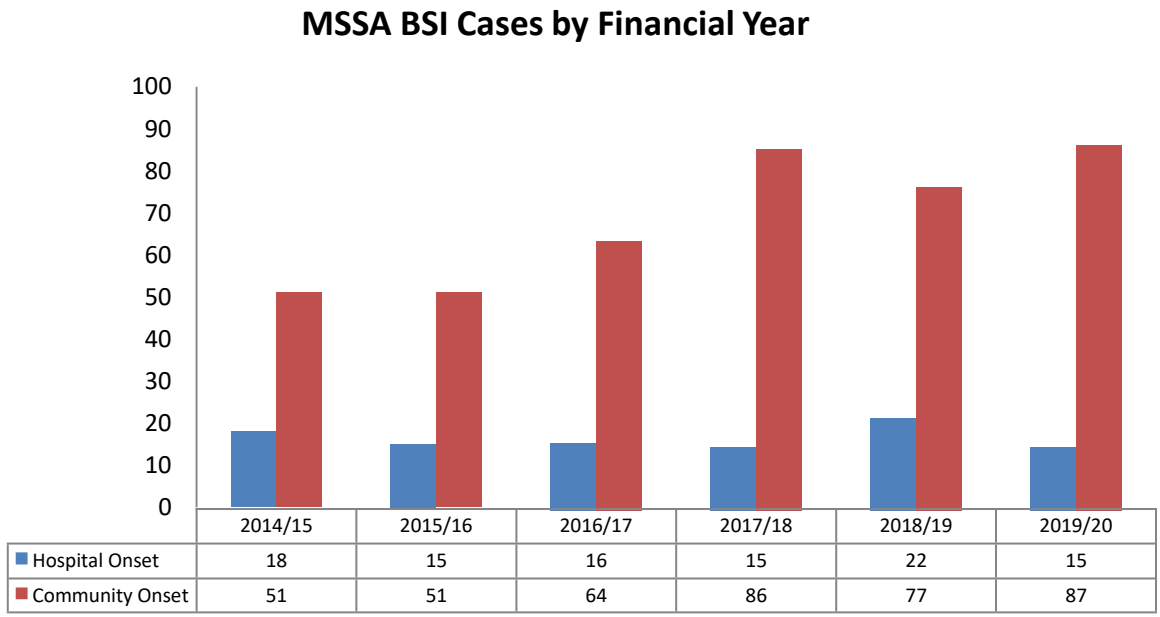
The clinical teams are responsible for the review. On the day of the result, the ward/department management team (patient consultant, ward manager and matron) are notified and given a date for the case to be fed back. The reviews are undertaken by a multidisciplinary team led by the patient's consultant. Feedback is undertaken at a Harm Free Care Panel chaired by the DIPC or Medical Director attended by the ADIPC and/or IPC matron, IPC doctor or Consultant Microbiologist and antimicrobial pharmacist. The cases are presented by senior doctor and a senior nurse from the department.

3.3 MSSA Bacteraemia

There are no national targets for MSSA cases. NHS England apportions cases in line with the process in **Appendix 1**. The IPC Committee created an internal stretch target of no more than 15 cases to bring the incidence back in line with the number of cases reported in 2017/18.

There was a reduction in MSSA cases in 19/20 to 15 Hospital Onset cases from 22 in the year earlier.

Fig. 5: MSSA cases



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Hospital Onset	18	15	16	15	22	15
Community Onset	51	51	64	86	77	87

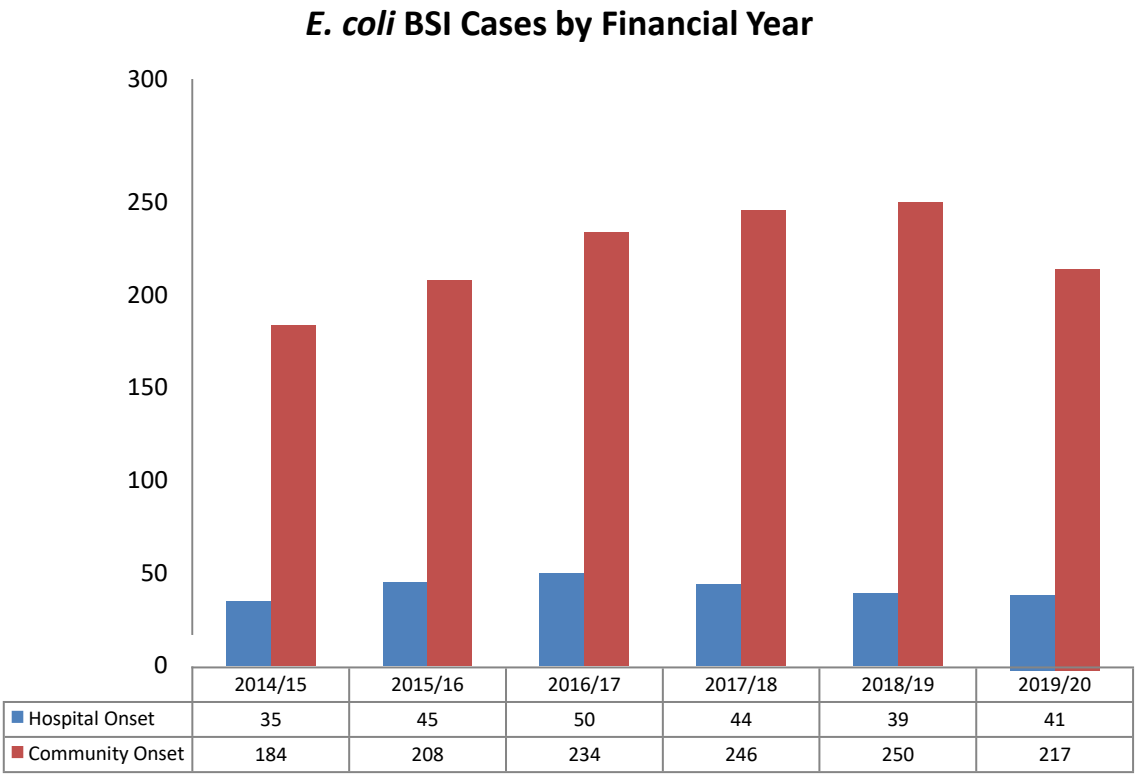
Gram Negatives

In November 2016, the government announced an intention to reduce all Gram negative bloodstream infections by 50% by the end of 2020/21. As a consequence, two new organisms were added to the mandatory surveillance list: *Klebsiella* species and *Pseudomonas aeruginosa*.

3.4 *E. coli* Bacteraemia

E. coli infections are more complex than MRSA or MSSA infections and much less likely to be attributed only to healthcare provision with personal hygiene and levels of hydration key risk factors for these infections.

Fig. 6: *E. coli* cases



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Hospital Onset	35	45	50	44	39	41
Community Onset	184	208	234	246	250	217

Bolton FT has seen a general reduction of cases over the past few years:

