BOARD OF DIRECTORS MEETING

Date: 26th May 2022
Time: 09.00-13.00
Venue: Zoom

Bolton NHS Foundation Trust

AGENDA - PART 1

TIME	SUBJECT	LEAD	PROCESS	EXPECTED OUTCOME
09.00	1. Welcome and Introductions	Chair	Verbal	To note
09.05	2. Patient Story		Verbal	To note
09.15	3. Apologies for Absence	DCG	Verbal	Apologies noted
	4. Declarations of Interest	Chair	Verbal	To note declarations of interest in relation to items on the agenda
09.20	5. Minutes of meeting held on 31st March 2022	Chair	Minutes	To approve the previous minutes
	6. Action Log	Chair	Action log	To note progress on agreed actions
	7. Matters arising	Chair	Verbal	To address any matters arising not covered on the agenda
	8. Chair's update	Chair	Verbal	To receive a report on current issues
Safety Quality and Effectiveness				
09.30	9. Chief Executive's Report	CEO	Report	To receive and note
09.40	10. Operational Update	COO	Presentation	To receive and note
09.50	11. Quality Assurance Committee Chair's Report	QAC Chair	Report	To provide assurance on work delegated to the Committee
10:00	12. Staff Story	DoP	Verbal	To note
10:15	13. People Committee Chair's Report	People Chair	Report	To provide assurance on work delegated to the Committee

10:25	**BREAK**			
10:40	15. Maternity Update	Chief Nurse	Presentation	To note
Governance				
11:00	16. Governance Self Certification 2022	DoCG	Report	To approve
11:10	17. ICP Business Plan	DoST	Report	To approve
11:20	18. Audit Committee Chair Report	Audit Chair	Report	To receive for assurance
11:30	19. Finance and Investment Committee Chair Report	F&I Chair	Report	To receive for assurance
11:40	20. Integrated Performance Report	Exec team	Report	To receive for assurance
11:50	21. Any Other Business	Chair	Verbal	To note
Questions from Members of the Public				
	22. 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				
12.00	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted			

Date of next meeting: 28th July 2022

Meeting:	**Board of Directors (Part 1)**
Date:	**Thursday 31st March 2022**
Time:	**09:00-12 noon**
Venue:	**Via Zoom**

PRESENT:

Jackie Njoroge	Non-Executive Director (Chair)	JN
Fiona Noden	Chief Executive	FN
Francis Andrews	Medical Director	FA
Sharon Martin	Director of Strategy and Transformation	SM
James Mawrey	Director of People	JM
Annette Walker	Director of Finance	AW
Rae Wheatcroft	Chief Operating Officer	RW
Angela Hansen	Interim Chief Nurse	AH
Malcolm Brown	Non-Executive Director	MB
Rebecca Ganz	Non-Executive Director	RG
Martin North	Non-Executive Director	MN
Alan Stuttard	Non-Executive Director	AS
Zed Ali	Non-Executive Director	ZA

IN ATTENDANCE:

Sharon Katema	Interim Director of Corporate Governance	SK
Faye Chadwick	Assistant Divisional Nurse Director, Family Care Division (item 2 only)	FC
Leona Ratcliffe	Registered Operating Department Practitioner (item 1 only)	LR
Lisa Gammack	Deputy Director of Occupational Development	LG
Louise McDade	Strategic Lead - Bolton Together (attended for patient story)	LMcD
Natasha McDonald	Director of Midwifery (attended for item 12 Ockenden Update)	NMcD
Rachel Hemingway	Assistant Director of AHPs (item 14 only)	RH
Tracey Joynson	Patient Experience Manager (item 2 only)	TJ
Victoria Crompton	Corporate Governance Manager	VC

1. Welcome

Jackie Njoroge welcomed everyone to the meeting and noting apologies from Donna Hall, advised that she would be chairing the meeting

2. Patient Story

Louise McDade presented the story of a nine-year-old boy (C) who had been referred by the School Nurse into the 0 – 19 service. Whilst awaiting an autism diagnosis as C was referred onto a six-week Decider Skills Programme, as he struggled with expressing his emotions.

Board members heard how C attended the programme, along with his father, and how the skills that they learnt have assisted the whole family.

It was acknowledged this was a good example of partnership working with the voluntary sector and the team were commended for the work they have completed to support young people.

It was noted that the uncertainty around future contracts and funding remained an issue as it prevented the team from developing long term plans.

It was confirmed the focus of the team is about early intervention. If a young person has received a diagnosis or requires medication they would receive support from CAMHS and not the 0 – 19 service.

JN thanked LMcD for sharing the patient story relating to a young person's mental health.

Resolved: The Board of Directors received the Patient Story.

3. Apologies for Absence

The Board noted Apologies for absence from Donna Hall and Bilkis Ismail.

4. Declarations of Interest

There were no declarations of interests relating to the agenda items.

5. Minutes of last meeting

The minutes of the meeting held on 27th January 2022 were approved as a correct record.

6. Action log

The action sheet was updated to reflect actions taken since the previous meeting.

7. Matters arising

There were no matters arising to report.

8. Chair's Update

No update provided.

9. Chief Executive Report

The Chief Executive presented the Chief Executive Report highlighting the key points.

In response to the report Board members raised a number of queries and the following responses were provided.

- Visiting had re-opened in some areas within the Trust, with relatives able to book appointments either on-line or by telephone.
- The Board Assurance Framework (BAF) was currently under review and a would be presented to the Audit Committee and to the Board at the end of Q.1.
- With regards to PPE, reassurance was provided that there were no instances where any out of date items or equipment, were donated or included as part of the shipment donated to Ukraine.

Board members discussed the implications of re-opening visiting and it was confirmed there are currently 109 inpatients with Covid which equates to three wards. There are two wards with patients who are contacts of Covid, and the current guidance is being followed for these patients. The Trust is awaiting further guidance and is managing and monitoring the situation closely.

Resolved: The Board of Directors received the Chief Executive for this update.

10. Operational Update

The Chief Operating Officer delivered the Operational update advising that it had been another challenging month for staff due to the increase in Covid19 figures. The following key points were highlighted:

- Urgent care attendances had peaked at 496 in one recent 24-hour period.
- The Trust has sourced support from AQUA to assist with reducing the number of patients with No Criteria to Reside (NCTR) as this was increasing.
- Whilst there was an increase in RTT, the Trust had submitted its trajectory and was on plan to achieve this.

With regards to the new interventions that the organisation was considering following The Emergency Care Improvement Support Team (ECIST) visit, it was noted that the main focus would be on getting back to basics ensuring that work was also being completed with the Discharge Team and therapists around risk and challenge and their risk appetite.

Discussion took place regarding the Accident and Emergency Department and whether another expansion is required due to the numbers of patients now being seen within the department on a daily basis. It was advised that discussions are taking place with the team and options about the estate will need to be considered within this.

In response to a query regarding the planned theatre expansion and whether this would be sufficient given the amount of elective recovery required, RW advised that the Trust had plans for an additional four theatres and it is imperative that GM had a role to drive productivity ensuring and maximise the capacity which is available.

Resolved: The Board of Directors received the Operational update.

11. Quality Assurance Committee Chair Reports

The Quality Assurance Committee Chair delivered the reports from the meeting held in February and March.

MB clarified that the colour coding on both reports would be amended from Green to Amber for the following items:

- Chief Nurse Update
- Operational Update
- Current Pressures
- Safeguarding Committee Chair Report

Resolved: The Board of Directors received the Quality Assurance Committee Chair Reports.

12. Ockenden Update

The Director of Midwifery presented the Ockenden Update which sought to provide the Board with a 'One Year On' assessment following the publication of the initial findings of the report.

The Interim Chief Nurse advised that Recruitment and retention plans were under review as there were midwifery vacancies within the organisation that were having a significant impact on the service. In recent weeks, the Trust had requested support from other maternity units and had been in contact with the CQC and NHSI regarding the issue.

In acknowledging that midwifery staffing remained a national issue, a summary of key recruitment incentives was provided. These included the:

- Participation in the Greater Manchester (GM) led international recruitment drive for midwives.
- Trust undertaking its international midwifery recruitment campaign working with the Clinical Recruitment Lead.
- Continuation of the rolling advert for vacancies which has been open since November 2021.
- Conditional offers of employment to all midwifery students and exploring how different roles could provide support to the service.

Following receipt of two anonymous complaints, the Trust had held listening events and was working with both universities to ensure that standards were maintained for student midwives undertaking placement at the Trust. In addition, practice educators had been allocated and would provide support and pastoral care to all student midwives.

Discussion took place regarding the actions with the Board noting that further assurance on progress in filling the vacancies would be provided to the Quality Assurance Committee.

AH advised that Louise Tucker would be commencing the role of Interim Director of Midwifery as NMcD was leaving the Trust. Board members thanked NMcD for the work she has completed at the Trust and wished her well for the future.

Resolved: The Board of Directors received and noted the Ockenden update.

13. Mortality Report

The Medical Director delivered a Mortality presentation which detailed the most recent mortality metrics available and to provided details of key actions and priorities for improving these metrics. It was noted that

- SHMI was Higher than expected as the 12 month rolling average was 113.87 for November 2020 to October 2021.
- The rolling average for HSMR was 118.97 for the 12 months to November 2021. Bolton was the highest amongst mortality peers
- In hospital crude mortality fell to 3.1% in February 2022 from 3.5% in January 2022, which is in line with the seasonal cyclical pattern over the winter months

FA advised that one of the key challenges the Trust was facing related to the reduction in the Coding team establishment resulting in reduced coding completeness and access for vital clinical engagement. He highlighted some of the difficulties in replacing the number of coders that had left the organisation included the time it took to train a new member of staff and the banding of the role. However, it was worth noting that the Trust does offered the roles on a higher banding compared to other local organisations.

In addition to the recruitment plans and the Trust was linking with local colleges and universities with a view of raising the profiles on the role of coders and securing a pipeline of staff coming through for various roles including coders. Bolton College was also working with the Trust to develop an apprenticeship course for coding within NHS.

Resolved: The Board received and noted the Mortality Update.

14. Staff Story

The Assistant Director of AHPs introduced LR who shared her experience as the first AHP apprentice to become a registered practitioner. The AHP apprenticeship was developed by staff, most of whom predominantly work in theatres, with colleagues from Bolton University. LR advised that prior to commencing the apprenticeship in January 2019, she had worked in various roles within the Trust for over 10years and it was whilst working in Theatres that she had the opportunity to progress with the apprenticeship. LR worked throughout the pandemic whilst continuing with her studies and graduated with a First Class degree and also winning the Student of the Year Award.

Following the completion of her studies in January 2022, LR was offered a substantive in theatres and was a keen advocate for apprenticeships as an alternative pathway for staff to learn and progress in their careers. It was noted that LR had inspired other colleagues to undertake apprenticeship resulting in oversubscription of the next few intakes and that LR has spoken at various events including a Careers Evening for college students which was held in the Library to promote apprenticeships.

With regards to improving recruitment from diverse communities, JM advised 35% of new recruits to the Trust were from a BAME background. He added that collaborative events with schools and colleges formed part of a workstream to inspire young people from a range of backgrounds.

Resolved: The Board received the Staff Story.

15. People Committee Chair Report

Board members received and noted the People Committee Chair Report from the February and March meetings.

Resolved: The Board received the People Committee Chair reports.

16. EDI Annual Report Scheduling

The Deputy Director of Occupational Development presented the EDU Annual Report Scheduling which sought to highlight the key areas of focus and next steps.

Board members queried the capacity of people to engage with the EDI training programme and it was agreed that on-line training is a challenge and is not now an adequate source for this training. A cost proposal is being developed and will be taken to Executives.

Further updates will be brought through the People Committee Chair Report.

Resolved: the report was noted.

17. Community Diagnostic Centre Update

The Director of Strategic Transformation presented the report advising that the proposal has been updated due to the reduction in available capital funding. SM highlighted that the CDC would now be located on the main Trust site and that discussions with Greater Manchester West Mental Health Trust regarding the possibility of locating the centre on the ground floor of J Block were progressing. However, whilst confirmation on availability of revenue funding was yet to be received, £10m had been requested over the term of the contract.

There was an expectation that organisations would produce a plan to support GM as a whole, but this remained unclear due to the funding streams available and the need to ensure there was a sustainable plan developed in conjunction with the GP Federation.

Resolved: The Board received the Community Diagnostic Centre Update.

18. Review of Performance Against 2019-24 Strategy

The Director of Strategic Transformation highlighted the performance against the 2019-24 strategy advising that a number of actions are still on track, but some have been delayed due to the focus on the pandemic over the last two years. There are some areas which are currently on hold which will require further consideration.

It was agreed it has been a helpful piece of work measuring performance against the strategy.

Resolved: The Board of Directors noted the update

19. Bolton Health and Social Care Locality Model

The Director of Strategic Transformation presented the Bolton Health and Social Care Locality Model which outlined the proposed model for Bolton and Board members were asked to approve.

It was confirmed that the Chief Executive and Director of Strategic Transformation are members of the Bolton Locality Board and the Director of Finance may also be invited to join. There are also representatives from organisations such as the Local Authority, Police, NWAS and GPs. As the Locality Board evolves further consideration will be given as to what additional representation is required.

Board members discussed the future vision noting that the Local Care Trust is not currently in a position to hold a section 75 until the governance implications have been worked through, so in the interim the Bolton Locality Board will hold the section 75.

Resolved: the Board received the Bolton Health and Social Care Locality Model and approved the nomination of the Trust Chief Executive as Place Based Lead and approved the model as set out in the paper. Board members also authorised the Chief Executive along with other stakeholders to further progress transition arrangements including the models responsibility and accountability arrangements.

20. Audit Committee Chair Report

The Board of Directors received and noted the Audit Committee Chair Report from the meeting held on 2 March 2022.

Resolved: The Board received the Audit Committee Chair report.

21. Finance and Investment Committee Chair Report

The Director of Finance presented the Chair Report from the meeting held on 23 February 2022 and provided a verbal update on the meeting held on 23 March 2022. Notable highlights included:

- The interim financial submission for 2022/23 shows a deficit of £23.8m with the total expected deficit for GM being £265m. There is a substantial gap across GM and a series of check and challenge meetings are taking place.
- There are a number of drivers to the deficit including inflation and costs of Covid not reducing as expected.
- The month 11 position is breakeven.

- It is expected the Trust will have a £24m capital spend this financial year which is a good achievement.

Board members discussed the rising cost of inflation and the impact of the increase in utilities on staff and the Trust and noted that organisations were awaiting national guidance regarding this.

Non-Executive Directors queried whether the Maternity EPR system will work in conjunction with the EPR software used in other areas of the Trust. It was confirmed the division have been asked for assurance around this and an update will be provided.

Confirmation to be given as to whether maternity EPR will work in conjunction with the EPR for rest of Trust.	**AW FT/22/07**

Resolved: The Board received and noted the Finance and Investment Committee Chair reports.

22. Trust Transformation Committee Chair Report

Board members received and noted the Chair Report from the Trust Transformation Committee which were held on 14 February and 14 March 2022.

The Director of Strategic Transformation extended her thanks to Martin North, Non-Executive Director for his chairmanship of the meeting.

Resolved: The Board of Directors received the Trust Transformation Committee Chair Reports.

23. Integrated Performance Report

Board members received the Integrated Performance Report and discussed whether the caesarean section target line should be removed from the report in view of the Ockenden report

Remove caesarean section target line from Integrated Performance Report	**AH FT/22/07**

In response to a query regarding deflections from A&E reducing, the Chief Operating Officer confirmed she would look into this further and respond off-line.

RW to investigate the reduction in deflections from A&E and feedback.	**RW FT/22/08**

Resolved: The Board received and noted the Integrated Performance Report.