Fig. 7: Bolton *E. coli* Cases

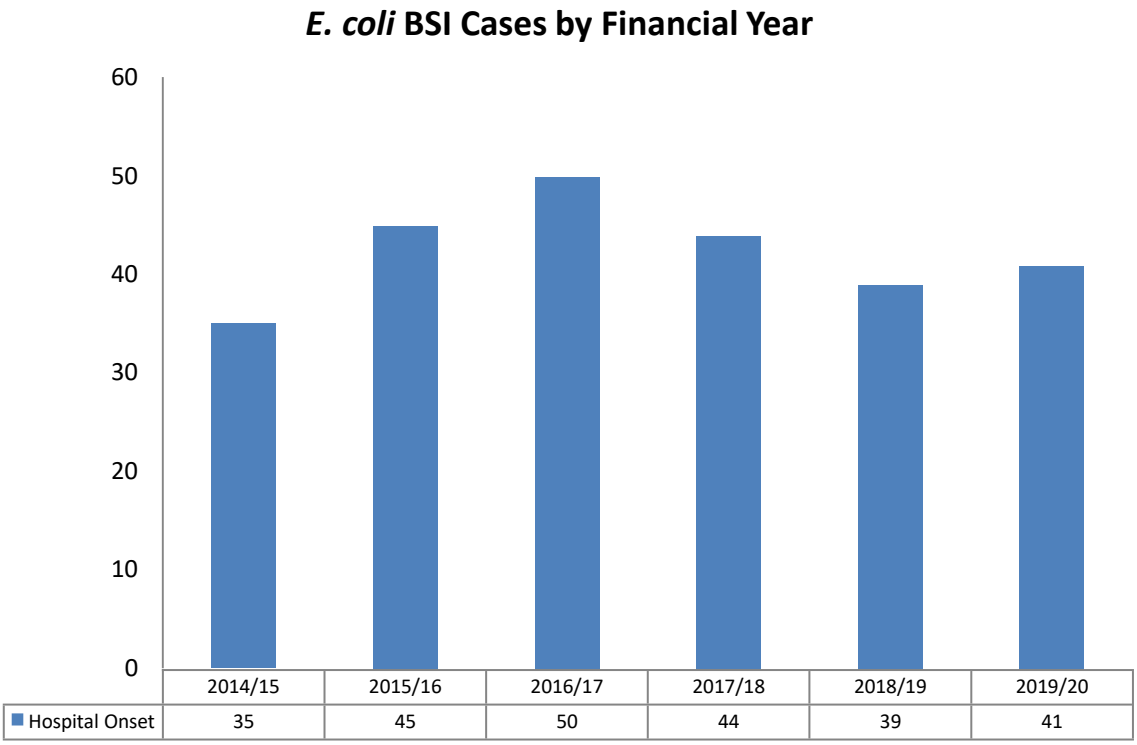
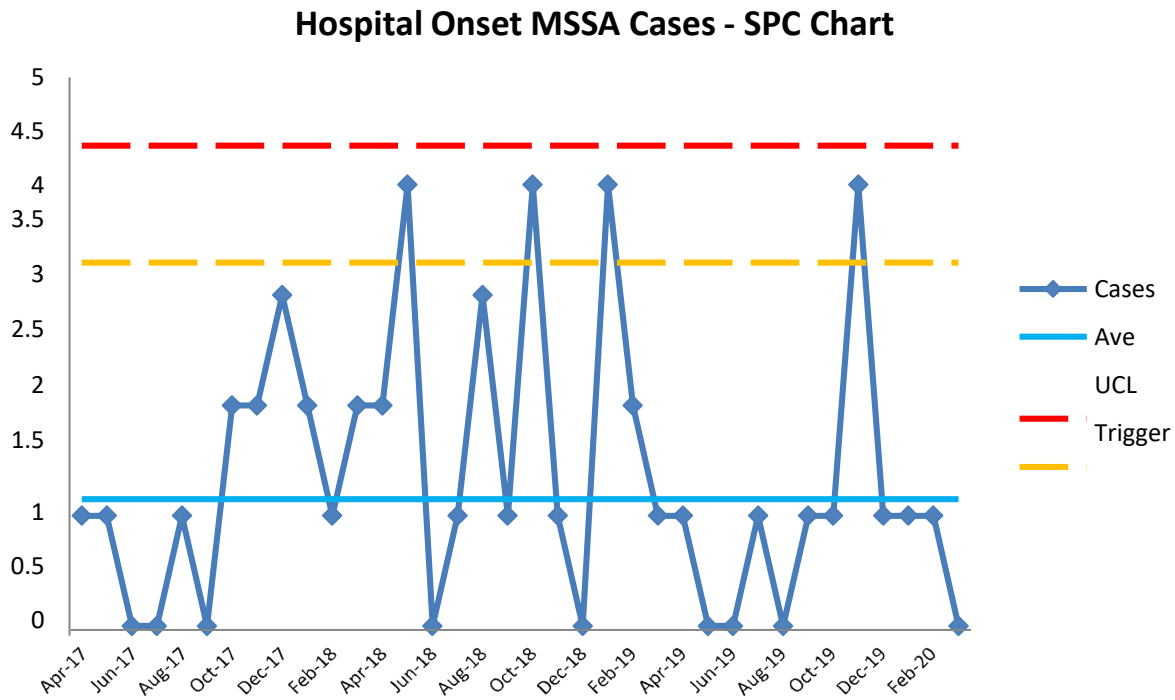


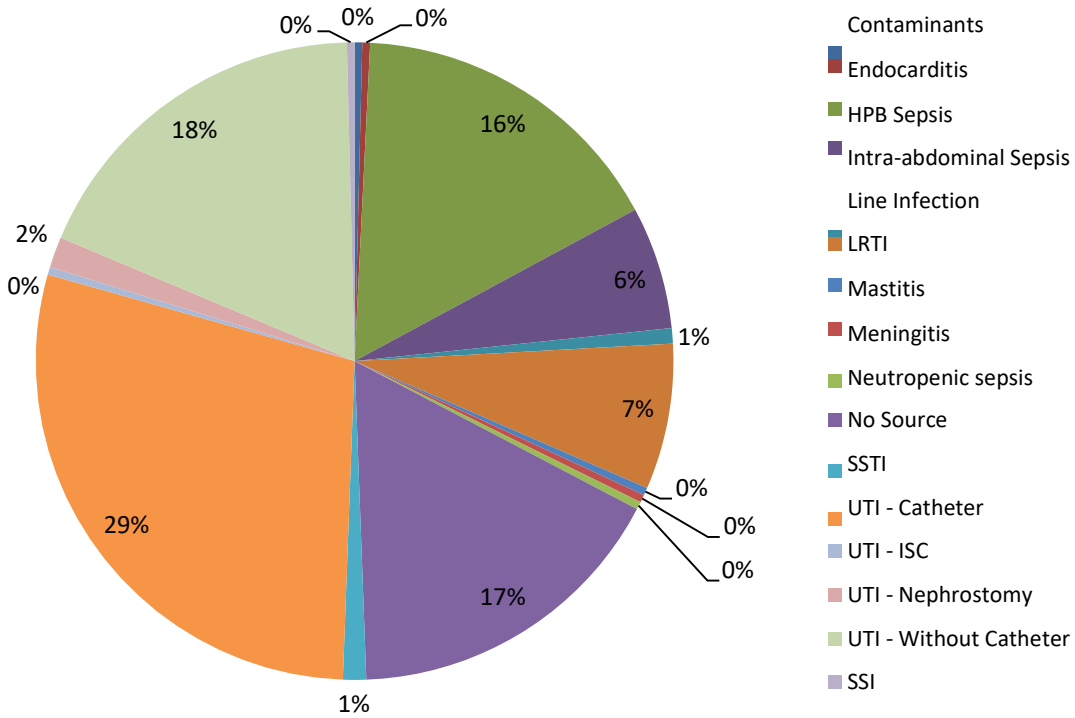
Fig. 8: *E. coli* SPC Chart



There are *E. coli* cases that are directly related to the provision of healthcare – *E. coli* infections due to urinary tract infections in patients with indwelling urinary catheters – others are less clear although hydration and cleanliness are known to be important.

The IPC Committee now sees a breakdown of *E. coli* cases by cause to better understand the impact of the provision of healthcare on the incidence of *E. coli* bloodstream infections. Shown here are cases for 2019/20:

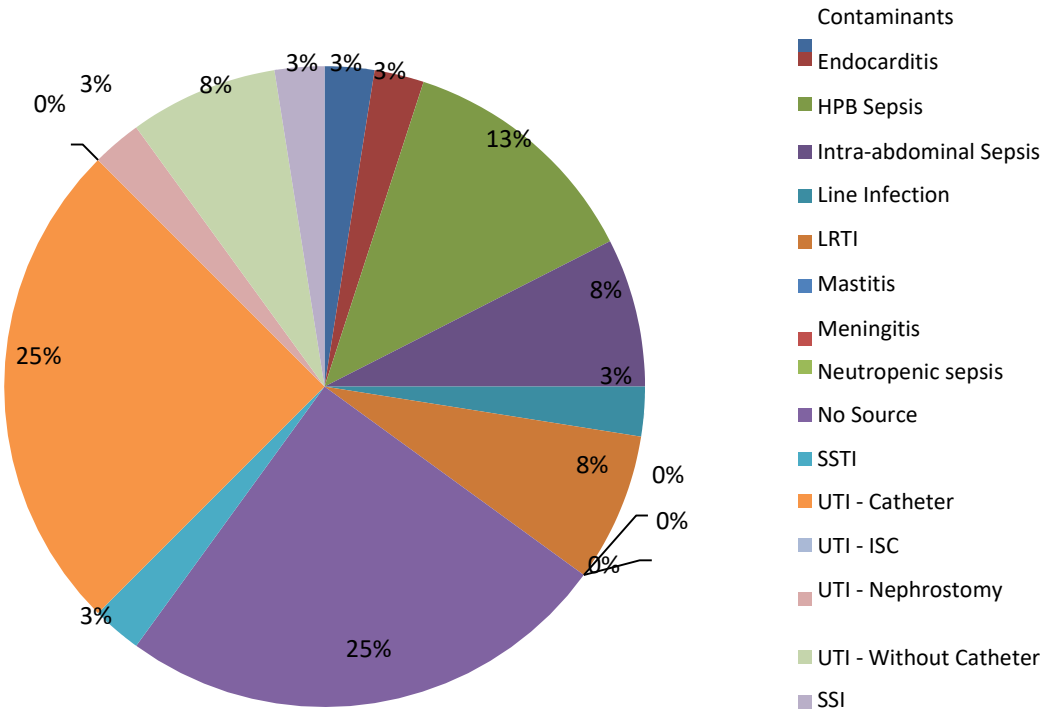
Fig. 9: *E. coli* by Proportion & Source; all *E. coli* BSI



Key to abbreviations	
HPB Sepsis	Hepatobiliary sepsis
LRTI	Lower respiratory tract infection
SSTI	Skin/soft tissue injury
UTI	Urinary tract infection
ISC	Intermittent self-catheterisation
SSI	Surgical site infection

The most common source was urinary tract infections (with a urinary catheter) followed by hepatobiliary infection and urinary tract infection (without a urinary catheter). No source was identified in 16% of cases.

Fig. 10: E. coli by Proportion & Source; Hospital Onset *E. coli* BSI

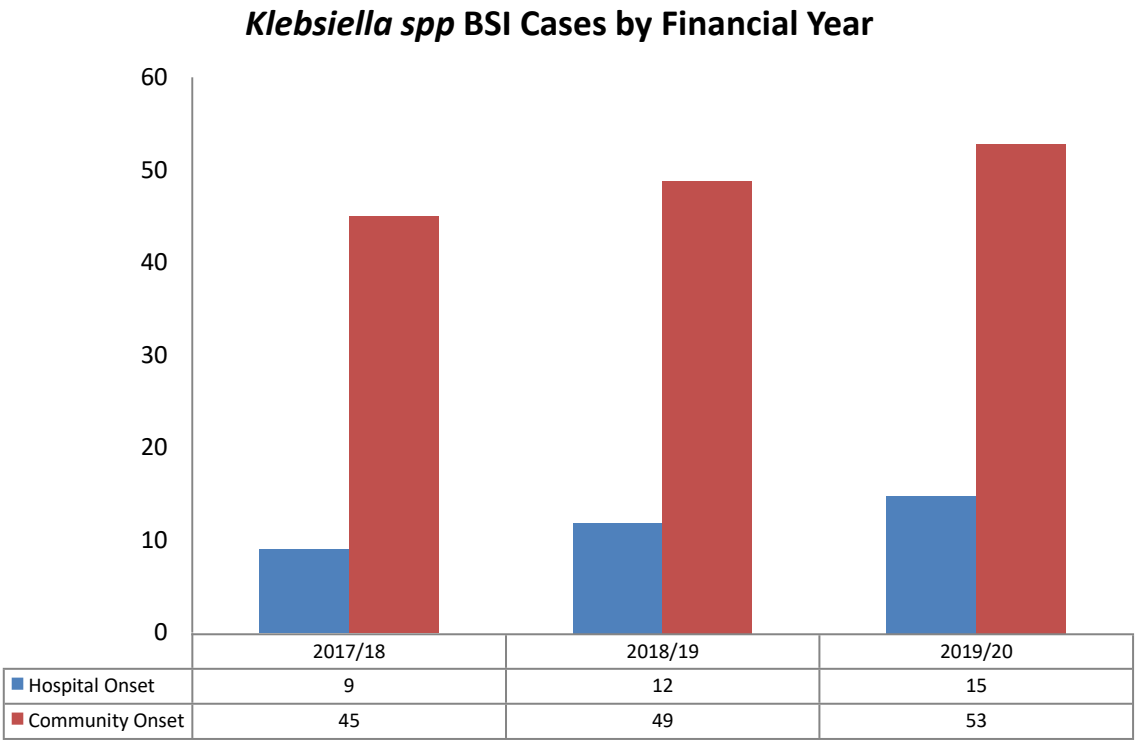


Urinary tract infections with a urinary catheter is the most common source and so needs to be the focus on harm reduction work in 2020/21.

3.5 *Klebsiella spp.* Bacteraemia

Mandatory surveillance of bloodstream infections caused by all species of *Klebsiella* started in 2017. There were 68 cases in total of which 15 were apportioned to the Trust. This compares with 60 cases in the year before of which 12 were apportioned as Hospital Onset.

Fig. 11: *Klebsiella spp* Cases

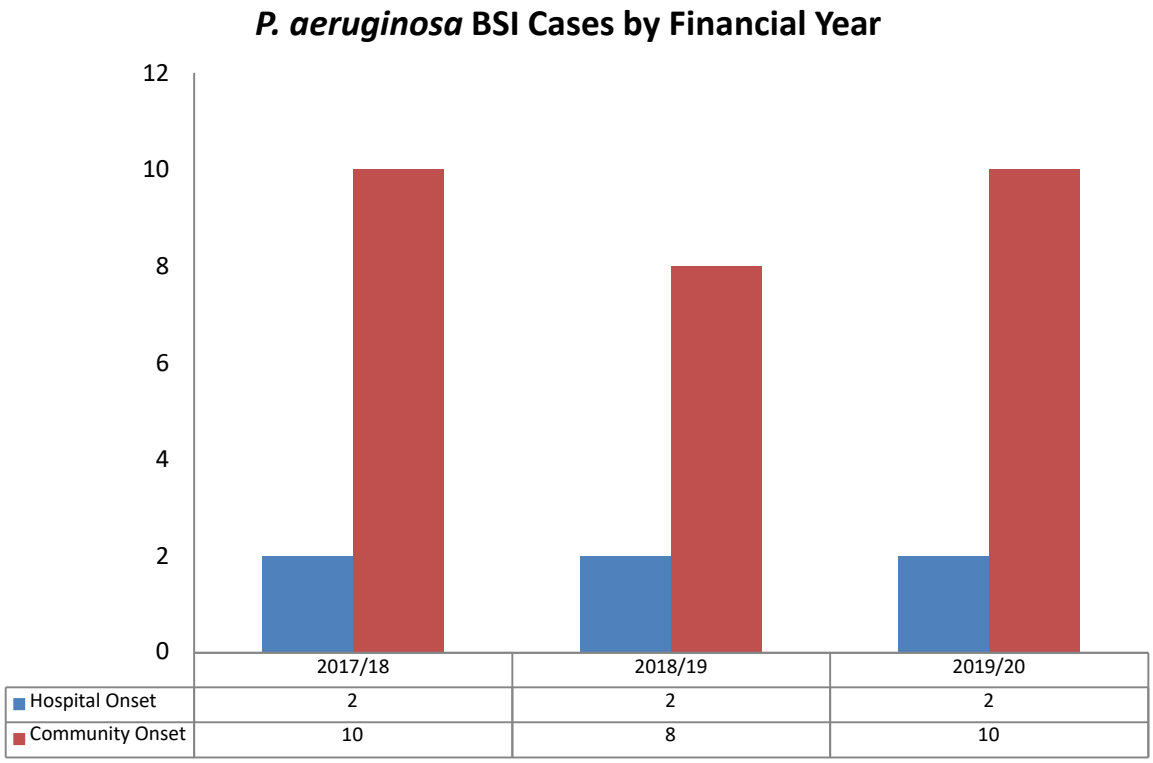


	2017/18	2018/19	2019/20
Hospital Onset	9	12	15
Community Onset	45	49	53

3.6 *Pseudomonas aeruginosa* Bacteraemia

Mandatory surveillance of bloodstream infections caused by *Pseudomonas aeruginosa* started in 2017. There have been no significant changes with 10 cases in total of which two were apportioned as Hospital Onset this compared to eight and two cases respectively in the year before.

Fig. 12: *Pseudomonas aeruginosa* Cases



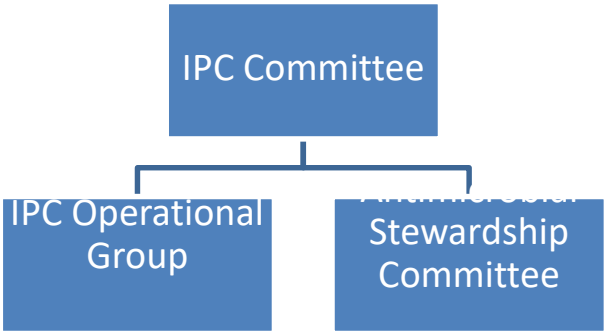
3.6 Additional Surveillance

In addition to these HCAI, the IPC team undertakes active surveillance of other infections or conditions that are important because of the illness they cause and the impact or due to the antibiotic resistance they confer.

These organisms are reported to the IPC team either by the ICNet (the IPC team surveillance system and electronic patient record) or by the laboratory on suspicion or confirmation.

4. Infection Prevention and Control Governance

IPC assurance continues to be provided by the following:



4.1 Infection Prevention Control Committee (IPCC)

The committee meets monthly and is chaired by the DoN/DIPC. This committee provides assurance to the DIPC to be reported to the Board where required and provides a strategic direction for the provision of IPC. The committee covers the following on a regular basis plus other topics by exception:

- HCAI surveillance
- Outbreaks/periods of increased incidence
- Antimicrobial stewardship
- Policy approval
- Emerging issues
- Divisional concerns

The revised Terms of Reference are available on request.

4.2 Infection Control Operational Group

This group also meets on a monthly basis. The purpose of this group is much more operational and covers agenda items such as:

- IPC audits
- Operational impact of emerging issues
- HCAI performance and corresponding feedback from RCAs

The revised Terms of Reference are available on request.

4.3 Antibiotic Stewardship Committee (ASC)

The antimicrobial stewardship committee is chaired by the Trust Antimicrobial Stewardship lead – who is a consultant medical microbiology – and includes representation from each of the clinical divisions. The remits of the group are to provide assurance on the following:

- Ensuring the relevant policies are in date and evidence based
- Provide assurance that key antibiotic prescribing policies are audited and that the audits are fed back
- The Trust has a strategy for providing safe and effective care related to antibiotic prescribing and use

The committee oversees the audit of antibiotic prescribing against the standards set out in the DH Start Smart Then Focus[4]. There are five auditable standards:

1. Compliance with Trust Antibiotic Guidelines (*including prescription in line with culture and sensitivity testing and/or microbiology recommendation).*
2. Indication for treatment written in the patient case notes at the point of antibiotic initiation.
3. Indication for treatment written in the antibiotic section of the prescription chart.
4. Stop date or a review clearly documented in the case notes by 48 hrs.
5. Stop or review date clearly documented on the prescription chart by 48 hrs.