22. Any other business

These was no other business discussed at this meeting.

23. Next meeting

The next Board meeting will take place on the 26 May 2022.

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.

January 2022 actions

Code	Date	Context	Action	Who	Due	Comments
FT/22/01	27/01/2022	Staff Story	Options appraisal to be completed around how preceptorship training for recruits is delivered and options to be taken through the People Committee.	KM/TR	May-22	Update via People Committee Chair Report
FT/22/03	27/01/2022	Integrated Performance Report	Update regarding complaint experience surveys to be brought back to future meeting.	KM	May-22	Full Task and Finish Group in place for future use of patient stories including how actions are managed and followed up and a proposal for an annual review.
FT/22/07	31/03/2022	Finance & Investment Committee Chair Report	Confirmation to be given as to whether maternity EPR will work in conjunction with the EPR for rest of Trust.	AW	May-22	Complete - confirmed via F&I Committee
FT/22/08	31/03/2022	Integrated Performance Report	Remove caesarean section target line from Integrated Performance Report	AH	May-22	Verbal update
FT/22/09	31/03/2022	Integrated Performance Report	RW to investigate the reduction in deflections from A&E and feedback.	RW	May-22	Complete - Peak in deflections was linked to covid oximetry at home pathway which has now returned to pre-pandemic levels.
Ft/22/10	31/03/2022	Operational and Financial Plan	8% figure in relation to agency costs to be checked and an update provided.	JM	May-22	Verbal update
FT/22/02	27/01/2022	Operational Plan Update	Presentation to Board regarding piece of work being completed on changes to community working	JM/SM	Jul-22	

Key

complete	agenda item	due	overdue	not due

Title:	Chief Executive's Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th May 2022		Discussion	
Exec Sponsor	Fiona Noden		Decision	

Summary:	The Chief Executive's report provides an update about key activity that has taken place since the last meeting, in line with our strategic ambitions.

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 Chief Executive	**Presented by:**	Fiona Noden Chief Executive

Ambition 1
Provide safe, high quality care

We have continued to be pragmatic in our approach to the measures we have in place to keep everyone safe from COVID. This is largely due our levels of people infected with COVID being higher than other areas throughout the pandemic, and still having a number of patients in our hospital with the virus.

Since the last Board of Directors meeting, we have approved and implemented a reduction in our infection prevention and control (IPC) measures, which brings us in line with neighbouring trusts across Greater Manchester, and reflects the changing picture as we adapt to live with COVID in our community. Staff working in non-clinical areas are no longer required to wear a surgical facemask, and the minimum PPE for clinical staff has reduced – both will continue to be monitored and adjusted accordingly.

We have also been really pleased to safely re-introduce visiting on some of our medical and surgical wards. We know how hard it has been for relatives and loved ones who have not been able to visit for a prolonged period of time. Visiting is being managed using an online booking system and all visitors are required to comply with some simple safety measures when they visit the ward, to keep everyone as safe as possible.

We are determined to learn as much as we can from the pandemic and have continued to contact people who acquired COVID whilst in our care. I signed over 400 letters this month to patients who recovered from the virus, to ensure that they fully understand what happened and have the opportunity to talk to us in further detail if they wish.

Behind the scenes, our critical care teams have been involved in two major research studies to ensure we continue to have the best defences against future cases. Our patients, research, pharmacy, nursing and medical teams have all supported the studies to enable us to continue to improve care for the future.

The inquest into the loss of baby Kingsley Olasupo concluded at the end of April. We fully accept the outcome, and are truly sorry that our care fell below the standards that Kingsley, and his family deserved. We undertook a thorough and transparent investigation, and have reviewed our practices to ensure we have learnt as much as we can, to prevent such a tragedy from happening again in the future.

Ambition 2
To be a great place to work

We have welcomed some new colleagues to the Bolton team; Tyrone Roberts - our new Chief Nurse, Tracy Iles - Divisional Director of Operations for our family care division, Stuart Bates - Director of Quality Governance and Laura Brookes - Deputy Divisional Director of Operations for diagnostics and support services have all joined us. Michaela Toms has also started her new role as Divisional Director of Operations for our integrated community services division, to cover maternity leave. Jake Mairs, our new Associate Director of Organisational Development and Janet Cotton to our Director of Midwifery role, will both also join us very soon.

Our teams came together during Ramadan to observe a day of fasting in solidarity with our Muslim colleagues, patients and service-users across Bolton. It was for the initiative Share Ramadan, which aims to promote better awareness of Islam and build cultural cohesion within communities, while raising money for charity and other worthwhile causes. We are working in partnership with Our Bolton NHS Charity to fund the relocation and refurbishment of the faith facilities on the Royal Bolton Hospital site for the benefit of staff, patients and their families. The new facilities will include a mosque, temple and community space suitable for meetings and events.

We are extremely proud that that five members of staff have been shortlisted for awards at the National BAME Health and Care Awards 2022. Every single nominee is deserving of recognition for the difference they are making to diversity and inclusion each and every day here in Bolton and we are committed to continuing to support them to do great work that benefits our communities. The winners will be revealed on the 9th June 2022.

We are looking forward to welcoming eight more international nurses, who are currently finishing their UK training before joining us later this year. The eight skilled nurses arrived in the UK at the end of April from Ghana, Kenya and Nigeria, and are in the process of completing their UK-based training to become Nursing and Midwifery Council (NMC) registered. We are delighted that they have chosen to work with us at Bolton and will do everything we can to help them settle in and feel at home.

Ambition 3
To use our resources wisely

A project to increase productivity and efficiency in our laboratories is underway and will be adopted further across the trust next month. ‘Think before you tick’ was initially a pre-pandemic pilot project, initiated by Dr Banerjee in our adult acute care division over a four-week period, to encourage clinicians to think before they request tests for patients that may have been done before or will not necessarily change the way their patient will be managed.

A clinically led task and finish group has been established and a cohort of junior doctors and consultants have been recruited to support the adoption of this process to enable this to become business as usual. The same principles will be adopted to support a 25% reduction in our printer fleet by initiating a ‘Think before you print’ campaign, linked to the our green agenda.

Our cost improvement sprint workshops have continued to run to help identify savings for the next financial year. We have identified £4.6 million so far following focused sessions with matrons, ward managers and housekeepers to explore further opportunities to use our recourses wisely. Future workshops will be held with our workforce and informatics teams in the coming weeks.

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

Site investigation works in preparation for the Bolton College of Medical Sciences (BCMS) is currently underway in anticipation of the approval of the revised planning application. A stakeholder engagement session is planned for the newly elected ward councillor

(Farnworth, Great Lever, Harper Green) this month to discuss how the proposed plans will unfold ahead of the Bolton Council Planning Committee meeting scheduled for the 9th June. The building work is due to commence in August. In line with our Estates Strategy some of our redundant buildings will be demolished which supports the planning application and displaced car parking as a result of the works.

Work is ongoing to establish a corporate hub based in Dowling House, on our Royal Bolton site. Plans have been developed with the involvement of senior corporate department leads and there will be a series of engagement sessions in the coming months, to inform decision making around design and associated systems and policies. The hub will support staff to work flexibly in a hybrid fashion and will be bring our corporate teams together. Once agreed, the estate work will take six months to complete.

Ambition 5
To integrate care

Mark Fisher was appointed as Chief Executive Designate of NHS Greater Manchester Integrated Care. This is the newly formed organisation, which will be in place from 1st July this year, to support integration within the NHS to take a joint approach to agreeing and delivering ambitions for the health of the population.

We have ambitious plans to truly integrate health and care services in Bolton, and conversations are ongoing to plan the steps we need to take to make this happen. Conversations with Greater Manchester Health and Social Care Partnership are ongoing to confirm the placed based health and care lead, so we are able to develop and progress our plans across the Bolton locality.

There are already some great examples of how integrating services can make a difference to our local population. Our first GP with an extended role (GPwER), Dr. Rafferty, has joined our breast services to support with urgent patient referrals, as part of her role. This collaborative approach between the trust and primary care services is enabling us to increase capacity and see as many patients as possible, as well as support our future ethos of building integrated services for our local communities.

Ambition 6
To develop partnerships

Working with our communities more to understand what they need from us to live healthy and happy lives is a key part of our future strategy. We hosted a community voices event this month, with representatives from across our Borough, organised by our Equality, Diversity and Inclusion team and look forward to what we can do together, for our Bolton communities and future generations.

Last month I was asked to attend the Bolton Cardiac Support Group at Egerton Church to discuss our future plans and understand the impact our COVID restrictions have had on them throughout the pandemic. I have also met with Bolton Carers Support about what more we can do to support the safe discharge of our patients and look forward to working together in the near future.

Since the launch of our new external website, we have been building on existing partnerships and developing new ones to test the content and make changes based on feedback. We have worked with an extensive group of stakeholders from our staff, Governors, Bolton Youth Council, diabetes champions, patients and members of the public. Engagement is ongoing, led by our communications and engagement team.

The number of people waiting in Greater Manchester for treatment has increased to 470,000, making our elective recovery programme increasingly important. There are resources in place to support people who are waiting, but the long waits are resulting in more people accessing their GPs and Emergency Departments and means that we are not always seeing people in the right places. Our focus remains on working as a GM system to address the growing waiting list, and return to our pre-pandemic levels of activity as soon as possible.

Agenda item: 11

Title:	Quality Assurance Committee

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	26th May 2022		Discussion	
Exec Sponsor	Francis Andrews/Tyrone Roberts		Decision	

Summary:	Chair Report from April & May Quality Assurance Committees

Previously considered by:	

Proposed Resolution	

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/Tyrone Roberts	**Presented by:**	QAC Chair

Committee/Group Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	20th April 2022	Date of Next Meeting	18th May 2022
Chair	Malcolm Brown (NED)	Quorate (Yes/No)	Yes
Members present	Malcolm Brown, Francis Andrews, James Mawrey, Angela Hansen, Rae Wheatcroft, Sharon Katema, Tyrone Roberts, Donna Hall. all Clinical Divisions in attendance	Key Members not present:	Fiona Noden, Jackie Njoroge, Sharon Martin, Phil Scott, Diane Sankey, Lynne Doherty

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Integrated Performance Report		Medical Director /Chief Nurse	• Pressure ulcers - Reduction in Cat 2 in hospital. No grade three or four grade ulcers. Reduction in Community Cat 2 grade ulcers. • Falls – Good performance - Trust trajectory less than 12.	
Clinical Governance and Quality Committee		Associate Chief Nurse	• Acute Adult's overall performance was good with assurance provided. • ED report indicated that admissions were down 2%. • Increase in ED patients screened for sepsis, 82.1% up from 66.7% with 100% of patients administered antibiotics within 60 mins of diagnosis. • Inpatient falls have reduced significantly within the quarter, falls reduction practice to be shared with staff members.	
Divisional Quality Report – Adult Acute Care Division		Division	• Complaints decreased from 23 Q2/16 Q3, PALS increased 181 Q2/192 Q3 • Compliments recorded increased from 13 in Q2 to 39 in Q3 • 4 BoSCA inspections conducted during Q3 with 9 inspections in total undertaken. Action plans in place managed by ADND and Matrons all reported at Nurse Leaders monthly meeting. • KPIs – Further improvements 88.7% against a target of 85% - following implementation of Safer Approach. • Gastro clinical correspondence indicated improvements with inpatients at 90.79% and outpatients at 85.88%. • ED Patients screened for sepsis 82.1%, up from 66.7% with 100% of patients received antibiotics within 60 minutes of diagnosis. • Pressure Ulcers to be prioritised to achieve 100%	

	No assurance – WILL have a significant impact on quality, operational or financial performance of the organisation if left unaddressed within 1 month;
	Moderate assurance – potential moderate impact on quality, operational or financial performance of the organisation if left unaddressed within 3 months
	Assured – no or minor impact on quality, operational or financial performance which can be managed through well documented controls/mitigation

Committee/Group Chair's Report

Divisional Quality Report – Integrated Care Services Division		Division	• Community pharmacy has been integrated into the community division to help provide better patient care. • Concerns raised which related to IT challenges for the division - assurance provided that funding had been secured with action plan in place to address any issues. • Committee acknowledged a comprehensive report and commended the division on a report inclusive of Quality & Improvement and information around NICE guidance. • Committee highlighted the need for uniformity of reports/presentations and any information contained within them.	LR, TR and Stuart Bates to review divisional report templates
Clinical Correspondence Action Plan		Medical Director	• Adult Acute Care - review of the specialty team in progress with plans in place to address all issues. • Anaesthetics and Surgical Services assured that out-patient problems relate to specific specialities i.e. Breast /Urology with action plan in place to address. • ICSD highlighted complex staffing issues which is being addressed via a comprehensive action plan - clinicians to support all areas.	Action plan to be brought back July-22
Maternal and Paediatric Sepsis Report		Medical Director	• Business Intelligence in process of reviewing staff reductions within the team. • Division to review staff pressures/adequacy of staff in areas that require support. Assurance provided that the new staffing tool has confirmed all required staff are in post.	Committee to review the summary update for assurance, with a plan to present a full paper on progress to the committee – October 2022
Dementia		Deputy Chief Nurse	• The update was noted by the Committee	
Urgent and Emergency Care Survey Action Plan Update		DND	• ED waiting times – work in progress to allow waiting times to be displayed electronically in the department – following Wi-Fi issue due to be complete May -22.	
Quality Account Summary report • Diabetes		MD/ Divisional MD	• Work in progress around red/amber actions with plans in place to improve data during the next quarter.	

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Committee/Group Chair's Report

Quality Account Summary report • Pneumonia		MD/ Divisional MD	• Positive progress against the four drivers that were either complete or on track for completion. Quarter 4 data in process of being analysed by AQUA and would be provided in the next report.	
Diabetes Steering Group Chair Report		MD/ Chief Nurse	• The update was noted by the Committee	
Group Health & Safety Chair Report		Corporate DoN	• The update was noted by the Committee	
Risk Management Committee Chair Report		Director of Finance	• The update was noted by the Committee	
Professional Forum Committee Chair Report		Corporate DoN	• The update was noted by the Committee	
Infection Prevention Control (Board Assurance Framework)		Divisional MD	• BAF actions have been revised and will not feature in the next report. • Business case in progress for RPE respirators, once complete will be presented at GH&S. • SOP in place to encourage natural ventilation. • Visiting standards – to be reviewed in line with new government guidance.	
For Escalation:				

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Committee/Group Chair's Report

(Version 4.0 October 2021, Review: October 2022)

Name of Committee/Group:	Quality Assurance Committee	Parent Committee:	Board of Directors
Date of Meeting:	18th May 2022	Date of Next Meeting	15th June 2022
Chair	Jackie Njoroge (NED)	Quorate (Yes/No)	Yes
Members present	Jackie Njoroge, James Mawrey, Francis Andrews, Sharon Katema, Rae Wheatcroft, Donna Hall, Fiona Noden, Sharon Martin, Tyrone Roberts, Zed Ali all Clinical Divisions in attendance	Key Members not present:	Malcolm Brown, Angie Hansen, Annette Walker.