Trustwide Compliance with Each Standard:

The set the Trust an objective of at least 85% compliance with all five standards for 2019/20

Fig. 13: Antimicrobial Stewardship Compliance Standard 1

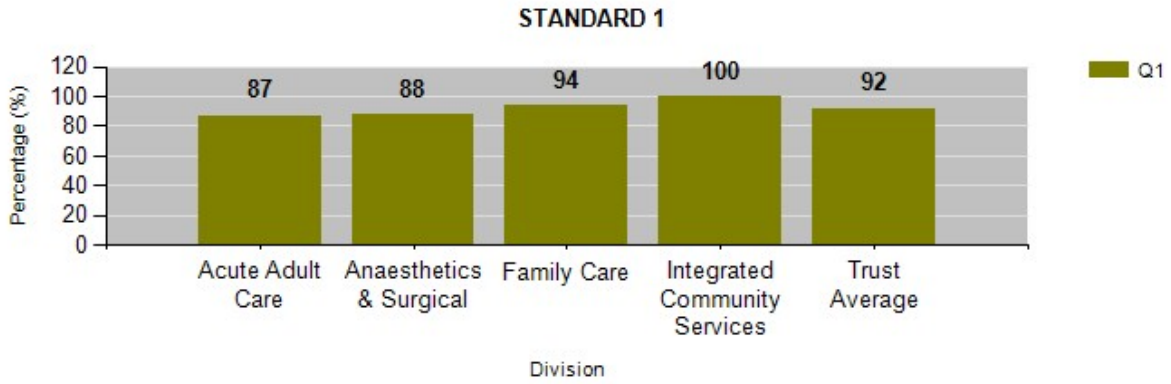
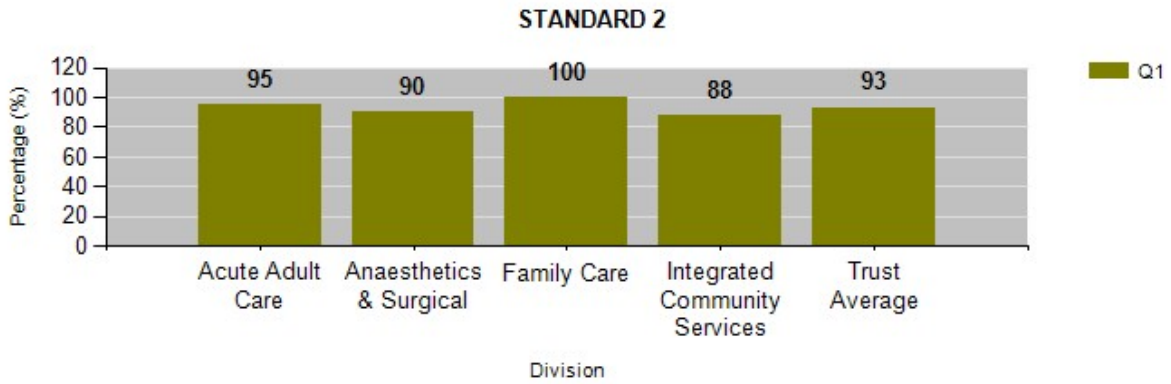


Fig. 14: Antimicrobial Stewardship Compliance Standard 2



4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF

Fig. 15: Antimicrobial Stewardship Compliance Standard 3

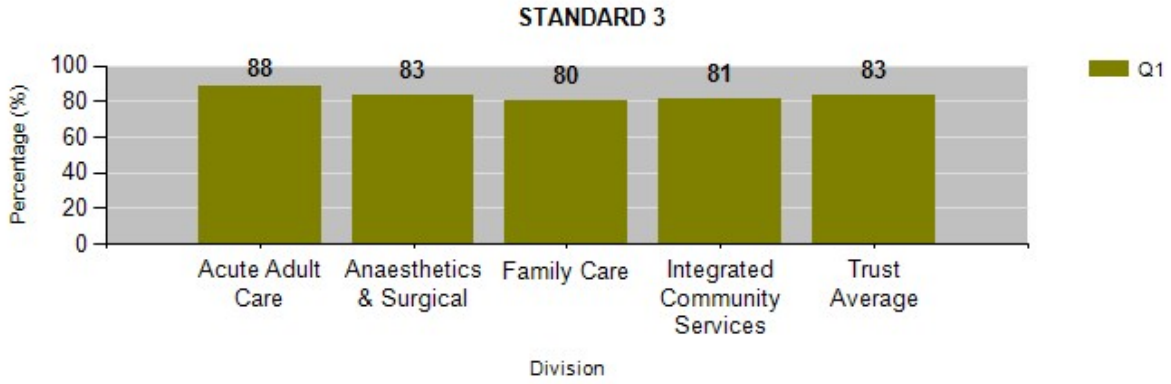


Fig. 16: Antimicrobial Stewardship Compliance Standard 4

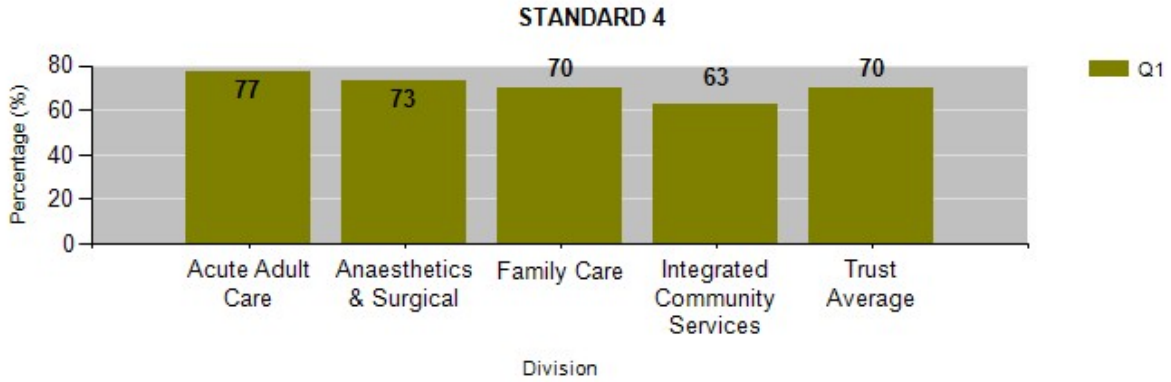
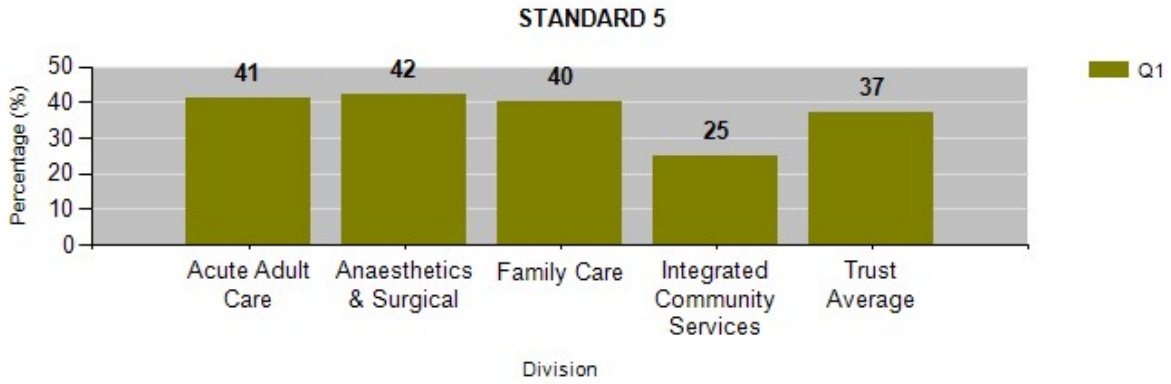


Fig. 17: Antimicrobial Stewardship Compliance Standard 5



With the implementation of electronic prescribing and medicines administration as part of EPR, the standards from 2020/21 have been revised to reflect the changes in prescription as review dates and indication documentation are required fields and will become less relevant:

1. STANDARD 1: Compliance with Trust Antibiotic Guidelines (including prescription in line with culture and sensitivity testing and/or microbiology recommendation).
2. STANDARD 2: Allergy status fully completed?
3. STANDARD 3: Stop or review date documented by 72 hours?
4. STANDARD 4: If stop/review performed - is the prescribed duration prescribed in line with guidelines / microbiology advice?
5. STANDARD 5: Saline flush administered (if on IVs)?

4.4 Representation at other Trust wide groups

Members of the IPCT represent the service at a number of Trust wide groups such as the medical devices group, Professional Advisory Group (PAG), Group Health and Safety Committee and is invited into other Trustwide groups such as building projects as required.