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Chief Nurse/Medical Director update		Chief Nurse /Medical Director	• IPC C-Diff cause for concern – further work required in relation to antibiotic stewardship, meeting arranged w/c 23rd May to review milestones • MSSA – preliminary analysis suggests improved cannula care required • Pressure ulcer prevalence (stage 2 and unstageable) of concern – scoping underway for Quality improvement collaborative • Patient Experience – Family Care Division – FFT satisfaction levels reduced, 'helpline' going live from 25.5.22 with aim of facilitating prompt resolution of concerns locally • Maternity – 6 still-births reported during April 2022. All have been subject to an MDT review and 1 referred for HSIB / serious incident consideration	

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Committee/Group Chair's Report

Clinical Governance and Quality Committee		Associate Chief Nurse	• Learning from national regulation 28s will be received quarterly	
Divisional Quality Report – Family Care Division		Family Care Division	• Reduction in incident reporting compared to previous quarters. 858 reported compared to 961 (Q1), 936 (Q2) - no death's reported as a result of an incident. • HFC – 8 SI's, 7 Div Reviews, 1 Fall no harm – child in special school, 3 HSIB cases. • Mortality – There were 12 stillbirths in Q3, of these 12, 3 were expected deaths due to congenital abnormalities where termination of pregnancy had been declined, 1 was a concealed pregnancy of an unknown woman, therefore unavoidable, and 1 was resultant from a true knot in the cord. 1 case is deemed potentially avoidable and an SI investigation is underway, and there was 1 case of undetected IUGR. • Reduction in complaints in Q3, 6-formal with 100% response within 35 working days. 92 PALS increase of 15 from Q2. • Divisional Risks: 12+ increased by 2, new risks increased by 11 and risks closed reduced by 11 in Q2. • Sexual health WT's have reduced due to reintroduction of face to face appointments. DNA's 2nd appointments – system to be implemented to follow up with patients. • Mobile phones – to be issued to lone working staff. • IPC – working well, closely monitored with action plan in place for all outliers. • MT/ST – some improvement - regular action plans/trajectories to be provided for assurance to the Committee.	

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Committee/Group Chair's Report

Divisional Quality Account 2021/22 – Final Annual Report (excluding CCG stakeholder statement).		DQC	• The Committee highlighted that despite work pressures caused by the pandemic the Trust should be proud of their achievements. • Good work has been carried out in Diabetes, AQUA • Quality Account Improvements 2022/23 required in relation to: - National Early Warning Score (NEWS) improving the response to escalation. - Antibiotic prescribing standards - Rheumatology - Improving information to patients - Accessible information standards	
Priority Five – Improving Safety in Maternity Services		Director of Midwifery	• Drivers 1 to 4 on-track although there are currently staffing resource issues in Diagnostics for the high risk pathways for perinatal mortality and HIE. • 3rd and 4th degree tear rates remain high, but April sees the start of OASI 2 in Maternity. Overall - an outlier in this area improvement required, positive actions include OASI 2 bundle roll out which is a national project which will provide teaching/training interventions within the department. • Ockenden 1 year on track to achieve compliance. Submitted to Trust Board March 2022/Board of Governors April 2022. One amber compliance with LMS actions included on action plan has been reviewed, approved at QAC in April. New template for the Ockenden 15 essential actions circulated. • Stillbirth rate 4.9/1000 compared to target of 3.5/1000/ Improvement work streams include; rainbow clinics and Saving Babies Lives	On page 17 the rating of green needs to be revised to amber in light of current Ockenden report completion of actions. Debbie Redfern will work with Families Division to update this section.

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Committee/Group Chair's Report

Learning from Deaths Report		Associate Medical Director	• Case identification to be more robust going forward with reviews completed within the initial four-week timeframe. • Escalation process to be followed when reviews are reallocated to ensure action and learning is captured in a timely fashion. • Average SJR completion rate April 21 – March 2022 is 63%, which is consistent with the national average. • Completion rates need to improve. • Training has been completed to increase the number of reviewers to support LFD admin team who at present allocate one SJR per month, per person max.	
Integrated Performance Report		Medical Director/ Chief Nurse	• pressure ulcer prevalence requires focussed improvement • Never events remain at low level, in March one reported which resulted in no harm to the patient • Clinical correspondence requires improvement, action plan in place to address issues. • CDiff is an area of concern, staff to focus on improved stewardship of prescribing • Patient Experience – Family Care Division launching a 'helpline' to facilitate prompt local resolution of concerns	
For Escalation:				

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Agenda item: 13

Title:	April and May People Committee Chair Reports

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th May 2022		Discussion	
Exec Sponsor	James Mawrey, Director of People		Decision	

Summary:	This report provides an update on the People Committee meetings which took place in April and May 2022.

Previously considered by:	

Proposed Resolution	

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 People	**Presented by:**	Bilkis Ismail, People Committee Chair

Committee/Group Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	21st April 2022	Date of next meeting:	19th May 2022
Chair:	Bilkis Ismail	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Fiona Noden, Sharon Martin, Malcolm Brown, Francis Andrews, Martin North, Lisa Gammack, Carol Sheard, Clare Williams, Bridget Thomas, Sharon Katema, Rachel Carter, Angela Hansen, Michaela Toms, Rachel Hemingway, Lianne Robinson, Andrew Chilton, Paul Henshaw, Rachel Noble, Tracey Garde, Tyrone Roberts, Caron Martin, Laura Smoult, James Logue, Rae Wheatcroft, Michaela Toms, Ryan Calderbank, Alan Stuttard	Quorate (Yes/No):	Yes
		Key Members not present:	Annette Walker, Rachel Hemingway, Andrea Gillan

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing/Agency	Agency	Updates were provided on the plethora of recruitment actions that are taking place throughout the organisation, including: a. a recruitment event held on 19th March 2022 during which 56 student nurses, who are due to qualify in September 2022, were offered roles. b. due to the successes outlined with international recruitment, NHSEI have also approved bids from the Trust to recruit up to 72 international nurses in 2022 (funding circa £250k). We are also utilising international recruitment to address the shortage of midwives in the UK (11) and radiologists (8). c. Following recent national attention an update was provided on how we use 'pay back' clauses for international recruits who leave within 3 years of commencement and this will be explored further to make the system fairer for all. d. The recently produced recruitment video was shared with Committee colleagues. This was warmly welcomed. e. Updates were provided on hard to fill roles – non exhaustive - Maternity, Nursing, Theatres and senior medical roles. f. A detailed update was provided on the actions being taken about the increasing agency spend. Whilst the Committee welcomed the actions	• The report was noted. • Detailed update in the next report on Direct Engagement and agency costs.

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		that had been taken to address Agency spend (for example - review of bank rates, controls, increased recruitment, working with suppliers), it was felt that additional focus was required.	
Apprenticeship Programme Q4 Update		• The Committee received an update on the 46 apprenticeship enrolments within the organisations – broken down by division, along with a full breakdown of divisional allocation levy spends. • Since the apprenticeship levy was introduced in 2017, until 31st March 2022, the Trust had spent £1.74m with a loss of £0.94m. We have a current levy balance of £2.23m remaining. • A detailed action plan was presented which included measures that will be taken to help fill existing vacancies, supporting current staff to undertake an apprenticeship programme, along with how we can work more innovatively with our education partner organisations.	• The report was noted. • Update report be provided to the Committee every 3 months
FTSU Q4 Update		• During the period from 1st January 2022 to 31st March 2022 (Q4) a total of 25 cases were reported through the FTSU route. This is a decrease of 11 from the previous quarter but only one less than the same quarter last year. All cases are broken down by staffing group, gender, division, and ethnicity. • Concerns relating to behaviour are the biggest cause for concern. The issue of behaviour was not isolated to one division but seen across all divisions. • Following additional recruitment and training we now have a network of 38 FTSU champions across the Trust. These individuals, from a variety of roles and backgrounds, will encourage and support workers to speak up and raise their concerns and also signpost where necessary. • The Executive team have supported the funding for an additional part-time FTSU Guardian. The interview panel consists of NED and Executive colleagues.	• The report was noted.
Mandatory & Statutory Training Recovery Plan		• Over the last 12 months mandatory and statutory training compliance levels across the organisation have continued to decline (reflected elsewhere in NHS). A number of factors have contributed to this including significant operational pressures which makes it extremely difficult for	• The report was noted. • Update report be provided to the Committee every 3 months

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		individuals to be released, staff absence and training being held off-site. In addition, some staff have experienced problems accessing e-learning modules following the transition from hosting our e-learning programme on the Moodle platform to ESR. • The report outlined the action that has been taken to help recover the position and planned next steps, including:- review of timings of programmes and thereby decreasing release times; improving the locations of training to reduce travel issues; close liaison with IT & HR to improve interfacing systems; and closer divisional planning.	

Maternity Action Plan		• The Committee heard that a number of concerns have been raised by Maternity colleagues (CQC whistleblowing, grievances; anonymous letters; FTSU; Complaints) and that external agencies had been in touch with Executive colleagues.
		  • An overview was provided on the actions being taken.
		  • Whilst the Committee welcomed the actions being taken regarding Leadership, staffing and communication, it felt that until there were clear signs of outputs improving, this would remain a monthly agenda item.
			• The report was noted.
			• Update report be provided to the Committee next month.

Integrated Workforce Report		• The report triangulated the key workforce data at a Trust and Divisional level.	• The report was noted.
Assurance reporting Groups		• People Development Steering Group • Staff Experience Group • EDI Steering Group • Resource & Talent Planning Steering Group • All Divisional People Committees	• All reports were noted and any risks being managed within the People Committee.

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Committee/Group Chair's Report

Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	19th May 2022	Date of next meeting:	16th June 2022
Chair:	Bilkis Ismail	Parent Committee:	Board of Directors
Members present/attendees:	James Mawrey, Fiona Noden, Sharon Martin, Tyrone Roberts, Francis Andrews, Martin North, Carol Sheard, Paul Henshaw, Jake Mairs, Laura Smoult, Clare Williams, Bridget Thomas, Sharon Katema, Rachel Carterm Angela Hansen, Rebecca Bradley, Lianne Robinson, Andrew Chilton, Claire McPeake, Ryan Calderbank, Rachel Hemingway, Vicky Fletcher-Simm, Alicia Lucas, Joanne Street	Quorate (Yes/No):	Yes
		Key Members not present:	Annette Walker, Alan Stuttard, Malcolm Brown, Rae Wheatcroft, Kate Myatt, Dawn Murray, Tracey Iles

Key Agenda Items:	RAG	Key Points	Action/decision
Resourcing/Agency	Agency	• Updates were provided on the plethora of recruitment actions that are taking place throughout the organisation. It was noted that the staffing position is very tight nationally, regionally and locally. Bolton continues to benchmark positively but notes significant pressures faced. • Detailed discussion took place on the high level of HCA vacancies within the organisation. Whilst a very large number of HCAs are due to commence in the coming weeks (following focused actions), it was noted that this enhanced activity will not fill all of the vacancies and the work will continue • Updates were provided on hard to fill roles – non exhaustive - Maternity, Nursing, Theatres and senior medical roles. • Whilst Agency costs had reduced in month, the Committee remained concerned about the high usage (Red rating), including in relation to Medical Agency spend. It was felt that more work needed to be done on 'organisational grip' with some cross triangulation with safe staffing levels. It was noted that this work is being led by head of Resourcing, Corporate Director of Nursing and Divisional Medical Directors. • NED colleagues noted that Agency had been high in 2018 and following a concerted focus the Agency usage then dropped in 2019. It was agreed that we need to review current actions, against the measures taken in previous years.	• Report was noted. • Future updates on agency which should include a focus on retention.

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Committee/Group Chair's Report

Employee Relations Quarterly Update		• Update provided on activity that took place between January and March 2022, including disciplinary and grievance, attendance management, and tribunal cases. • The Committee were informed by the Staffside Chair that regular meetings are held between the Trust and Staffside membership. Assurance provided that ER matters were being managed positively and in a timely manner.	• Chair of Staff-side to attend the PC and present a report quarterly. Future reports to go into greater detail on the activities of Staffside. • Partnership Steering Group Chair reports to continue to come to the People Committee. • People Committee Chair to be given an open invitation to future Partnership Steering groups.
Occupational Health Update		• Report provided an update on the Trust Occupational Health Services. The report detailed KPI overview and achievements for Q4, along with the focus for the forthcoming months. • The Committee were pleased to hear that the Divisions felt it had been a very positive step forward bringing the service in house (12 months ago).	• Report to be provided every 6 months.
Bolton FT Staff Engagement Plan		• The Committee commended the Trust's high-level Staff Engagement Plan which addresses Trust-wide areas of concern and amplifies examples of good practice. • The actions are focused around the following themes from the 2021 NHS national staff survey: We are compassionate and inclusive; We are recognised and rewarded; we each have a voice that counts: We are safe and healthy; We are always learning; We work flexibly; We are a team; Staff engagement; Morale.	• July People Committee to receive update on Trust action plan, along with the 'Divisional great Place to Work plans'.
Communications Quarterly Update		• The report provided an update on the organisation's communications and engagement activity undertaken during the last three months, feedback received on areas that needed key focus, and planned activity for the months ahead. • It was discussed that improvements were required on the intranet (BoB) as all stakeholder feedback have commented that this is an area for immediate development.	• Report was noted • It was agreed that future reports will also focus on the other 2 communication workstreams, namely patients and community engagement.
Maternity Engagement Update		• A full presentation is being provided to the BoD. Therefore to avoid repetition no update is provided on this item.	• Update to be provided to the full Board of Directors

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Committee/Group Chair's Report

Assurance reporting Groups		• People Development Steering Group • Staff Experience Group • EDI Steering Group • Resource & Talent Planning Steering Group • All Divisional People Committees	• All reports were noted and any risks being managed within the People Committee.

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Title:	**Compliance with NHS Provider Licence, Annual Self-Certification**

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26 May 2022		Discussion	
Exec Sponsor	Sharon Katema, Director of Corporate Governance		Decision	✓

Summary:	As part of its annual reporting process, the Board is required to sign off on the following self-certifications: a) General Condition 6 The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution. b) Continuity of Service Condition 7 - The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. c) Condition FT4 (8) of the NHS provider licence - The provider has complied with required governance arrangements. d) Training of Governors This report provides the Board with the assurance it needs to approve the self-certification of compliance required under the NHS Provider Licence.

Previously considered by:	The Board considers this declaration on an annual basis.

Proposed Resolution	The Board is asked to **review** the evidence and **confirm** compliance with the NHS Self Certification for the NHS Provider Licence.

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:	Sharon Katema	**Presented by:**	Sharon Katema

1. Introduction

1.1. NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence. This includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012.

1.2. On 1 April 2013 the Trust's Terms of Authorisation with Monitor were replaced by the Licence (Licence Number: 130014). The conditions within the Licence are detailed at **Appendix I** with assessment of compliance made against each condition.

1.3. The NHS provider licence was last updated in February 2013) and as a consequence this document contains multiple references to Monitor which should be read in this context.

2. The requirements

2.1 The Trust is required to carry out self-certification as assurance that it complies with the conditions. Where the Trust is not compliant, it is required to explain why and develop an action plan to achieve compliance.

2.2 Whilst there is no requirement for the Trust to submit the Self-Certification to NHSI, the Trust is required to make the Self-Certification public on its website. NHSI will contact a select number of NHS trusts to ask for evidence of self-certification.

2.3 The Trust is required to self-certify the following Licence Conditions after the financial year-end:

- General Condition G6 - The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution
- Continuity of Services Condition CoS7 - If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service
- Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.
- Governor training - NHS foundations trusts must review whether their governors have received enough training and guidance to carry out their roles

3. Condition G6

3.1 The Licensee should 'take all reasonable precautions against the risk of failure to comply with:

- the conditions of this Licence;
- any requirements imposed on it under the NHS Acts; and
- the requirement to have regard to the NHS Constitution'.

3.2 The steps the Trust is expected to take (paragraph 2(a) and 2(b) of the Licence) are:

- the establishment and implementation of processes and systems to identify risk and guard against their occurrence; and
- regular review of whether those processes and systems have been implemented and of their effectiveness.

3.3 **Evidence of Compliance**

3.3.1 The Board and supporting Committees (Audit Committee, Quality Assurance Committee, Finance and Investment Committee, People Committee and the Trust Risk Management Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance.