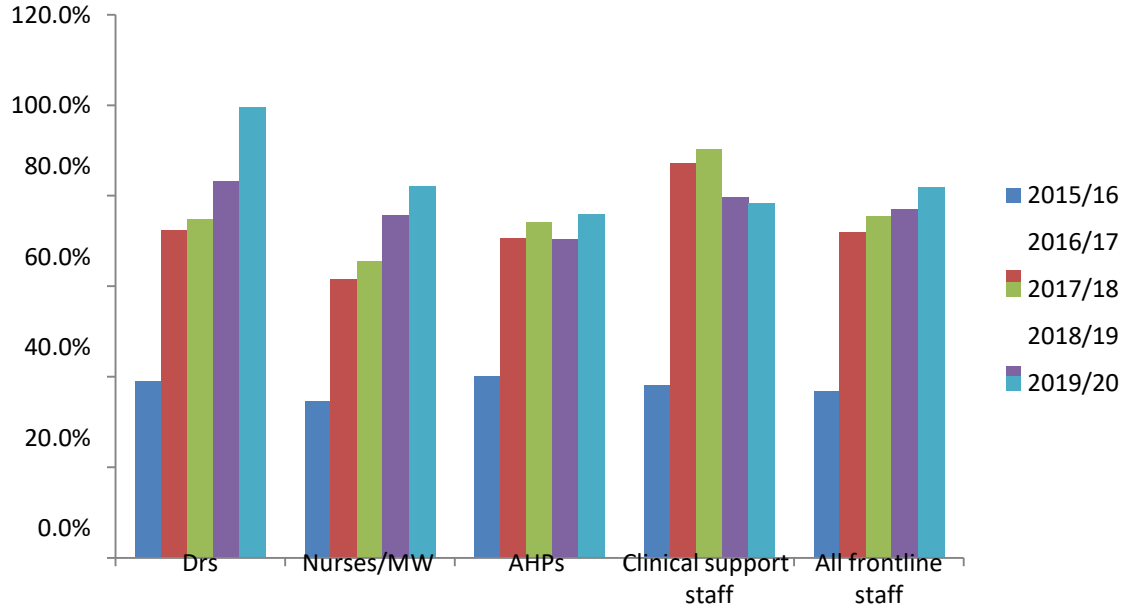
The IPCT also represent the Trust at external meetings including the Greater Manchester West Mental Health Trust IPCC, North West Infection Control (NORWIC) and the NHS North IPC collaborative group.

5. Flu

5.1 Staff Flu Vaccination Campaign

The IPCT led on a successful flu vaccination programme for frontline staff in 2019/20[5]. Uptake in all frontline staff groups increased based on the previous years. Overall uptake for the Trust for frontline healthcare staff was 81.9% and was the joint highest uptake in acute trusts in Greater Manchester.

Fig. 10: Flu Vaccine Uptake



In total 4464 staff were vaccinated of which 3530 were frontline staff.

6 COVID-19

In November 2019 a novel viral pneumonia was recognised in Asia. This was later identified to be a novel coronavirus – initially referred to as Novel Wuhan Coronavirus, this has now been formally named as:

- SARS-CoV-2: the name of the virus
- COVID-19: the name of the disease

This is a new coronavirus that has recently had a primary host in an animal and has undergone two significant changes:

1. The ability to cause disease in humans
2. The ability to spread from human to human without an intermediary animal host

COVID-19 was declared a pandemic by the World Health Organisation (WHO) on March 11 2020.

[5] Frontline staff are classified by the DH as: doctors, GPs, qualified nurses/midwives, other registered healthcare professionals and support staff to clinical staff

The first case of COVID-19 was identified at Bolton FT 2nd march 2020 and by the end of March 2020 132 people had tested positive for SARS-CoV-2.

The virus has been hugely disruptive to hospital services and society during 2020 but the impact of the disease was seen in the next financial year although the Prime Minister did declare a national lockdown 23rd March 2020.

7. Community IPC

The team covers such services as care, homes, Bolton hospice, schools, district nursing, podiatry and community loan stores as examples. The team provide an informative, open, and knowledgeable service working cross organisationally to promote safe and effective infection prevention and control practices.

The team have worked with care homes, schools and nurseries around the importance of reporting and appropriately managing outbreaks of infection - including diarrhoea and vomiting, and influenza. They have visited schools and carried out education sessions with the smallest of children, and also liaised with the local authority neighbourhood teams to encourage the 'Making Every Contact Count' approach to infection prevention and control with a view to this message being shared with the wider community.

There are now separate bi-monthly link meetings for both FT community staff and care home staff which serve as an educational and informative forum for staff to feed back to their areas of work. The team also carries out mandatory training for our community staff, and have made time to visit several individual teams at their request, including podiatry and respiratory services, to carry out more 'tailor made' training for staff.

The team also liaise directly with patients where necessary to ensure they are receiving the correct treatment and have a good understanding of their infection. This might include an initial conversation (by phone or in person) and it often followed up by a home visit to ensure correct practices and treatment are in place. This usually involves communication and close liaison with other teams - including district nurses, Children's Community
Nursing Team, tissue viability service, podiatry and GPs amongst others.

7.1 Care Homes

The team continue to work consultatively with care homes to ensure that they are safe and improving.

7.2 Training

IPC mandatory training for staff in ICSD predominantly remains face-to-face delivered by the CIPCT. In addition to delivering this, the team have provided 23 training sessions to care staff, monthly training at IPC link meetings, training for schools and education staff. The team has made efforts to provide IPC awareness sessions to hard to reach groups like parents with children with long-term health conditions and vulnerable adults who are homeless or who are injecting drug users.

During 2019/20 a decision was made to move all IPC mandatory training from face-to-face to e-learning to improve access.

7.4 Other Functions

The team also take queries by phone, contribute to RCAs of Trust and non-Trust related infections. The team continue to lead on work in the Bolton population in raising awareness of infections related to injecting drug use such as MRSA and Group A *Streptococcus*.

The IPC team were also critical in helping to provide the flu vaccine for staff in the Trust community services – providing much of the uptake in this division.

8. Cleaning and Decontamination

8.1 Decontamination across the Trust

The Infection Prevention and Control team continues to provide decontamination advice throughout the Trust. The IPCT are available to give specialist advice on policies, procedures and the purchase of equipment in relation to decontamination.

The methods, processes and audits have been reviewed in year in response to a spike in CDT cases as described earlier.

8.2 Cleaning Service

Domestic services continue to be delivered by Bolton iFM. Bolton iFM continue to monitor cleaning standards as part of the service contract. Audits are undertaken using national standards. The audits are visual inspections incorporating 41 standards.

Departments are considered to be high-risk (for example, complex care) or very high-risk (for example, ICU). The same standards are monitored, but a successful audit in a high-risk area is 95% compliance with the audit whereas the required compliance in a very high-risk area is 98%.

All cleaning performance is reviewed and discussed at the Trust IPC Committee and the IPC Operational Group. Scores are reviewed monthly by the IPC team and area with consistently low scores or scores that generate a specific concern are discussed with the relevant managers.

At the intermediate care facilities there is local authority in-house cleaning staff. Darley Court's cleanliness is now assessed exactly the same as any other inpatient department in the Trust and reviewed with the same processes. All community healthcare facilities perform a 3 monthly audit which checks the standards of cleanliness and identifies any building fabric or building concerns. The audits are returned to the management team to progress any actions.

In the new build health centres the cleaning is performed by Eric Wright associates and is performed to a high standard they perform monthly environmental/cleaning audits which are reported to the relevant management teams.

All environmental cleaning audits are reported to the IPC Committee via the revised divisional IPC monthly reports for assurance and exceptions are challenged and discussed.

8.3 Infection Control audits

The IPCT carry out audits of practice and adherence to key IPC standards on at least an annual basis. High risk areas (listed below) are audited at least twice yearly:

- ICU
- HDU
- A&E Dept
- Ward D1
- Ward D2
- CDU
- NICU
- Main Theatres

The audits are planned in advance and carried out by a member of the IPCT with a member of the ward staff; ideally the ward manager or IPC link nurse.

An action plans are completed by the ward staff and returned to the IPCT and the results are fed back at the IPC operational group. The group is attended by representatives from Bolton iFM facilities to assist if there are environmental issues that the ward staff cannot resolve them themselves.

If the initial audit is unsatisfactory then a re-audit is required and if there are significant concerns, the issue may be escalated to the senior management team for support.

These audits are reported to the IPC Committee via the revised divisional IPC monthly reports for assurance and exceptions are challenged and discussed.

8.4 Hand Hygiene Audits

Hand hygiene audits are completed by nominated departmental staff continue and are inputted into secure applications. All grades of all types of staff are included in the audit and up to five members of staff are observed to check that hand washing before and after patient contact is taking place. Managers are able to generate reports for feed back to their team/department.

Hand hygiene audits are reported to the IPC Committee via the revised divisional IPC monthly reports for assurance and exceptions are challenged and discussed.

8.5 Bolton System of Care Accreditation (BoSCA)

The IPCT participate in the review of wards as part of BoSCA. The IPCT undertake elements 1, 10 and 13 of the BoSCA:

1. First Impressions: 15 Step Challenge
10. Infection Control
13. Environment

This is another opportunity for the IPCT to work with the ward staff to review and improve the care standards on their ward related to cleanliness and infection prevention and control.

The team work supportively with the ward staff to resolve any issues identified which helps to improve understanding and standards.

9. Education and Training Activities

The delivery of training remains a core component of the IPC service. The IPCT provides training for the Trust on the corporate induction and day 2 of the induction for clinical staff. There is now an e-learning module for clinical and non-clinical mandatory training for acute staff although this training is still face-to-face with community staff.

Table 3: IPC Mandatory Training Compliance (end March 2020)

Division	Training Compliance
Acute Adult Care	92.2%
Anaesthetic & Surgery	93%
Diagnostic & Support Services	95.3%
Family Care	92.8%
Integrated Care Services	95.2%
Total	**93.6%**

The IPCT increasingly deliver training on an ad hoc basis as required and in response to incidents. More time is being devoted to training on a one-to-one basis or in small groups in the work setting as this is known to be an effective way of training staff.

An example of such is the 'Germ Warfare' sessions undertaken by the band 6 nurses in the IPC team. This is a regular, planned in-reach programme where the IPC nurses for a month will engage with clinical and frontline staff on a one-to-one basis or in small groups on key topics such as MRSA, CDT, SIGHT, the appropriate use of personal protective equipment or hand hygiene. The feedback from staff is that this is a valuable approach and supports the e-learning well.