3.3.2 The Risk Management Strategy, including the Board Assurance Framework is reviewed by the Board and the Audit committee and the Risk Registers are reviewed through the Risk Management Committee.

3.3.3 The Trust has a comprehensive monthly dashboard, which on a monthly basis triangulates key performance indicators using (Standard PerSPC methodology and is now presented to all committees prior to presentation at Board.

Please see Appendix 1 for a full break down of the assessment of compliance with the licence conditions

3.4 The Board is required to sign off on self-certification no later than: **G6: 31 May 2022.**

4. Continuity of Services Condition CoS7

4.1. Commissioner Requested Services CRS are defined as *"services that will be subject to regulation by NHSI in the course of a licensee's operations, that, in the event of a provider failure, must be identified and kept in operation at that specific locality."*

4.2. The Board is asked to consider confirmation of the following statement:

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

4.3. **Evidence of compliance**

The Going Concern report provides evidence that the Trust will continue to have the resources required to operate

5. Declaration of compliance with conditions of the NHS Provider Licence: Condition FT4

5.1. The standards set out in FT4 are similar to the standards of governance set out in the NHSI general objective.

5.2. There is no set approach to these standards and objectives but there is an expectation that any compliant approach will involve effective board and committee structures, reporting lines, performance and risk management systems.

5.3. NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

5.4. The Board is required to sign off on self-certification no later than: **FT4: 30 June 2022.**

5.5. **Evidence of compliance**
Appendix 2 sets out the detail for the Corporate Governance Statement declaration

6. Governor Training

6.1. A Governor training programme has been in place since the election of the shadow council of Governors in 2008.

6.2. Following the Covid-19 outbreak, all face to face Governor training were postponed and were subsequently resumed albeit virtually, and include a formal induction session for any newly elected Governors.

7. Self-Certification Recommendation

7.1. Whilst the deadlines for self-certification are different, the Board is recommended to **consider:**

- Confirmation of self-certification against the requirements of General Condition 6 of the Licence.
- Confirmation of the continuity of services condition (CoS7)
- Each statement within the Corporate Governance Statement and confirms compliance.
- Approving the declaration of compliance with regard to Governor training

7.2. All Self-Certifications will be made public on the Trust's website by 30 June 2022.

7.3. The Board is asked to note and support the proposed declarations which will be published on the Trust website on 30 June 2022.

Appendix I - Checklist of Compliance

NHS Provider Licence: Checklist of Compliance to underpin self-certification against licence conditions

Licence Condition	Compliance
Section 1 – General Conditions	
G1: Provision of information *'the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for any of the purposes set out in section 96(2) of the 2012 Act'*	**Confirmed**. No compliance issues identified.
G2: Publication of information '*The Licensee shall comply with any direction from Monitor for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services'*	**Confirmed**. No compliance issues identified.
G3: Payment of fees to Monitor '*The Licensee shall pay fees to Monitor in each financial year of such amount as Monitor may determine'*	**Confirmed**. No compliance issues identified - no fees charged to date
G4: Fit and proper persons '*The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor'* *'The Licensee shall not appoint as a Director any person who is an unfit person'*	**Confirmed**. Governor eligibility and disqualification criteria and code of conduct ensures compliance. Trust Employment policies ensure compliance. CQC review Director files to test fit and proper person documentation

Section 1 – General Conditions	
G5: Monitor guidance '*the Licensee shall at all times have regard to guidance issued by Monitor*'	**Confirmed**. No compliance issues identified.
G6: Systems for compliance with licence conditions and related obligations	**Confirmed**. No compliance issues identified. Risk Management system in place throughout the Trust including Board Assurance Framework and Risk Register.
G7: Registration with the Care Quality Commission	**Confirmed**. The Trust is registered, without conditions, with the Care Quality Commission (CQC). An internal assurance process is in-place to minimise the risk of non-compliance with essential standards of quality and safety. The Trust is rated Good overall by the CQC with a rating of excellent for the Well Led review.
G8: Patient eligibility and selection criteria	**Confirmed**. There is an annual review of the contract with commissioners to agree eligibility criteria, in accordance with Department of Health and Social Care guidance.
G9: Application of Section 5 (Continuity of Services)	Refer to Section 5 below.
Section 2 – Pricing	
P1: Recording of information '*the Licensee shall obtain, record and maintain sufficient information about the costs which it expends in the course of providing services*'	**Confirmed**. No compliance issues identified.

P2: Provision of information '*the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for the purpose of performing its functions'*	**Confirmed**. No compliance issues identified.
P3: Assurance report on submissions to Monitor *'If required in writing by Monitor the Licensee shall, as soon as reasonably practicable, obtain and submit to Monitor an assurance report in relation.to costing.*'	**Confirmed**. No compliance issues identified.
P4: Compliance engagement concerning local tariff modifications *'the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by Monitor'*	**Confirmed**. No compliance issues identified.
P5: Constructive engagement concerning local tariff modifications *'The Licensee shall engage constructively with Commissioners'*	**Confirmed**. No compliance issues identified.
Section 3 – Choice and competition	
C1: The right of patients to make choices *'the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found'.*	**Confirmed**. No compliance issues identified.

C2: Competition oversight *'The Licensee shall not enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services'*	**Confirmed**. No compliance issues identified.
Section 4 – Integrated care	
IC1: Provision of integrated care *'The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services'*	**Confirmed**. No compliance issues identified.
Section 5 – Continuity of Services	
COS1: Continuing provision of Commissioner Requested Services *'The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service except where permitted to do so in the contract'*	**Confirmed**. No compliance issues identified.
COS2: Restriction on the disposal of assets '*The Licensee shall establish, maintain and keep up to date, an asset register'* *'The Licensee shall furnish Monitor with such information as Monitor may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset'*	**Confirmed**. Asset register maintained.

COS3: Standards of corporate governance and financial management '*The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:* *suitable for a provider of the Commissioner Requested Services provided by the Licensee, and* *providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern'*	Outstanding in the CQC Well Led Review with "Good" for the *"use of resources review"* Position against Monitor's Code of Governance regularly assessed and reviewed through the Audit Committee (last review February 2022). Monthly monitoring of financial performance and risks at Finance and Investment Committee and Board
COS4: Undertaking from the ultimate controller **'***The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee'*	Not applicable (relates to non-FT whose ultimate controller may be a separate legal organisation).
COS5: Risk pool levy **'***The Licensee shall pay to Monitor any sums required to be paid in consequence of any requirement imposed on providers by way of levy'*	**Confirmed**. No compliance issues identified - no charges levied.
COS6: Co-operation in the event of financial stress **'***if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern…the Licensee will: provide such information as Monitor may direct to Commissioners, allow such persons as Monitor may appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as Monitor may appoint to assist in the management of the Licensee's affairs, business and property'*	**Confirmed**.
COS7 Availability of resources **'***The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources'*	Robust plan and quarterly profile that is approved as part of the Operating Plan submission.

Section 6: NHS Foundation Trust conditions	
FT1: Information to update the register of NHS foundation trusts '*The Licensee shall ensure that Monitor has available to it written and electronic copies of the following documents:* *a) the current version of Licensee's constitution;* *b) the Licensee's most recently published annual accounts and* c) *any report of the auditor on them, and the Licensee's most recently published annual report'*	**Confirmed**. No compliance issues identified.
FT2: Payment to Monitor in respect of registration and related costs *'the Licensee must pay to Monitor a fee in respect of Monitor's exercise of its functions'*	**Confirmed**. No compliance issues identified. (no fee levied as yet)
FT3: Provision of information to advisory panel *'The Licensee shall comply with any request for information or advice made of it'*	**Confirmed**. No compliance issues identified - no requests for information to the advisory panel

FT4: NHS Foundation Trust governance arrangements *The Licensee shall have regard to such guidance on good corporate governance as may be issued by Monitor from time to time.* *The Licensee shall establish and implement:* a) *effective board and committee structures;* b) *clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and* c) *clear reporting lines and accountabilities throughout its organisation* *The Licensee shall establish and effectively implement systems and/or processes:* *(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;* *(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;* *(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);* (d) *to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;* *(e) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;* *(f) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and* (g) *to ensure compliance with all applicable legal requirements*	**Confirmed**. Please refer to Appendix two and separate declaration

The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence. *The Licensee shall submit to Monitor within three months of the end of each financial year:* *(a) a corporate governance statement* *(b) if required in writing by Monitor, a statement from its auditors either:* *(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or* *(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.*	Forms part of the monthly performance report submitted to the Board. **Confirmed** – Submissions made to NHSI as required/requested

Appendix 2 – proposed declaration using a modified version of the template *(to be published on 30 June 2022)*

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence		
1 & 2	**General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)**	
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**
3	**Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**	
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**
	Statement of main factors taken into account in making the above declaration In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:	
	The Board reviewed a detailed paper providing assurance with regard to compliance with the provider licence. The Going Concern report reviewed by the Board in June 2022 and included within the Annual Report and Accounts sets out the assurance provided to the Board to confirm that the management of the Trust are confident that the Trust will remain a Going concern and will therefore be able to continue the provision of Commissioner Requested Services with due regard to the NHS Constitution.	
	Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors	

Appendix Three – Corporate Governance Statement

Corporate Governance Statement	Compliant	Risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Yes	**Risk:** not adhering to accepted standards of corporate governance or best practice **Assurance and Mitigating actions:** • CQC rated as Outstanding for Well Led • Compliance with Monitor's Code of Governance for Foundation Trusts regularly assessed and reported through Audit Committee • The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Director of Corporate Governance/Trust Secretary who has accountability for its maintenance. • There are no material conflicts of interest in the Board. • All governors elections and by elections held in accordance with election rules. • Director of Corporate Governance/Trust Secretary in post who holds responsibility for corporate governance. • Systems and controls assurances are obtained via the Audit Committee. • Further formal external governance review will take place every three years or as required by NHSI. • More complete explanations about systems of corporate governance are set out in the annual governance statement and the Trust's annual report
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Yes	**Risk**: non-compliance with Monitor's Code of Governance for foundation trusts and other governance guidance issued by the regulator **Assurance and Mitigating actions:** • Compliance with Monitor's Code of Governance for Foundation Trusts assessed each year as part of the annual reporting process. (February 2020 Audit committee

		• Any guidance requirements are routinely assessed and implemented as necessary - over view of guidance provided in KPMG Technical Update received at each Audit Committee meeting. Assurance and advice is provided as required by the Audit Committee
3. The Board is satisfied that the Licensee has established and implements: a) Effective board and committee structures; b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and c) Clear reporting lines and accountabilities throughout its organisation.	Yes	**Risk**: Ineffective board and committee structures in place which are not reviewed and updated. Unclear reporting lines **Mitigating actions:** • CQC outstanding for Well Led domain • Board committees established with clear lines of reporting. • Terms of Reference in place for all Board and other committees and groups within the Trust which are regularly reviewed and updated where necessary? These set out remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. • Standardised Chair reports to escalate assurance and concerns in line with reporting structure. • Clear delegation of actions to committees • Annual Governance Statement in place which identifies areas of potential risk and mitigating actions.
4. The Board is satisfied that the Licensee effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	Yes	**Risk:** Lack of systems to assess compliance with Licensing requirements **Assurance and Mitigating actions:** • Risk Management Strategy in place and regularly reviewed. • Board Assurance Framework • Safeguard risk management system in place.

b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and		• Use of internal and external audit services to investigate any areas of concern. • Inpatient and other CQC surveys utilised with action plans put in place where necessary. • External reviews undertaken where appropriate or necessary. • Contracts for services agreed with clinical commissioning groups. • Finance and Investment Committee considers detailed financial performance report at each meeting • Monthly performance report considered by Board, detailed performance discussed at monthly performance reviews. • Comprehensive agendas for Board meetings circulated to directors at least 3 days before each meeting • Cost Improvement Plans in place which are risk assessed for quality • Standing Financial Instructions and Standing Orders in place • Counter Fraud specialist reports to the Audit Committee • In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high level risks facing the Trust and ways in which these are being mitigated. The four areas are: quality and safety, finance, operations and governance • Points as set out in 1), 2) and 3) above apply. **Risk**: Potential loss of control through devolution of authority to the Trust's wholly owned subsidiary **Mitigating actions:** • Group Audit Committee and Risk Management Committee • FT Board representation on iFM Board

h) To ensure compliance with all applicable legal requirements.		• Contract review process • Group Health and Safety Committee • Deloitte review of iFM Governance • iFM compliance with corporate governance requirements
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care; d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	Yes	• The Medical Director and the Chief Nurse are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity • Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Clinical quality, patient safety & patient experience metrics are reported to the Board monthly. • Quality Assurance Committee – chaired by a NED – Terms of Reference include reporting from Clinical Governance Committee and reports from clinical divisions. • Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to Clinical Audit Committee. Full list included within the Quality Account • Learning from national reports with comparative reports undertaken and action plans devised and implemented. • National reports and benchmarking e.g. NICE guidelines – NPSA safety alerts managed via Clinical Governance Committee • Regular ward and department visits undertake by all Board members • PLACE • Ward to board heat map

f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		• Exec team ward buddies • Board go and see • Processes in place to escalate and resolve issues - risk management committee established with reporting line to the QA Committee
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Yes	• The Medical Director, Director of Nursing and Director of Finance are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust). • All Executive Directors' performance and competencies are reviewed through annual appraisals. • Collective & individual skill-sets reviewed as part of board development • Chairman receives an annual performance appraisal from the Senior Independent Director, • NEDs receive an annual performance appraisal from the Chairman who advises the governors • NEDs have been appointed by the Council of Governors as advised by the governors' Nominations Committee. • NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance, and, OD. Collectively, the NED component of the Board is suitably qualified to discharge its functions. • Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction.

		• Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and workshops as required. • NED progress is monitored by the Chair via one to one meetings including a formal appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established. • This is supplemented by a number of Board development/strategy sessions to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. • Divisions are led by experienced and capable teams consisting of a Divisional Medical Director, a Divisional Director of Operations and a Divisional Director of Nursing. • Nursing levels on wards are reported to Board and are monitored and published on a daily basis on the ward staffing boards.

Title:	Bolton Integrated Care Partnership Annual Business Plan

Meeting:	Board of Directors	**Purpose**	Assurance	
Date:	26th May 2022		Discussion	Y
Exec Sponsor	Sharon Martin		Decision	

Summary:	The Board as a key partner within the ICP are asked to comment and note the ICP's Business Plan for 2022/3. The plan sets out the Integrated Care Partnership's (ICP) outcomes to date and priorities for the next 12 months. It outlines how the partnership will continue to work together across public, community and voluntary services, including acute and primary care, to deliver integrated health and care with the aim of improving outcomes for Bolton people. The report reflects on the collective impact over the last year to inform the approach for the future, recognising the continued challenges Bolton people, services and organisations face.

Previously considered by:	ICP Board Bolton Locality Board

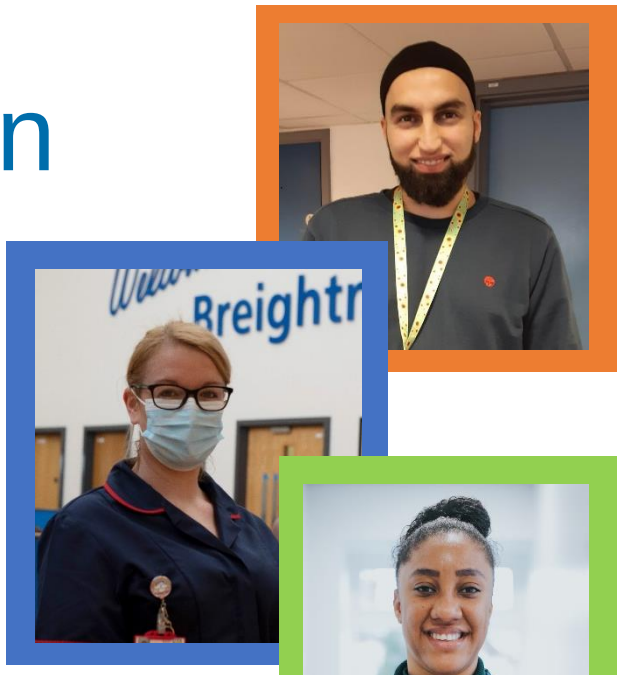
Proposed Resolution	To comment upon the achievements to date and continue to support the partnership and ambitions for 2022/3.

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 Tanner	**Presented by:**	Rachel Tanner

Bolton Integrated Care Partnership

Business Plan 22/23



Bolton Integrated Care Partnership Business Plan 22/23

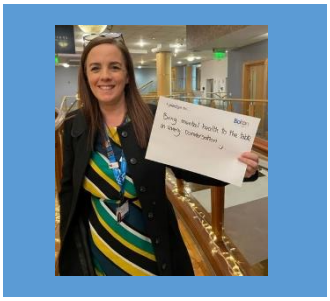
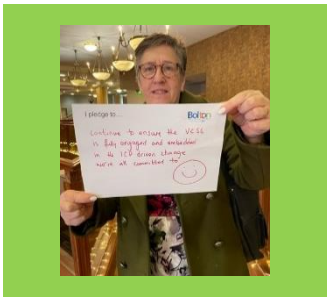
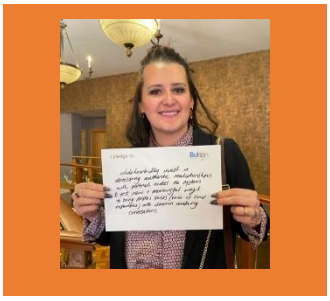
Purpose of this Document

This Business Plan sets out the Integrated Care Partnership's (ICP) outcomes to date and priorities for the next 12 months. It outlines how we will continue to work together across public and community and voluntary services, including acute and primary care, to deliver integrated health and care with the aim of improving outcomes for Bolton people. It reflects on our collective impact over the last year to inform our approach for the future, recognising the continued challenges Bolton people, services and organisations face.

The Integrated Care Partnership is a collaboration of providers who come together to enable place based, joined up health and care services delivered closer to home, focussed on what matters to people. We work together to meet the diverse needs of the Bolton population and we are responsible for:

- Focusing on prevention and proactive joined up care to improve the health and lives of Bolton people. In turn, we will reduce unwarranted escalation and unnecessary use of high cost services
- Actively managing health and wellbeing for Bolton people, improving key risk factors and delivering person centred care
- Achieving the triple aim of improved health and wellbeing, better quality care and sustainable finances

This is a strategic business plan for Bolton Integrated Care Partnership and links to our local partnership plans: Vision 2030 and the Bolton Locality Plan as well as national documents.

Introducing our Plan

Sally McIvor, Independent Chair, Integrated Care Partnership

Rachel Tanner, Managing Director, Integrated Care Partnership

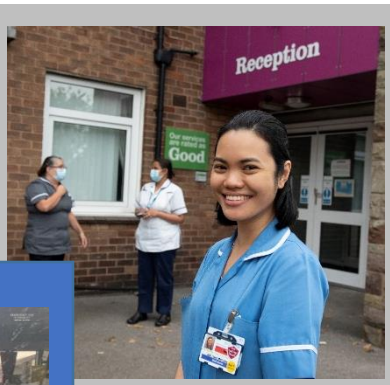
Reading this Business Plan for the year ahead, we take incredible pride in Bolton, our people, communities and our workforce. The strong commitment shown has helped us to work together during another year of unprecedented challenges arising from the pandemic. The desire to do the right thing for Bolton people, ensuring they get the best possible care has been inspiring and has seen our volunteers, workforce and Bolton people yet again going out of their way to support their community. Some examples include our joint response to vaccinate our most vulnerable residents; supporting people to stay well at home with COVID-19 through our Pulse Oximetry service and providing ongoing support to Care Homes including development of our virtual ward. At times, this work has been exceptionally difficult and success is testament to the strong relationships the ICP has formed over the last two years. We would like to take this opportunity to thank our workforce, our partners and Bolton people for their remarkable response over the last year.

While we have continued to respond to the pandemic working together to keep people well at home and safely discharged from hospital where needed, we have also worked hard to progress our plans to improve people's health and wellbeing in their communities. This year we have established our district teams in three sites linked into our nine neighbourhoods - an ambition that was delayed by the multiple challenges of the pandemic. While these integrated health and care teams are in their early stages, the goal is for these teams to work closely with Primary Care Networks as well as developing stronger relationships with the local community voluntary sectors, housing and other partners to improve the health and wellbeing of Bolton people. It will also be an opportunity to begin to expand our All Age approach in the next year working closely with our partners on the Family Hubs and Start for Life Programme and improving the experience of young people transitioning from children to adult services. Only by focusing together on preventing ill health in people's communities, will we improve outcomes for people and reduce the pressures on services.

We now know that Bolton's population has been hit harder by COVID-19 both directly in terms of people experiencing complications and indirectly through deepening existing health and social inequalities. We also know that the growing pressures of cost of living is already having a significant impact on Bolton people and their wellbeing. A reduction in health inequalities will not be achieved through health and care services alone. Instead, we must work with all public voluntary and private stakeholders as well as local residents if we are change the current trajectory. The ICP's model of care is focussed on, not only integrating our health and care services, but working more closely with the community and voluntary sector, police and housing services whilst recognising the impact our homes, work and communities have on our wellbeing. This is a key focus in our plan for the year ahead.

The next year will continue to challenge us in terms of addressing our collective demands and pressures. Ensuring that we work together as a partnership to make best use of resources and identify opportunities to redirect resources that focuses on prevention will be a key focus of the Partnership. We also recognise the importance of working with wider Partnerships and Boards at a local and GM level where we have common aims. This will include working more closely with our Adult Safeguarding Board colleagues on an audit assurance approach to developing new models of care ensuring we are keeping adults safe.

Our Business Plan sets out our priorities for the year ahead and the outcomes we want to achieve to help deliver a new way of providing health and care services in Bolton. This responds to both the learning and anticipated future challenges for Bolton. For lasting change to happen every member of our partnership from senior leaders, managers and frontline staff and volunteers will have to work together where necessary being prepared to change their planning and delivery



Our Partnership

The Integrated Care Partnership is a collaboration between community based services. The ICP was established to work across providers to design and deliver a very different approach to health and care and deliver tangible improvements for all local people. In February, 2020 the Integrated Care Partnership (ICP) formally became a partnership of key providers to deliver integrated place based health and care services and improved outcomes for people in our neighbourhoods. The CCG, Council and Foundation Trust also agreed to deploy their staff as part of an ICP integrated operational directorate to ensure closer joined up delivery across adult social care, community health services and primary care development.

Under these arrangements it was agreed that the Foundation Trust would act as the 'infrastructure host' for the Integrated Care Partnership with an Independent Chair and Managing Director overseeing the direction and day to day running of the partnership. The structure would enable closer collaboration across providers working together as a single delivery and accountability structure.

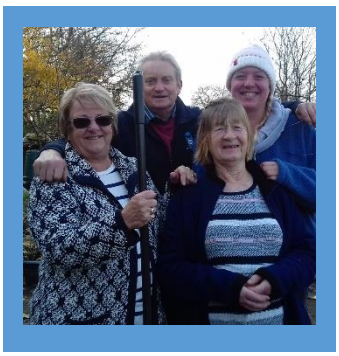
This is our second annual plan, which responds to the ICP's vision for place based, person centred care and the specific challenges our communities and services continue to face as a result of the pandemic and rising and increasingly complex demand for services.

Our work; our impact in 2021/22

- Adult social care has made over 25,287 contacts with people throughout Bolton with over 5,870 people receiving support and 4,321 people accessing packages of care
- Together with our care provider partners we support over 400 people, including people with learning disabilities, to live as independently as possible in Supported Living properties across Bolton
- Primary Care's COVID-19 Vaccination Team have given over 190,000 COVID-19 vaccines across local vaccination sites, pop-up and mobile clinics, reaching people with learning disabilities, pregnant women, refugee and asylum seekers, street sex workers and taxi-drivers
- Age UK's Home from Hospital service has supported over 1,000 people over 65, who live alone or are the main carer of another, for up to six weeks post discharge form hospital, to support them to recover safely at home
- Between April 2021 and January 2022, our community health services had more than 385,000 contacts with people in their own homes, community clinics, and in hospital
- Bolton at Home's Careline service supports over 2000 people through both practical (going out to people who have had a fall etc), and emotional support (checking in on them over the phone)
- Public Health have worked jointly with NHS and community partners to increase the uptake of Flu and COVID-19 vaccinations
- Bolton at Home and the Council have collaborated on the first of its kind Extra Care Scheme in the borough which will feature 62 affordable extra care apartments and 6 bungalows, offering older people their own home and access to care and support services.
- Bolton Care homes have been able to maintain or improve their Good or Outstanding ratings with CQC meaning Bolton has the lowest rate in GM for Care homes requiring improvement work
- Bolton CVS with Public Health has been working with 83 Community Champions identified through existing community, voluntary and social enterprise groups, they speak over 30 languages and engaged with over 6714 people in their respective communities

Our work; our impact in 2021/22

- Primary Care Networks have offered almost 20,000 Extended Primary Care evening and weekend appointments during 2021/22 to residents needing to see a GP, nurse, physiotherapist or mental health worker
- Adult Social Care have provided 6031 adaptations, equipment and telecare products have been provided for 2876 people in 12 months
- Since Greater Manchester Mental Health (GMMH) introduced the CYP THRIVE navigator role (who reviews and triages all referrals) in early 2021, the current wait for first appointment is 2.4 weeks vs the previous 13.4 weeks, making Bolton's Centre for Addiction and Mental Health Services (CAMHS) the best performing service across GM
- Bolton at Home works with approximately 700 vulnerable households at any one time by providing, support for mental health, domestic abuse support, family support, tenancy support.
- Public Health continued to use shared intelligence and data from the NHS and the Council to support the development of our neighbourhoods whilst refreshing the JSNA (Joint Strategic Needs Assessment)
- Bolton Community Homes (BCH) manage, maintain and invest in over 25,000 safe, decent and affordable homes. In an average year, BCH Partners invest over £86million in our homes and £1.9million in our communities.
- Four ICP commissioned VCSE sector leaders have worked with us to design the implementation of our District teams, Health and Care Hub and worked with the ICP on supporting innovative, safe and timely discharge of people from hospital.



Our Vision and Principles for working together

All organisations in Bolton's integrated health and care system are committed to improving both the services people experience, and the health outcomes for Bolton's ever-changing population. We have a shared Bolton Vision for a healthier place and people as set out in our Vision.

our vision...

"Bolton people will be involved in their own health and wellbeing with the aim of staying well for longer and in their own homes, as part of a strong, connected and engaged community"

The Integrated Care Partnership will enable the different providers of health and care in Bolton to work together for the benefit of local communities.

Our Vision and Principles for working together

How we work together is critical to improving the care that Bolton people experience. As an ICP our operating principles are to:

- Adopt a ‘whole family approach’ which co-ordinates care around the person and not organisations
- Ensure people will be supported in their home and community for as long as it is appropriate and possible. The right care, at the right time by the right person
- People will only have to ‘tell their story once’
- Work with people with lived experience to help design and deliver care using the ICP ‘I statements’ to measure the impact of what we deliver
- Work together and with wider partners, to tackle health inequalities and inequity between neighbourhoods including the wider determinants of health
- Focus on increasing prevention and early intervention
- Support solutions in communities
- Enable one workforce empowered to make the right decisions sharing collective resources, skills and knowledge, focussed on keeping people safe
- Enable the workforce to have conversations that focus on personal strengths and that connect people to their community assets
- Maximising technology to enable self care and independence
- Optimal use of the Bolton £ ensuring we maximise our role as key organisations in Bolton to deliver social value and directly benefit our communities
- Create the conditions for services to work together to meet the needs of the whole person avoiding risk shift from organisations

Our Bolton

While Bolton has many strengths within its communities and across its organisations, it has significant strides to make to improve people's health and wellbeing and reduce inequality. The long-term inequalities between communities in Bolton have been exacerbated by the impact of COVID-19, further deepening social and health differences between communities of geography and identity.

Alongside this demographic challenge, like all health and social care economies, Bolton also faces significant financial challenges despite each organisation delivering sizeable cost improvement and efficiency programmes over recent years.

The complexities of these inequalities are such that no one organisation or sector can resolve these in isolation and therefore a strong partnership approach, not only working across the public and voluntary sector, but also actively with our communities is required.

Our Bolton

Bolton's population currently stands at **288,248** (mid 2020 estimate)

with a higher proportion than the GM average of older people.

20% most deprived districts/unitary authorities in England (IMD 2019)

(12,120) of children live in low income households (relative low income, 2020)

33%

20% of the Bolton population have a long term health condition or disability which limits their day to day activities a little or a lot; so are considered to be disabled under the Equality Act.

10% of the Bolton population have a long term health condition or disability which limits their day to day activities a lot.

As with many local authorities in the north of England, the health of people in Bolton is generally worse over a range of measures than the average for England

COVID-19

Bolton has been hit by COVID-19 harder than most with our population more vulnerable to serious complications form COVID.

Bolton is richly diverse with over one fifth of the population from a Black, Asian or Minority ethnic (BAME) background.

Life expectancy

81.1 years

77.3 years

*2 years less than England

35% of Bolton adults are classed as physically inactive (2019/20), doing less than the equivalent of half an hour's brisk walk a week. This is the highest level in England.

Bolton sees higher than average levels of alcohol related harm, smoking related deaths, and hip fractures in older people, more deaths from drug misuse and more hospitalisation for self-harm.

Bolton has higher than average rates of adult admission into long term care than comparator areas with significant numbers of adults receiving care at home.

Our Impact: ICP in action in 2021-22

Pulse Oximetry

Working closely with Primary Care, the ICP developed a virtual ward to monitor patients with COVID-19 in their own homes using telephone/video link support. This avoided unnecessary admissions and provided ongoing support and reassurance to individuals as well as reducing unnecessary demand on primary care and visits to A and E. There have been a total of 3939 patient supported to date.

Vaccinating our most vulnerable

The specialist learning disability team have worked in partnership with the GP Federation to offer COVID-19 vaccination clinics and home visits to all adults living in supported living accommodation. The uptake rate has been positive, achieving around 85% uptake.
Similarly the ICP across primary care, community services, social care, commissioning public health and VCSE sector have worked together over the year to vaccinate the most vulnerable for Flu and Covid 19. Often this has involved working together to find innovative solutions to reach housebound, homeless and other individuals who might otherwise not receive their vaccination.

District Teams

Key to delivering the ICP's Vision is developing multidisciplinary teams closely connected to their local neighbourhoods whom have adopted a single vision and way of working. In February, we began working from three district sites with health, therapy and social work staff working together with daily huddles and Multidisciplinary Team meetings (MDTs) to bring together health and care support for Bolton residents.

ICP in action in 2021-22

Multidisciplinary disciplinary team meetings (MDT)

A key element of realising our ambition in day to day operations of coordinated care with 'no wrong front door' is through the MDT approach- particularly for those individuals with multiple and complex health and social care needs. There are now MDTs in place for neighbourhoods, and supporting integrated discharge into community services. They are all linked to PCNs and care homes but also draw on services such as housing, mental health, drug and alcohol services and community asset navigators. Plans are in place to further improve and scale up our approach including 'reactive' MDTs to speed up the support offered to people.