The IPC team provide core training for cascade trainers – for example for cascade trainers for fit testing or aseptic non-touch technique (ANTT). An important part of the development of the Trust IPC link nurses is also teaching, training and information sharing.

9.1 Student Nurse Placements

The IPCT is a spoke placement area for both student nurses and qualified staff. During their placement the student/staff are given an insight into the daily working of the team which includes ward and patient visits, training, audits, community aspects and reviewing microbiology results. Visiting staff are given an information package which includes the names and contact details of the IPCT/microbiology team and the key roles and responsibilities in relation to infection prevention and control of all staff within the Trust. They are also given an opportunity to undergo a brief training session to discuss the fundamental aspects of infection control.

9.2 IPC Link Meetings

The link group meetings have now been split into two discreet groups: acute staff link nurses and community staff link nurses. Each group is held bi-monthly and held mid-afternoon to facilitate maximum attendance.

The meetings generally incorporate a short presentation or demonstration related to an aspect of IPC. This is followed by the team giving the group up to date information on recent events, new initiatives, key priorities and educational opportunities. The purpose of the meeting is for the attendees to disseminate the information to their clinical areas.

The 'Link Champion' trophy is presented to a link person who has shown initiative in their area. The link person is presented with a trophy and a certificate. A certificate is also given to the ward/department to display on their achievement board.

10. Plans for 2020/21

During the next 12 months the IPCT aims to ensure a high quality and effective service across the whole Trust with an aim of preventing infection by the application of clean, safe care against a backdrop of the COVID-19 pandemic. This will be the most challenging period experienced by the NHS in its existence and the risks to staff and health are difficult to calculate. At all times the IPC team and DIPC will endeavour to meet the 10 core standards in the Code of Practice and NICE guidance.

Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (updated 2012)		**NICE (2011) Quality Improvement Guide for HCAI**
Criterion	**The registered Provider is required to demonstrate**	**Quality Improvement Statement**
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them	1
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	**2**
3	Provide suitable accurate information on infections to service users and their visitors	
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion	**4**
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people	**5**
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	**6**
7	Provide or secure adequate isolation facilities	**7**
8	Secure adequate access to laboratory support appropriate	**8**
9	Have and adhere to polices, designed for the individual's care and provider organisations. That will help to prevent and control infections	**9**
10	Ensure so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with provision of health and social care	**10**

At the time of writing there have been no objectives set by NHS England.

As a consequence, the IPC has advised that the objectives from the previous year be adopted and where none exist, has adopted its own objective:

MRSA BSI	Zero tolerance (NHSE 2019/20)
CDT (HOHA + COHA cases)	No more than 32 cases (NHSE 2019/20)
MSSA BSI	No more than 14 hospital onset cases (local)
***E. coli* BSI**	No more than 36 hospital onset cases (local)
Pseudomonas	Zero tolerance (local)
***Klebsiella spp.* BSI**	No more than 13 hospital onset cases (local)

Appendix 1: HCAI Nomenclature from 2019/20

Blood Cultures – including MRSA, MSSA, *E. coli*, *Klebsiella spp.* and *Pseudomonas aeruginosa*

The nomenclature and classification of these infections is unchanged from previous years.

- **Community Onset:** these are cases that are likely to have originated from care or exposure in the community prior to admission to hospital. This classification of infections is likely to be evident on admission or to become evident shortly after the infection is evident. Samples collected on the day of admission of the following day are classified as being of community onset and are reported here and publically as such.
- **Hospital Onset:** these are cases that are more likely to have originated from care or exposure in the hospital setting. Infections that become evident after two days of admission are less likely to be related to a community source. Samples collected from the second day after admission are classified as being of hospital onset and are reported here and publically as such.

Sample Collected Prior to Admission	Sample Collected on the Day of Admission	Sample Collected on the Day Following Admission	Sample Collected Later in the Admission
Community Onset	Community Onset	Community Onset	Hospital Onset

Clostridium difficile Cases

There has been significant change in the classification and nomenclature of *Clostridium difficile* infections from 2019/20.

Before 2019/20 these infections, these infections were classified as community onset and hospital onset infections in a similar way to blood cultures:

Sample Collected Prior to Admission	Sample Collected on the Day of Admission	Sample Collected on the Admission Day plus 1 day	Sample Collected on the Admission Day plus 2 days	Sample Collected Later in the Admission
Community Onset	Community Onset	Community Onset	Community Onset	Hospital Onset

This has been changed in to better reflect the progress of *Clostridium difficile* disease.

- **Community onset community associated:** cases that occur in the community or on the day of admission or the following day **and** the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA).
- **Community onset indeterminate association:** cases that occur in the community or on the day of admission or the following day **and** the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA).

- **Community onset healthcare associated:** cases that occur in the community or on the day of admission or the following day **and** the patient has been an inpatient in the trust reporting the case in the previous 4 weeks (COHA).
- **Healthcare onset healthcare associated:** cases detected from a sample collected from the third day of admission (admission being day 1 – HOHA).

From 2019/20 it is the HOHA and COHA cases that count towards the centrally agreed objectives for acute Trus

Agenda Item

Title:	Medical Appraisal & Revalidation Update

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th November 2020		Discussion	
Exec Sponsor	Dr Francis Andrews		Decision	

Summary:	Medical appraisal and revalidation quarterly update including changes resulting from Covid 19 and update of action plan

Previously considered by:	N/A

Proposed Resolution	For approval

This issue impacts on the following Trust ambitions			
*To provide safe, high quality and compassionate **care** to every person every time*	✓	*Our Estate will be **sustainable** and developed in a way that supports staff and community Health and Wellbeing*	
*To be a great place to work, where all **staff** feel valued and can reach their full potential*	✓	*To **integrate** care to prevent ill health, improve wellbeing and meet the needs of the people of Bolton*	
*To continue to use our **resources** wisely so that we can invest in and improve our services*		*To develop **partnerships** that will improve services and support education, research and innovation*	

Prepared by:	Mrs Rabeya Rashid	**Presented by:**	Dr Francis Andrews

Glossary – definitions for technical terms and acronyms used within this document

A&R	Appraisal & Revalidation
AOA	Annual Organisation Audit
RO	Responsible Officer
ASPAT	Appraisal Summary and PDP Audit Tool

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Bolton NHS Foundation Trust

Designated Body Annual Board Report

Section 1 – General:

The Board of Directors of Bolton NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission:

October 2020. This year there was a shortened AOA report which was completed and submitted to NHS England.

Action from last year:

1. Completion of the Revalidation Entry form and its journey to the MA&R (Medical Appraisal and Revalidation) team at the recruitment stage

2. Monitoring and supporting the agile doctors including additional training/technical support as and when required.

3. Introduction of 'Priming' appraisals - A&R Officer will plan to meet new starter within 1 month of commencement to develop individualised plan to support doctor requirements.

4. Supporting Doctors with varied Job Plans – To develop a pathway between Trusts for information sharing RO to RO to enable ease of sharing concerns, inclusion of complaints/SI's etc.

5. Patient Activity Reports – Increasing quality of appraisal portfolios and supporting our doctors especially our Staff grade doctors in obtaining their information in a timely manner. This also reduces the administrative burden for doctors.

6. Inclusion of never events and serious incident reporting within appraisal portfolios.

7. Implementation of The Appraisal Summary and PDP Audit Tool (ASPAT) - A tool that may be used to audit the appraisal summary and PDP of all doctors.

Comments:

Appraisal has been on 'pause' since March and a large portion of the year has been consumed by the covid-19 pandemic and had impacted on the completion of planned actions. The actions that were not completed will be deferred to next year.

The introduction of Priming appraisals has not been fully implemented due to the pandemic and the delivery of the priming appraisal meeting will need to be considered and revisited to ensure social distancing is maintained.

Lockdown was an opportunity for the Clinical Lead to be able to complete the ASPAT audit. Where initially the plan was to complete only a subset of appraisers, the Clinical Lead was able to fully complete the audit and the findings of this can be viewed in Appendix 1.

Action for next year:

1. Priming appraisals – A&R officer will plan to meet a new starter within 1 month of commencement to develop individualised plan to support doctor 5irequirements. A&R officer to consider how this will be delivered.

2. Supporting Doctors with varied Job Plans – To develop a pathway between Trusts for information sharing RO to RO to enable ease of sharing concerns, inclusion of complaints/SI's etc.

3. Patient Activity Reports – Increasing quality of appraisal portfolios and supporting our doctors especially our Staff grade doctors in obtaining their information in a timely manner. This also reduces the administrative burden for doctors.

4. Inclusion of never events and serious incident reporting within appraisal portfolios.

5. Appraisal restart - following further guidance and clarification from NHS England, Bolton will restart appraisal in October and will maintain appraisal anniversary dates as much as possible.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:

SLA for ABL Health is due for renewal in July 2020.

Comments:

The RO for Bolton NHS Foundation Trust is also the RO for a company called ABL Health and for Bolton Hospice. There is a Service Level Agreement (SLA) in place for ABL Health and the SLA will be submitted to the Medical Director for sign off next month.

Action for next year:

No action required for next year.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:

To support an increase in hours for the A&R Officer in terms of funding the increase in hours and ability to work flexibly.

Comments:

Request for increasing hours has been denied on the basis of no funding and a business case will be required to request increase of funding to support the increase in hours.

Action for next year:

Business plan for additional funding.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:

Monitoring completion of the Revalidation Entry form and its journey to the MA&R team at the recruitment stage.