Support to Care homes

The ICP has continued to work with Council commissioners to provide ongoing support to Care Homes over the last year and in the face of pressures arising from COVID-19 waves. This included ongoing advice and guidance to Care Homes on public health guidance, testing, PPE and other concerns. In addition, training and support has been provided on signs of COVID-19, monitoring residents and end of life care. Bolton is also one of the few localities implementing Safe Steps Restore 2 Mini which enables carers to recognise 'soft signs' of deterioration in residents, take observations where possible and respond and escalate their concerns appropriately.

Different conversations with our communities

Changing the way we work to focus on what matters to people and the communities in which they live, recognising their inherent strengths, knowledge and skills is critical to delivering on the ICP ambitions and improving outcomes for Bolton people. One aspect of this has been agreeing an Occupational Development (OD) package of support initially to those staff working in district teams across health, therapy and social care to work with people in a way that recognises their unique strengths and that connects them to their community. While the waves of the pandemic have posed significant challenges to staff capacity and the ability to bring people together on a large scale, the programme has now been co-designed by the workforce and delivery is now beginning across the District teams.

ICP in action in 2021-22

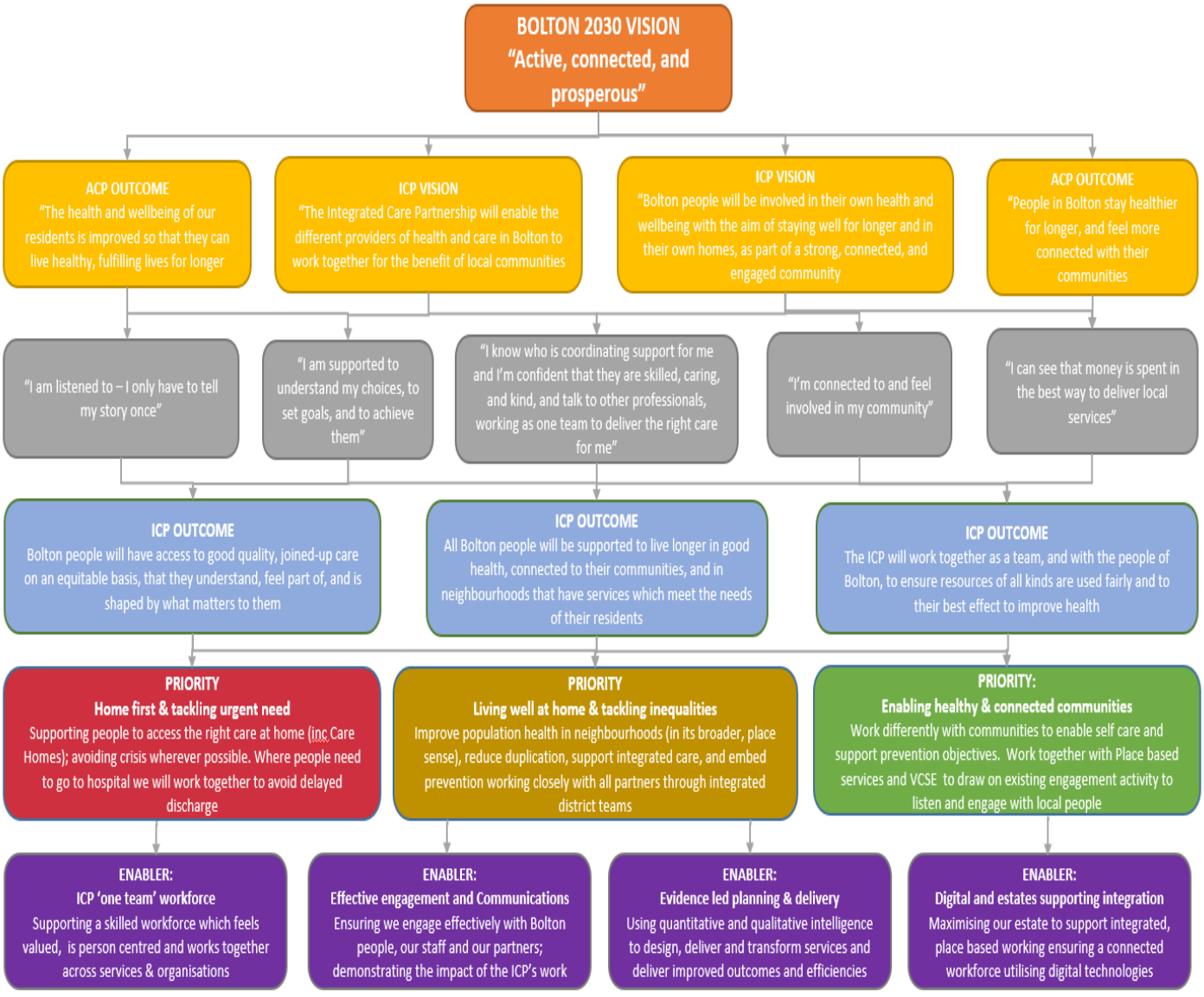
Getting home from hospital

The ICP has provided intensive support to enable people to go home from hospital and reduce demands on the local system. Collaboration has taken place across services from community services, social care to the voluntary sector. This includes teams from across the system coming together to hold daily discharge meetings. The Pathway 1 Discharge Meeting, works to support those patients with a new or restarted package of care and / or those who require support from community services The IDT, inpatient and community therapy, reablement team and Bolton CCG work together, addressing any concerns around environment, equipment and mobility to get people home.
While reducing the number of people waiting to be discharged from hospital remains challenging, ICP led actions have had positive impacts on flow and managing the numbers of people awaiting discharge.

ICP Outcomes and Priorities 2022/23

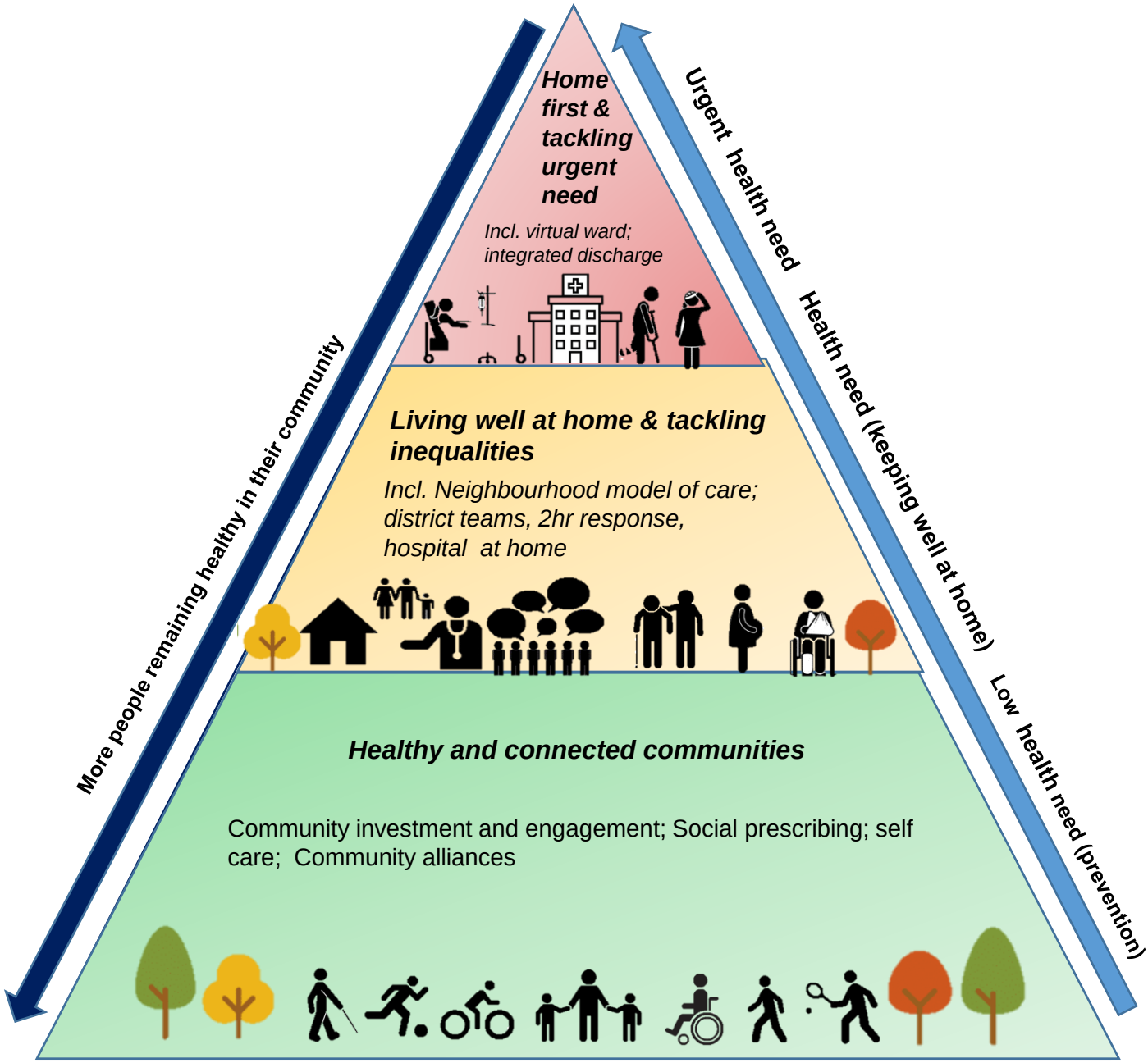
The ICP is committed to working together to improve the health and wellbeing of its residents. Our vision and each of the outcomes and priorities for the year ahead have been developed to align and accelerate the Borough's wider 2030 Vision focussed on improving the health and wellbeing of local people and preventing the causes of ill health whilst developing a sustainable health and care system. At the heart of these ambitions are the desire to make a tangible difference to people's lives represented in the 'I statements' in the below diagram

The individual delivery plans for each priority will be appended to this Business Plan. These priorities reflect the complex challenges that our communities and organisations continue to face and which therefore require a partnership approach with a single plan by which to drive the transformation required.



ICP Outcomes and Priorities 2022/23

The below triangle demonstrates the ICP's whole population integrated care approach, supporting and enabling healthy and connected communities; targeting support to those needing support in their community and enabling timely discharge when people do need to access hospital or acute care services.



Breakthrough Transformation Programmes for this year

This year our focus will be on delivering against our priorities and measuring our impact against our 'I statements'. Below are highlights of some of our programmes of work which we believe will make a big difference to Bolton people if we plan and deliver these together. Our Delivery Plan will detail all activity for 2022-23.

Agreeing shared Neighbourhood priorities to address Health Inequalities

ICP partners including PCN Health Inequality leads, VCSE sector, housing and Public Health to draw on shared qualitative and quantitative data to identify neighbourhood priority areas to address inequalities in each of our neighbourhoods

A Virtual Ward for Care Home

A Virtual Ward will allow patients to receive the care they need at home, including in care homes, safely and conveniently rather than in hospital. Bolton will pilot test the use of technology to remotely monitor patients who are discharged home from hospital earlier than they would have been. Training to use the technology and working to identify suitable cohorts of patients will be undertaken. The programme will be expanded to a cohort of patients, initially in care homes, who meet the threshold for hospital admission but can be managed in their usual place of residence with the use of technology and the support of community teams.

SEND Transition Programme

The ICP will work with Council Children's Services, NHS 0-19 services and wider partners to ensure early identification and a smooth transition for young people into adult services to improve experience of care and outcomes. It will aim to provide a framework for our workforce to deliver shared, coordinated and person centred planning to ensure that young people, family and carers are appropriately supported before and after the transfer.

Home First approach to Hospital Discharge

The ICP, with Adult Acute partners, will build on the integrated discharge approach; to develop a home first model to ensure timely discharge. Working with AQuA on a whole system flow programme to understand the root issues causing delays, the programme will connect closely to the development of the district teams recognising the interdependency of the two work programmes to reduce the number of people waiting to be discharge from hospital and improve outcomes for Bolton people.

Coordinating physical and (serious) mental health in communities

The ICP will work with GMMH and wider partners to develop a model of care aligned to existing programmes of neighbourhood and mental health programmes of work, to support improved physical and mental health outcomes for people with serious mental illness

Changing the way we do things

From this:	To this:
Process driven, single assessment, top-down conversations	Co-design and co-production, MDTs, plans based on the needs of individuals, co-ordinated assessments
Reactive response, treating at point of need	Proactive and preventative response, focus is on empowering people and keeping well
Policy based conversations, fixing problems within policy limits	Person-centred, strengths-based conversations, focus on understanding and building on people's strengths
Top-down decision making, not always in touch with the front line and people	Decision making connected to individuals and communities, informed by the frontline and people
Focus on achieving organisational outcomes	Focus on what matters to people – their individual needs, their culture and community

High Level Impact Measures for 22/23

Initially reporting on these measures will be monthly into the ICP Board (where KPIs allow) and quarterly to wider system partners via Locality Board. It should be noted that reporting of the ICP's Integrated Operations Directorate will be aligned but separate to the above process bringing together a single report across social care, community services and primary care development services which will be reported into the parent organisations.

'I statements' and Person Centred Metrics: This is a critical area for the ICP. Demonstrating the difference we are making to people and their families in terms of both their experience of services but also their overall wellbeing is critical to understanding our effectiveness. This year we want to move to measuring the impact of our approach at individual person level using our 'I statements' rather than evaluating mainly at service level.

We recognise that this needs further development to agree an indicator for measuring a broader range of factors to supplement existing KPIs. Therefore our Data and intelligence leads will bring forward proposals to the ICP Board as to how we measure the impact delivery has on local people.

Output System measures: These are standard measures which show how we are making a difference to reducing demand on acute/high cost services in line with wider Bolton priorities.

Process: These are transactional measures which show we are meeting the key tasks we have set ourselves such as establishing integrated teams, or implementing an ICP Communications and Engagement Plan.

Stories, case studies: We will work with local people, our workforce and partners to share the stories and voices of local people to understand the impact of the ICP's delivery. We will genuinely reflect on the learning generated.

Agenda item: 18

Title:	Audit Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th May 2022		Discussion	
Exec Sponsor	Annette Walker, Director of Finance		Decision	

Summary:	Chair's Report for Audit Committee which took place on 4th May 2022

Previously considered by:	

Proposed Resolution	

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, Director of Finance	**Presented by:**	Alan Stuttard, Audit Committee Chair

Committee/Group Chair's Report

Name of Committee/Group:	Audit Committee	Report to:	Board of Directors
Date of Meeting:	4th May 2022	Date of next meeting:	15th June 14.00-16.00
Chair:	Alan Stuttard, Non-Executive Director	Parent Committee:	Board of Directors
Members Present:	Alan Stuttard, Martin North, Malcolm Brown, Bilkis Ismail, Annette Walker, Sharon Katema, Lesley Wallace, Othmane Rezgui, Karen Finlayson, Imogen Milner, Catherine Hulme, Collette Ryan	Quorate (Yes/No):	Yes
		Key Members not present:	Tim Cutler

Key Agenda Items:	RAG	Key Points	Action/decision
Going Concern Report (2021/22 Accounts and Reporting)		The Head of Financial Services presented the Going Concern Report for 2021/22 in accordance with the national requirements. This was approved by the Committee.	Approved
Draft Annual Accounts 2021/22		The Head of Financial Services presented the Draft Annual Accounts for 2021/22. The Trust reported an overall year end deficit of £1071k with an operational deficit of £35k. However, the Committee discussed the fact that this figure does not appear in the accounts due to a number of technical adjustments. The key figure which is reported to NHSi is the operational figure of £35k. The Committee recommended the inclusion of a table to show how the figure is arrived at, which the External Auditors agreed to look at. The Committee considered the overall cash position which was reported at £57m. Due to a high number of capital creditors and the receipt of some large capital sums in the year it would be useful to understand the full impact moving into 2022/23. The Committee agreed that this should be undertaken by the Finance & Investment Committee. The Committee also considered some minor adjustments to the presentation of the Capital Report within the accounts.	Noted with thanks

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

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

Committee/Group Chair's Report

		The Head of Financial Services reported that the Draft Accounts had been submitted in accordance with the national timetable. The Committee expressed their appreciation to the Finance Team for their work in producing the accounts.	
Draft Annual Report		The Interim Director of Corporate Governance asked the Committee that the Draft Annual Report be circulated on the 20th of May to be considered for approval at the Audit Committee on the 15th June for final approval by the Board of Directors.	Noted
Draft Annual Governance Statement 2021/22		The Interim Director of Corporate Governance presented the Draft Annual Governance Statement for 2021/22. The IDoCG asked the Committee to provide their comments by the 20th of May. It was noted that some comments had already been received from the Chair and the Local Counter Fraud Specialist. The Committee did agree that the AGS should be strengthened to include further reference to iFM.	Noted
External Audit VFM Risk Assessment 2021/22		The External Auditor presented the value for money risk assessment. The report covered Financial Sustainability, Governance, Improving Economy Efficiency and Effectiveness. There were no significant risks identified and there were no recommendations requiring any action.	Noted
Internal Audit Update 2021/22		The Internal Auditor provided an update report on the progress for the Audit Plan 2021/22. The report covered the following: 1. Field work had commenced for a number of reviews. 2. Reports completed against the last Audit Committee meeting. 3. Action tracking updates.	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

Committee/Group Chair's Report

		4. Thought leadership on managing risk in the NHS. This report covers comparative work across a number of Trusts on the Board Assurance Framework. The report was referred back to the Interim Director of Corporate Governance in respect of the Trust's BAF. Overall good progress was made against the plan. The Committee considered the completed reports on: • **IT access controls** – it was confirmed that this report had been shared with the Director of Strategy and Transformation and the Chief Digitisation Officer. The report was classed as advisory but the Committee asked that a full review be undertaken as part of the 2022/23 Audit Plan once the controls had been implemented. • **EPR deployment** – this report concentrated on one specific area of the Trust. However, it was discussed and agreed that this should also be looked at across the whole EPR project in terms of benefits realisation. • **Procurement/tender waivers –** the Committee noted that there were a number of actions to be undertaken as this was an area where concerns have previously been raised regarding the number of waivers. The Chief Finance Officer confirmed that this work was underway. The Internal Auditor reported good progress with regards to the completion of outstanding Audit recommendations.	
Draft Internal Audit Annual Opinion		The Internal Auditor reported on the work carried out in 2021/22 together with the associated conclusions and opinions for the year. The Overall opinion was that both the Trust and iFM Bolton Ltd was 'generally satisfactory with some improvements required'. In context the Internal Auditors have a range of 5 ratings and this is the second highest.	Noted

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

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

Committee/Group Chair's Report

		The Internal Auditor advised that there had been an overall reduction in the number of findings. The Internal Auditor confirmed that in terms of the outcome of the Audits still under review it would not impact the overall conclusion.	
Counter Fraud Work Plan 2022/23		The Local Counter Fraud Specialist presented the Counter Fraud Work Plan for 2022/23. The plan represented a very comprehensive programme of work for the coming year with a number of anti-fraud events planned for the year. The Committee approved the plan.	Approved
Local Counter Fraud Specialist Progress Report		The Local Counter Fraud Specialist presented the progress report covering the period March - April 2022.	Noted
Register of Waivers		The Chief Finance Officer presented the waivers for the Trust and iFM Bolton Ltd for the period February – March 2022. The Committee asked a number of questions regarding the waiver report and the CFO agreed to report back to the Committee on the queries raised.	Noted
Losses and Special Payments Report		The Head of Financial Services presented the losses and special payments report for the Trust and IFM Bolton Ltd for the period April 2021 to March 2022. It was agreed that further details would be provided going forward in relation losses and special payments to iFM Bolton Ltd.	Noted
Risks Escalated There were no matters to be escalated to the Board of Directors.			

	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: 19

Title:	Finance and Investment Committee Chair Report

Meeting:	Board of Directors	**Purpose**	Assurance	✓
Date:	26th May 2022		Discussion	
Exec Sponsor	Annette Walker, Director of Finance		Decision	

Summary:	Finance and Investment Committee Chair Report from the meeting which took place on 27th April 2022.

Previously considered by:	

Proposed Resolution	

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, Director of Finance	**Presented by:**	Jackie Njoroge, Finance and Investment Committee Chair

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:	27th April 2022	Date of next meeting:	25th May 2022
Chair:	Jackie Njoroge	Parent Committee:	Board of Directors
Members Present:	Jackie Njoroge, Bilkis Ismail, Becks Ganz, Annette Walker, Rae Wheatcroft, Fiona Noden, James Mawrey, Sharon Katema, Andy Chilton, Catherine Hulme, Rachel Noble, Lesley Wallace, Sam Ball, Lianne Robinson	Quorate (Yes/No):	Yes
		Key Members not present:	

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Strategy Refresh – Financial Ambition	N/A	Deputy Director of Strategy	The committee received an update on the refresh of the corporate strategy as a result of changes to local and national NHS system architecture. The opinions of committee members were sought on the overarching ambition, key objectives and the committee's role in the oversight of delivery. The committee discussed the strategy and agreed that more information is required on the Local Care Trust in order to put the strategic ambitions into context.	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

Committee/Group Chair's Report

Month 12 Finance Report		Operational Director of Finance	The committee received an update on the financial position as at Month 12. Key points were noted as follows: • The final NHSI reported surplus was £35k against a breakeven plan. The accounts position after adding in items excluded by NHSI is a deficit of £1.1m. This was due to a number of technical items that we have had to account for that have either no impact on overall performance or are excluded from the NHSI target. • The CIP target was achieved although this is rated Amber due to the significant reliance on non-recurrent schemes. • Variable pay remains a cause for concern. • Capital of £25.8m was spent in year. This is £53k more than the adjusted plan. • The cash balance is currently £56.8m. It was confirmed that the Annual Accounts were submitted the previous day and that the Auditors were due in the following week. The committee expressed their thanks to all staff across the Trust for delivering the financial plan for 2021/22.	Noted.
Financial Plan 2022/23	N/A	Chief Finance Officer	The committee received a presentation on the financial plan for 2022/23. The Chief Finance Officer noted some additional risks not included in the presentation. These were concerning capital (Theatres, Paediatric Hub and the Community Diagnostic Centre).	Noted.
Cost Improvement Plan 22/23		Associate Director of Improvement and Transformation	The committee received an update on the Cost Improvement Plan for 2022/23. There was a discussion on how realistic the CIP target of 3.8% (£12.8m) is. It was acknowledged that this will be difficult but that there is a good level of engagement.	Noted.
Update on the Trust's Banking Arrangements	N/A	Head of Financial Services	The committee noted the update on the Trust's banking arrangements.	Noted.
High Value Supplier Payment Register	N/A	Head of Financial Services	The committee noted the update on high value supplier payments.	Noted.

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

Chairs' Reports	N/A	Chief Finance Officer	The committee noted the Chair's Reports from the following meetings: • Digital Performance and Transformation Board – 11th April. • Performance and Transformation Board – 4th April.	Noted. It was agreed that future reports would try to pull out the more salient points in order to keep them relevant for the committee.
Comments				
Risks escalated				

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

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

Title:	Integrated Performance Report

Meeting:	Board of Directors	**Purpose**	Assurance	X
Date:	26/05/2022		Discussion	X
Exec Sponsor	James Mawrey		Decision	

Summary:	Integrated Performance Report detailing high level metrics and their performance across the Trust

Previously considered by:	Divisional IPMs

Proposed Resolution	The Board are requested to note and be assured that all appropriate actions are being taken.

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:	Emma Cunliffe (BI)	**Presented by:**	James Mawrey

Bolton NHS Foundation Trust

Integrated Performance Report

April 2022

Guide to Statistical Process Control

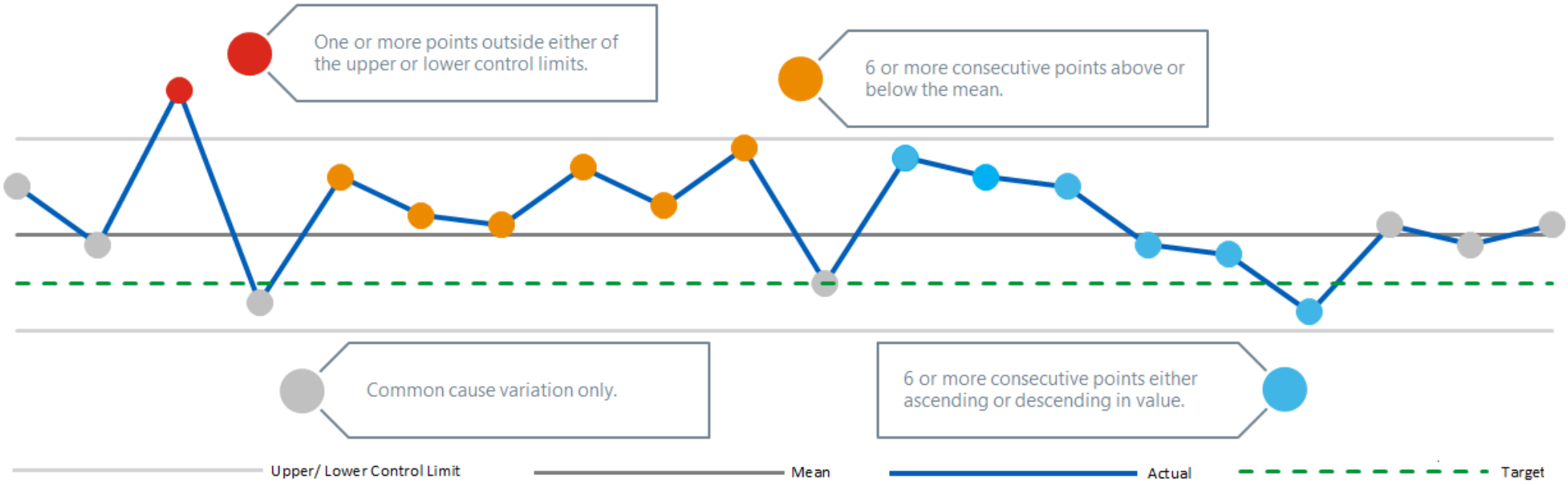
Bolton
NHS Foundation Trust

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

NHS Bolton NHS Foundation Trust

Trust Objective	Variation					Assurance		
	Common cause	H	L	H	L	P	F	?
Quality and Safety								
Harm Free Care	13	1	0	1	0	1	2	12
Infection Prevention and Control	6	0	1	3	0	0	0	7
Mortality	4	0	0	0	0	0	0	3
Patient Experience	5	1	0	0	10	3	0	13
Maternity	6	0	0	2	2	1	0	9
Operational Performance								
Access	3	0	0	5	3	0	6	5
Productivity	7	3	1	2	1	3	2	8
Cancer	4	1	0	0	2	0	1	6
Community	1	0	0	1	0	0	0	2
Workforce								
Sickness, Vacancy and Turnover	1	0	1	2	0	0	2	1
Organisational Development	0	0	0	0	4	1	2	1
Agency	0	0	0	3	0	3	0	0
Finance								
Finance	2	1	0	0	0	0	0	3
Appendices								
Heat Maps								

Variation

	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
In April there has been common cause variation in the number of hospital acquired category 2 pressure ulcers, 2 of these were device related, associated with oxygen masks. There were no category 3 or category 4 pressure ulcers in April in the acute hospital setting. There were 5 Unstageable pressure ulcers in hospital in April, which is a slight increase from March. Unstageable pressure ulcers are pressure ulcers that the accurate category cannot be determined at the time of reporting due to an overlying cover of devitalised tissue. It should be noted that these pressure ulcers are at least category 2 pressure ulcers, and will be added to the accurate category in the month the pressure ulcer developed when the wound bed is visible allowing accurate categorisation.

In the community there were 12 category 2 pressure ulcers, which is a slight increase from 11 in March. 2 of these pressure ulcers were device related, from oxygen therapy devices. There were no category 3 or category 4 pressure ulcers in April. There were 6 unstageable pressure ulcers in the community, which is a slight increase from 4 in March.

A review is currently underway regarding improvement activity in this fundamental area. Reducing pressure ulcer occurrence is typically multi-faceted and preliminary options include an 'end PJ paralysis' quality improvement collaborative, which would include a primary driver around pressure ulcer prevention across both acute and community settings, with clear trajectories for improvement.

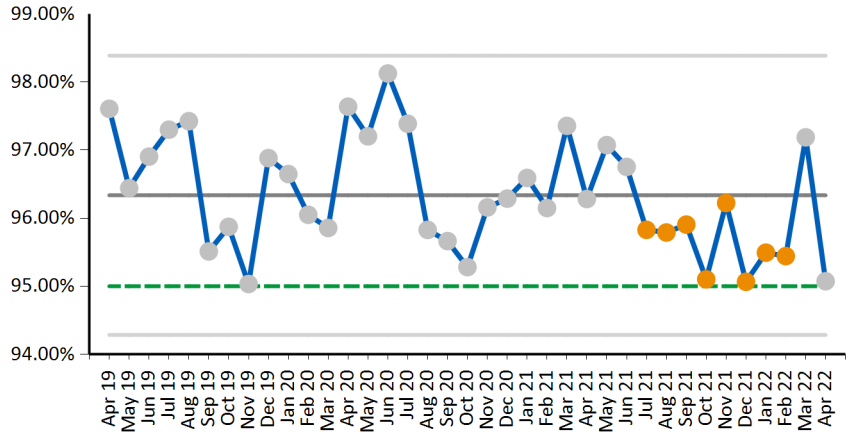
Falls
Falls in the first month of quarter 1 show a positive improvement overall from the previous month. We are below our local stretch target of 5.3 falls per 1000 bed days and have seen 26 less falls this month. This is the strongest position for April since 2019/20. Unfortunately falls with harm have increased from 1 to 3 this month with all cases being reviewed at harm free care panel.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
6 - Compliance with preventative measure for VTE	>= 95%	95.1%	Apr-22		>= 95%	97.2%	Mar-22	>= 95%	95.1%	
9 - Never Events	= 0	1	Apr-22		= 0	1	Mar-22	= 0	1	
13 - All Inpatient Falls (Safeguard Per 1000 bed days)	<= 5.30	4.48	Apr-22		<= 5.30	5.69	Mar-22	<= 5.30	4.48	
14 - Inpatient falls resulting in Harm (Moderate +)	<= 1.6	3	Apr-22		<= 1.6	1	Mar-22	<= 1.6	3	