Continue to regularly review GMC Connect list.

Comments:

The entry report was included in the pre-employment packs in May 2018 however the forms are seldom received but this impact has been mitigated by making use of the fortnightly induction registers.

Monthly ESR reports are used as backup to ensure all new starters have been captured. This is used as a backup because ESR reports are usually 1-2 months behind and delays first contact with a doctor.

The portal for maintaining prescribed connections, GMC Connect sends notification emails whenever a doctor connects or removes from our Designated Body. This assists the MA&R team to maintain an accurate record of all prescribed connections. Every connection/removal is reviewed to ensure accuracy of our list.

Action for next year:

No additional actions for next year.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:

Medical Appraisal and Revalidation Policy is not due for review till December 2021 but any updates or significant changes to systems and protocols will be updated and reviewed accordingly within correct channels.

Comments:

No significant changes to systems or protocols.

Action for next year:

Policy due for review December 2021.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year:

To continually review internal processes and how they can be improved.

Comments:

NHS England encourages each designated body to both host and conduct a minimum of one peer review in each revalidation 5-yearly cycle. Our aim is to conduct the next peer review in 2022.

Action for next year:

To continually review internal processes and how they can be improved.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:

1. Priming Appraisals – A&R Officer will plan to meet new starter within 1 month of commencement to develop individualised plan to support doctor requirements.
2. Further communication/invitation will be emailed to the doctor 4-5 months after commencement to ensure they are engaging in the appraisal process, but to also offer advice/assistance as and when required. This will encourage timely appraisals and highlight the importance of appraisals.

Comments:

The introduction of priming appraisals has not been fully implemented due to the pandemic. The delivery of the priming meeting will need to be considered and revisited to ensure social distancing is maintained. The A&R officer will explore virtual methods of conducting the meeting that is compatible with Trust IT systems and access.

Access to completing patient and/or colleague feedback is always accessible for all doctors with a prescribed connection.

In the North sector alone, there has been an increase of Short Term Contract/Locally employed doctors. Unfortunately this does impact on the Appraisal & Revalidation resources i.e. Difficulty for the admin team to support their induction to the Trust, Appraiser capacity, training etc.

Action for next year:

To explore Trust systems and resources that will support inductions for doctors.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:

To develop a pathway between Trusts for information sharing RO to RO to enable ease of sharing concerns, inclusion of complaints/SI's etc.

Comments:

The Trust uses the appraisal system, Premier IT. The appraisal portfolio is compliant with national requirements and is based on the GMC framework for good medical practice.

Inclusion of Complaints reports within the appraisal portfolio commenced in April 2018 for all doctors. The report includes complaints where a doctor has provided information or has been directly involved. If a doctor has not been involved then a nil return report is uploaded.

Inclusion of Never Events, Serious Incidents and Divisional Reviews will need to be included within the appraisal portfolio similar to that of the complaints report. These reports are uploaded by admin and cannot be removed by the Doctor.

Work continues to progress to ensure increased appraisal compliance however the compliance rates will understandably look different this year due to COVID-19.

Action for next year:

To include Never Events, Serious Incidents and Divisional Reviews within all appraisal forms.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

To continue to record any reasons for delayed appraisals, record approved postponements and any absence as a special circumstance on their electronic appraisal portfolio.

Comments:

Reasons are recorded on Premier IT for all doctors where a specific reason has been given. Where a specific reason has not been stated, a record of any letters/communication is kept that follows local non-engagement processes.

The A&R team have also enlisted the help of the MSC to support slow/non-engagers. The Chair of this committee is an Appraiser.

The A&R Team also receive monthly ESR reports regarding medical sickness and maternity absence. These are recorded on the Premier IT system.

Action for next year:

To continue to record any reasons for delayed appraisals, record approved postponements and any absence as a special circumstance on their electronic appraisal portfolio.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:

Appraisal Policy due for review in December 2021

Comments:

To undertake review of Appraisal policy for review date of December 2021.

Action for next year:

Appraisal policy will be updated and be forwarded to relevant committees for approval.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

On-going allocation process - requirement to change appraiser after 3 consecutive appraisals. Appraiser allocation is also required for new starters.

To explore incentives to recruit more Appraisers (including SAS Doctors).

Comments:

Training went ahead in January 2020 for a further eight appraisers, however we have had 3 experienced appraisers step down over the last few months however we are unsure whether if this is an impact from COVID-19. We are anticipating further notices of stepping down due to retirement and this will impact the service and pressure on existing appraisers.

Following the National trend, there has been an increase of Locally Employed Doctors. This contributes to the impact on the Appraisal & Revalidation resources and the burden on existing Appraisers.

Action for next year:

May need to consider approaching specialties where there is little or no representation for appraisers i.e. Breast, Urology and Orthopaedics.

5. Medical appraisers participate in on-going performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year

To implement the ASPAT (The Appraisal Summary and PDP Audit Tool). This is a generic tool that may be used to audit the appraisal summary and PDP of all doctors.

Comments:

Appraiser performance is monitored by inspection of the appraisal output forms by our Appraisal and Revalidation Clinical Lead. Our electronic appraisal system provides the opportunity for appraisee feedback. This information is collated, and a report generated for each appraiser prior to their own appraisal meeting for discussion and reflection. The Appraisal & Revalidation Clinical Lead chairs the Appraiser Network Meetings which is held every 6 months. These meetings are aimed at continuous improvement in the quality and consistency of appraiser performance and an opportunity to discuss topical issues.

Lockdown was an opportunity for the Clinical Lead to be able to complete the ASPAT audit. Where initially the plan was to complete only a subset of appraisers, the Clinical Lead was able to fully complete the audit and the findings of this can be viewed in Appendix 1.

Action for next year:

To continue as above.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:

To continue reporting as above in to the Workforce Assurance Committee and Board of Directors.

Comments:

Appraisal has moved from being a 'tick box' exercise to a more robust process where the focus is on quality supporting information to encourage better patient care and personal development.

All Appraisers are assessed by their appraisees after each completed appraisal. This is then collated in to an anonymised feedback report which the appraisers receive prior to their own appraisal meeting. The current performance is very satisfactory and no concerns have been raised to date. All appraisal outputs are reviewed by the Clinical Lead to monitor the quality of appraisal documentation.

The CLAR completed the ASPAT audit and the findings of the audit can be viewed in Appendix 1. Results of the audit will be shared with each appraiser.

Reporting in to the Workforce Committee will occur biannually to ensure oversight of MA&R processes and reporting in to the Board of Directors occurs annually.

Monthly meetings take place between the Medical Director/Responsible Officer (RO), Clinical Lead for A&R (CLAR) and A&R Officer where issues and concerns are discussed and where revalidation recommendations are signed off by the RO

While the CLAR reviews all appraisal Output forms to quality assure appraiser summary outputs, a review of the appraisee input forms and portfolios are often also reviewed. This is done for atleast 20 portfolios annually.

Action for next year:

To continue as above.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made 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 responsible officer protocol.

Action from last year:

A total of 94 revalidation recommendations were made to the GMC between the period 01/04/2019 – 31/03/2020. These are detailed below:

Positive Recommendation – 85

Deferral Recommendation – 9

Non-engagement Recommendation – 0

Late Recommendations – 0

Incorrect Recommendation – 0

Comments:

Revalidation recommendations will vary on the next report and this is due to the GMC changing revalidation dates for doctors in response to the COVID-19 pandemic.

On 18th March, the GMC communicated to all RO's that from the 17th March 2020, doctors who are due to revalidate before the end of September will have their revalidation date deferred for one year. Further communication was received on 4th June to inform RO's and their teams that doctors with revalidation dates between 1st October 2020 and 16 March 2021 will have their dates moved back by one year.

Flexibility was introduced to the system to allow RO's to make recommendations to revalidate doctors where they're ready to do so. This will include the first cohort of doctors mentioned above.

Action for next year:

A&R team will work closely with doctors to help them achieve their supporting information items for a positive revalidation recommendation, and where a deferral is necessary, a clear plan will be communicated with the doctor.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

To minimise the number of deferral recommendations made. It is recognised that this is not always possible and sometimes the best course of action in order to support a doctor, is to defer their revalidation date particularly in cases of absence due to ill health/sickness.

Comments:

With Appraisal and revalidation on pause since March, it is understandable that fewer recommendations will be made this financial year. However, the GMC has introduced more flexibility to the system to allow recommendations to be made outside of the normal 4 month window so this will help support doctors with their revalidation.

Every doctor is kept fully abreast with recommendations, especially where it is likely that a deferral or non-engagement recommendation will be made.

Action for next year:

A plan is put in place to ensure the doctor achieves the necessary requirements for a positive recommendation for their new revalidation date.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

We will review the document "effective clinical governance for the medical profession" and use the accompanying checklist as a tool to support the development of further good practice

Comments:

The GMC asked designated bodies to complete a self-assessment tool on 'Effective clinical governance for the medical profession'. This was completed in August 2020 and is presented as a separate paper.

The board has medically qualified non-executive board director who takes a lead interest in matters relating to clinical governance for doctors. The board is sighted on appraisal information and also clinical indicators. The Medical Director reads all clinical incident reports and chairs scoping panels to determine how serious issues are dealt with within 72 hours of reporting. The Trust was rated for its CQC well led domain and encourages staff to speak openly and there is in addition an active speak up Guardian.

Action for next year:

A&R Team to also upload reports for serious incidents, never events as well as complaints report into doctors' portfolios

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

1. Formation of a HR tracker to provide a better evidence base for timeliness of actions and decisions

2. Audit to ensure that relevant complaints and serious incidents are being declared in appraisal discussions

Comments:

Any concerns regarding conduct or performance are collated by the MD from a number of sources. These include complaints (where a system has been put in place to monitor the frequency of complaints against individual

doctors), involvement in serious incidents and never events, and conduct concerns raised by staff, patients, relatives and external agencies. The MD meets regularly with the deputy director of HR to review all concerns regarding conduct and performance and these are tracked. Advice is sought from NHS resolution on all cases and the GMC liaison officer holds quarterly discussions with the MD on cases of concern. Issues with trainees are dealt with through the Lead Employer with support from HR. Relevant information around complaints and involvement in serious incidents/never events is fed back to the appraisal lead to ensure that they are included in appraisal discussions.

Understandably, some actions remain outstanding as they have been side-lined due to the pandemic and therefore there has not been much progress. Plans are in place to get this work restarted along with appraisal.

Action for next year:

Actions deferred.

1. Formation of a HR tracker to provide a better evidence base for timeliness of actions and decisions

2. Audit to ensure that relevant complaints and serious incidents are being declared in appraisal discussions

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

None

Comments:

There is a well-established process including capability, conduct and remediation policy and disciplinary policy.

Action for next year:

None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action from last year:

To devise a quality assurance process with the required metrics and analysis and outcomes, with agreed reporting timescales to Workforce Assurance Committee

Comments:

Understandably, some actions remain outstanding as they have been side-lined due to the pandemic and therefore there has not been much progress. Plans are in place to get this work restarted along with appraisal.

Action for next year:

To devise a quality assurance process with the required metrics and analysis and outcomes, with agreed reporting timescales to Workforce Assurance Committee

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year:

Development of a more formal process working with the A&R team to support RO to RO communication.

Comments:

Where doctors work in addition for other organisations, these issues are rapidly communicated to the relevant responsible officer by the MD.

Understandably, some actions remain outstanding as they have been side-lined due to the pandemic and therefore there has not been much progress. Plans are in place to get this work restarted along with appraisal.

Action for next year:

Development of a more formal process working with the A&R team to support RO to RO communication.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year:

Ensure a framework is in place to ensure that decision making is free from bias and discrimination and provide evidence for application of this.

Comments:

The capability, conduct and remediation policy and disciplinary policy are subject to an equality analysis before approval. The Trust has a new Workforce racial equality standards document approved by the Trust Board with a supporting action plan. The RO (medical director) has received full RO training which includes ensuring responses to concerns are free from bias and discrimination

The aim is to complete this by December 2020.

Action for next year:

To share the framework of decision making process and evidence of application.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

None

Comments:

The Trust uses an e-Recruitment system which supports completion of all required pre-employment checks (in line with NHS Employment Check Standards). This system is used to check all substantive and bank medical staff, and all Foundation Doctors, before they commence work for the Trust.

All agency medical staff are sourced through accredited (through NHS Framework agreements) agency partners and the Trust receives confirmation that all appropriate checks are in place before work is permitted. NHS Frameworks regulate agency partners on their frameworks with regular compliance audits.

Action for next year:

None

Section 6 – Summary of comments, and overall conclusion

Overall Comments:

It has been an unprecedented quiet start to the financial year for the A&R team with the global pandemic at the forefront of attention. Unfortunately this has meant not much progress has been made in the way of the A&R agenda as they had to be side-lined due to the pandemic. Plans are in place to get this work restarted along with appraisal.

There has been a new shift in emphasis from the GMC around quality assuring the effective governance of the medical profession by boards and governing bodies, but there are plans in place for these and in many cases work is starting following the recent report to board that identified the need for these developments.

Overall Conclusion:

Appraisal and Revalidation at Bolton FT is carried out to a high standard and robust processes are in place to ensure that all doctors are supported to achieve appropriate appraisal in a timely manner to ultimately support successful revalidation. Work particularly needs to be undertaken to provide evidence for the new GMC Good governance principles.

Section 7 – Statement of Compliance:

The Board of Directors of Bolton NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Bolton NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Appendix 1

Appraisal Summary & PDP Audit Tool (ASPAT) Report 2020

Miss Priya Bhatt

Clinical Lead for Appraisal & Revalidation

Contents

Background and uses for the Appraisal Summary & PDP Audit (ASPAT)

Introduction

The ASPAT has been developed by doctors from the primary, secondary and independent care sectors and is a generic tool that may be used to audit the appraisal summary and PDP of all doctors in England. It may also be useful as a reference for appraisers as they write their appraisal summaries.

The ASPAT has been written after reviewing other available appraisal audit tools such as PROGRESS, EXCELLENCE, the East Midlands tool and the Oxford tool. This audit tool covers many similar areas to its predecessors and offers further development in certain areas. Whilst the ASPAT is not specifically intended to replace other tools where these are being used to good effect, it may act as a suitable standard tool in places where no such process has been in place before.

Uses of the ASPAT

It may be used:

- for quantitative and qualitative assessment of an individual appraiser's appraisal outputs (summaries and personal development plans (PDPs) of the appraisals they have carried out
- as a guidance document for when an appraiser is preparing for an appraisal and writing up an appraisal summary
- as a guidance document for all doctors when preparing for their own appraisal
- as a tool for local, regional and national benchmarking when looking at the standard of appraisal outputs.

Appraiser Assurance

The designated body's appraisal lead is usually responsible for the quality assurance of appraisal. Currently this is provided via 2-3 yearly Appraiser Network Meetings, individual feedback and Aggregated Appraiser Feedback Reports completed by appraises after an appraisal is completed.

The quantitative and qualitative results of an audit of an appraiser's appraisal outputs using the ASPAT tool may be fed back to the appraiser as part of a process of development, and this can form part of an appraiser one to one review.

This is a further step in our quality assurance of the Appraisal & Revalidation processes in place at Bolton NHS Foundation Trust.

The ASPAT scoring system and defined standards

The ASPAT has a scoring system of 0-2 for each question:

0 - unsatisfactory

1 - needs improvement

2 - good

The total score is out of 50. The maximum score is obviously 50 with scores rated as:

- Excellent (80%) being 40 and above
- Satisfactory (40-80%) scores of 20-40
- Unsatisfactory (<40%) scores below 20

In addition to the total scores the component scores are further divided into:

- Overview of supporting information (max score 18)
- Reflection (max score 6)
- PDP (max score 16)
- General standards (max score 10)

For further details on specific questions and how scores are interpreted please refer to the official guidance:

https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2017/01/aspat-guidance-notes.pdf

Results

2 appraisal output forms were reviewed for each appraiser and their average scores collected. Only active appraisers who had done over 2 appraisals were included. This audit took place over April/ May 2020 using our Trust electronic appraisal and revalidation system, Premier IT.

To ensure consistent scoring, only one assessor was involved: Miss Priya Bhatt, Clinical Lead for Appraisal and Revalidation at Bolton NHS Foundation Trust.

The results were as follows.

Organisation average scores:

Sections	Score	Max score	Rating(Percentage)

Overview of supporting information	16	18	Excellent (80%+)
Reflection	5	6	Satisfactory (40-80%)
PDP	15	16	Excellent (80%+)
General standards	9	10	Excellent (80%+)
Total score	**44**	**50**	**Excellent (80%+)**

53 appraisers were included in the audit (106 appraisal outputs and PDP forms).

Total score range for individual appraisers: 32-49

7 appraisers scored 'Satisfactory (40-80%) scores of 20-40'

46 appraisers scored 'Excellent (80%) being 40 and above'

0 appraisers scored 'Unsatisfactory (<40%) scores below 20'

Analysis of results and actions

1) Bolton NHS Foundation Trust is maintaining excellent standards of appraisal outputs.
2) No appraisers showed unsatisfactory outcomes.
3) All elements of the ASPAT scored Excellent (80%+) apart from reflection which scored Satisfactory (40-80%). This will be an area on which we should facilitate further learning and guidance.
4) Areas that good scores could be improved further across the board with minor additions are: to start with scope of work and to state CPD covers all of this, commenting on stage of revalidation cycle and stating what requirements have been achieved and what if any are still required in the summary, and more detail in PDP summary regarding items deferred.
5) The results of individual scores will be fed back to appraisers individually and they should be able to access their individual breakdown and scores and comparison to organisation scores on Premier IT.
6) The results of the ASPAT will be shared at the next Appraiser Network Meeting.
7) Possible re-audit in 2-5 years' time with possibly smaller numbers.

Flaws in the ASPAT

- Long, laborious process.
- Questionable addition to current QA process in place as relatively small institution and appraisal outputs all reviewed by Clinical Lead for Appraisal & Revalidation already and issues raised directly with appraisees and appraisers.
- Element of observer bias as only one assessor and know appraisers professionally/ personally.
- Difficulty with benchmarking as many Trusts are not performing the ASPAT.

- The ASPAT does not take in to account stage of doctor's career. This can have bearing on some of the questions and the PDP.
- Disagree with PDP needing 3-6 items.
- PDP too prescriptive. Items in reflection and effective learning are not always relevant.
- A lot of questions are irrelevant as they are automatic on Premier IT such as statements on health and probity which must be ticked to progress on the system and last year's PDP sign off which has to be completed to access the output form.