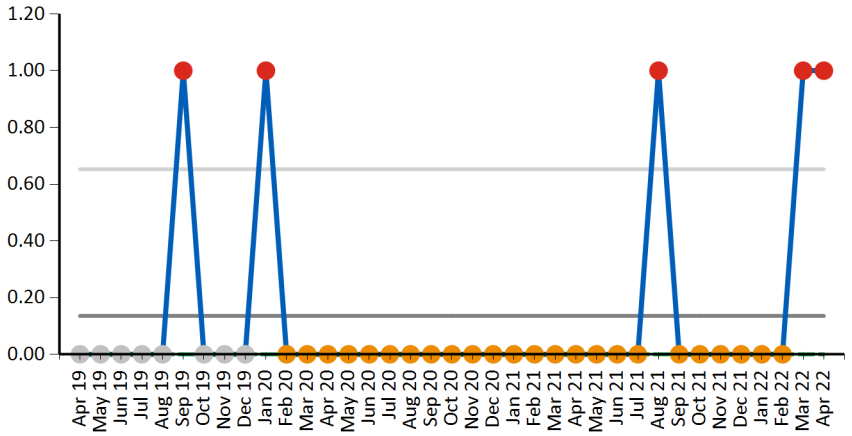
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
15 - Acute Inpatients acquiring pressure damage (category 2)	<= 6.0	9.0	Apr-22		<= 6.0	10.0	Mar-22	<= 6.0	9.0	
16 - Acute Inpatients acquiring pressure damage (category 3)	<= 0.5	0.0	Apr-22		<= 0.5	0.0	Mar-22	<= 0.5	0.0	
17 - Acute Inpatients acquiring pressure damage (category 4)	= 0.0	0.0	Apr-22		= 0.0	0.0	Mar-22	= 0.0	0.0	
515 - Acute Inpatients acquiring pressure damage (unstagable)		5	Apr-22			2	Mar-22		5	
18 - Community patients acquiring pressure damage (category 2)	<= 7.0	12.0	Apr-22		<= 7.0	11.0	Mar-22	<= 7.0	12.0	
19 - Community patients acquiring pressure damage (category 3)	<= 4.0	0.0	Apr-22		<= 4.0	1.0	Mar-22	<= 4.0	0.0	
20 - Community patients acquiring pressure damage (category 4)	<= 1.0	0.0	Apr-22		<= 1.0	1.0	Mar-22	<= 1.0	0.0	
516 - Community patients acquiring pressure damage (unstagable)		6	Apr-22			4	Mar-22		6	
28 - Emergency patients - screened for Sepsis (quarterly)	>= 90%	86.9%	Q4 2021/22		>= 90%	88.5%	Q3 2021/22	>= 90%		
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%	50.0%	Q4 2021/22		>= 90%	50.0%	Q3 2021/22	>= 90%		
513 - Inpatients - screened for Sepsis (quarterly)	>= 90%	22.0%	Q4 2021/22		>= 90%	22.0%	Q3 2021/22	>= 90%		
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly)	>= 90%		Q4 2021/22		>= 90%		Q3 2021/22	>= 90%		
30 - Clinical Correspondence - Inpatients %<1 working day	>= 95%	78.0%	Apr-22		>= 95%	75.9%	Mar-22	>= 95%	78.0%	
31 - Clinical Correspondence - Outpatients %<5 working days	>= 95.0%	67.2%	Apr-22		>= 95.0%	58.8%	Mar-22	>= 95.0%	67.2%	
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance	= 100%	87.5%	Apr-22		= 100%	80.0%	Mar-22	= 100%	87.5%	
88 - Nursing KPI Audits	>= 85%	92.3%	Apr-22		>= 85%	91.7%	Mar-22	>= 85%	92.3%	

Outcome Measure	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Target Assurance
91 - All Serious Incidents investigated and signed off by the Quality Assurance Committee within 60 days	= 100%	100.0%	Apr-22		= 100%	50.0%	Mar-22	= 100%	100.0%	

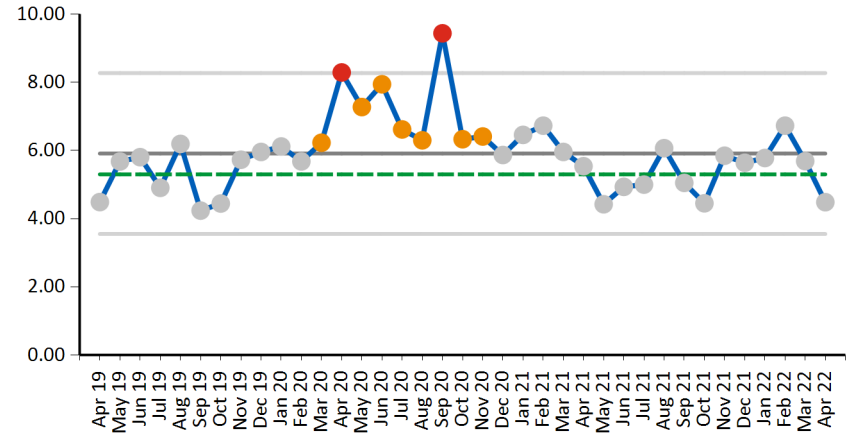
6 - Compliance with preventative measure for VTE



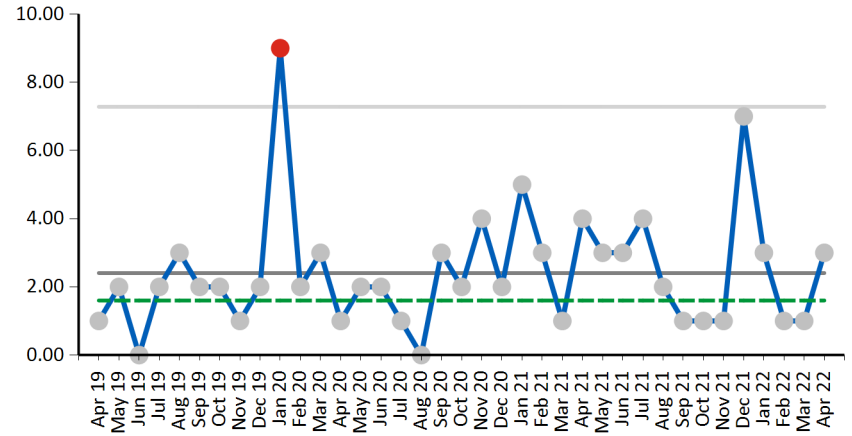
9 - Never Events



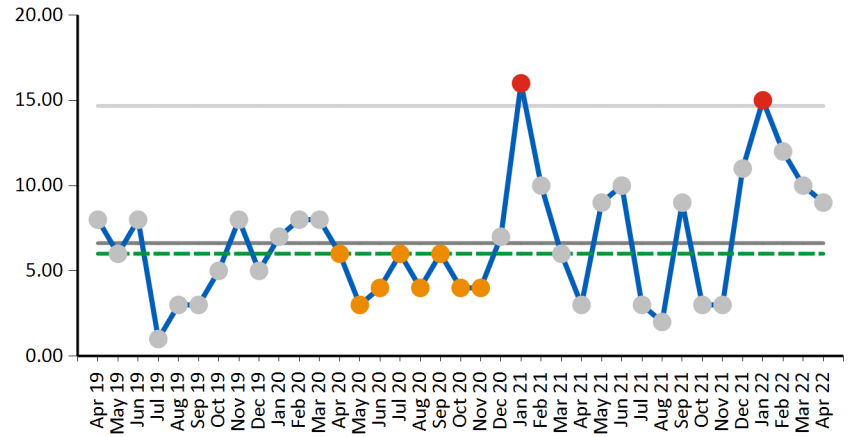
13 - All Inpatient Falls (Safeguard Per 1000 bed days)



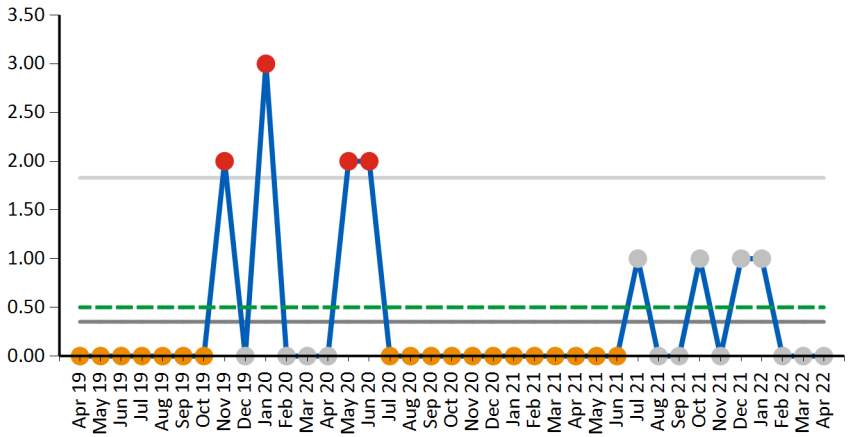
14 - Inpatient falls resulting in Harm (Moderate +)



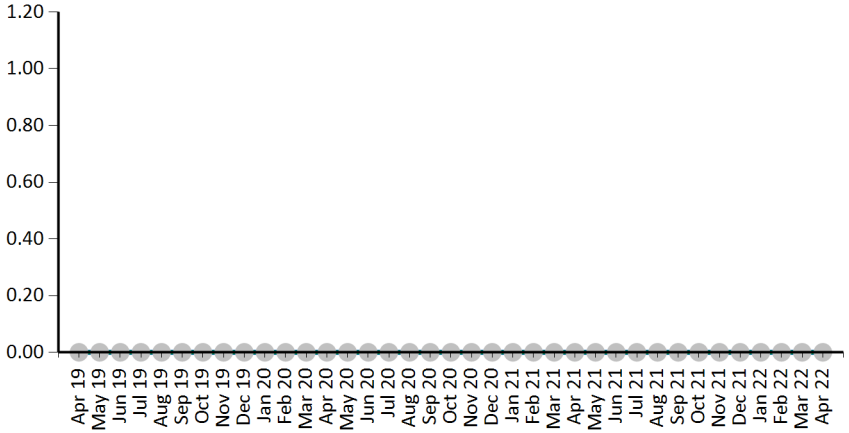
15 - Acute Inpatients acquiring pressure damage (category 2)



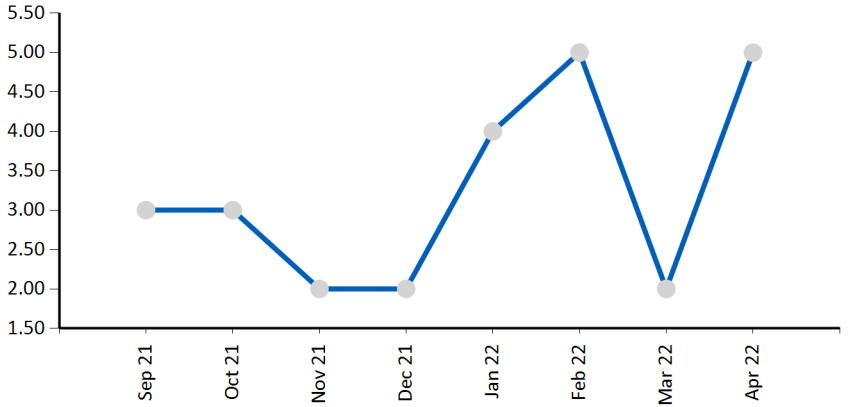
16 - Acute Inpatients acquiring pressure damage (category 3)



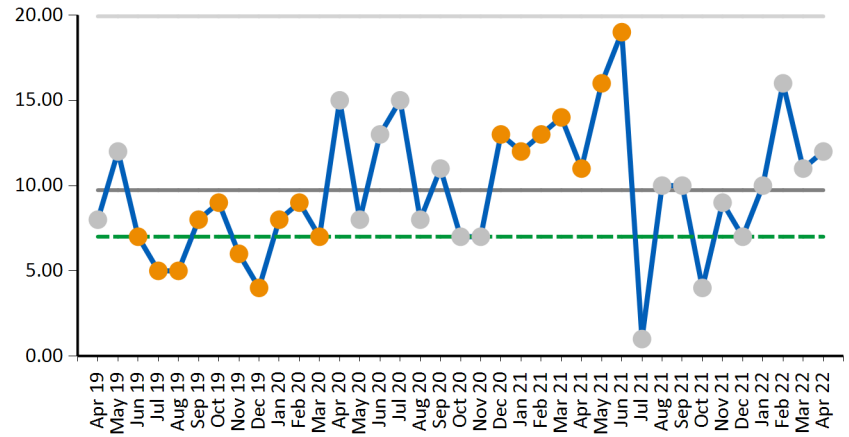
17 - Acute Inpatients acquiring pressure damage (category 4)



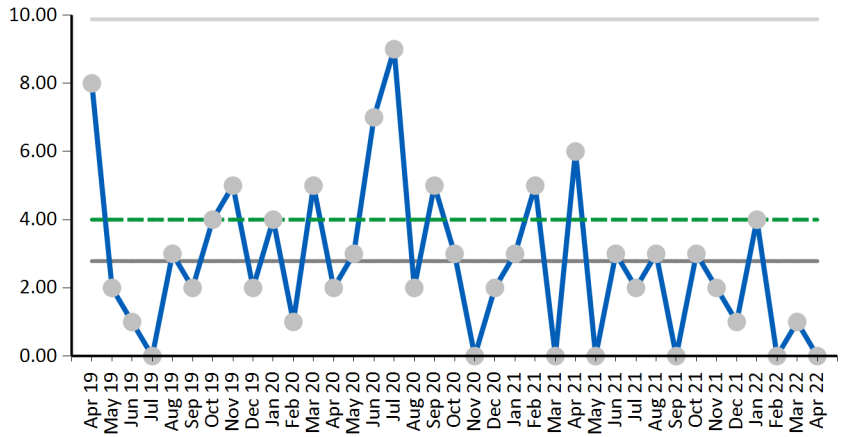
515 - Acute Inpatients acquiring pressure damage (unstagable) - SPC data available after 20 data points



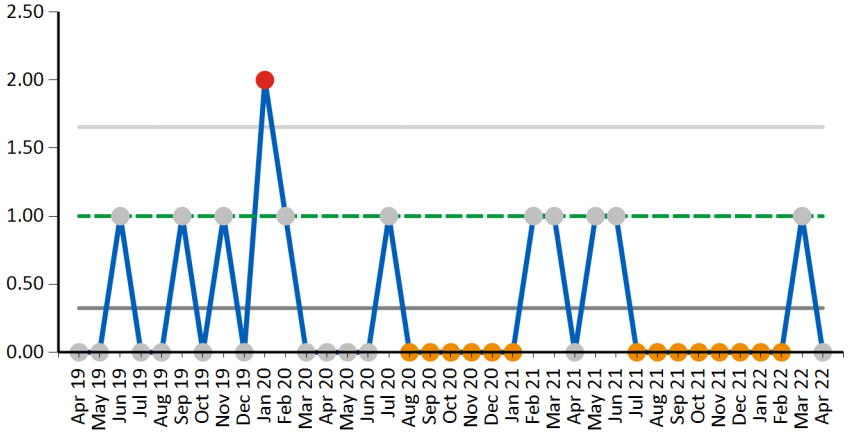
18 - Community patients acquiring pressure damage (category 2)



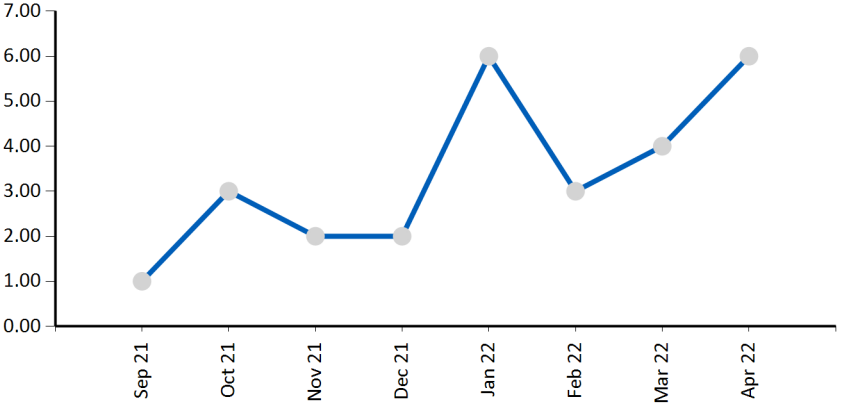
19 - Community patients acquiring pressure damage (category 3)



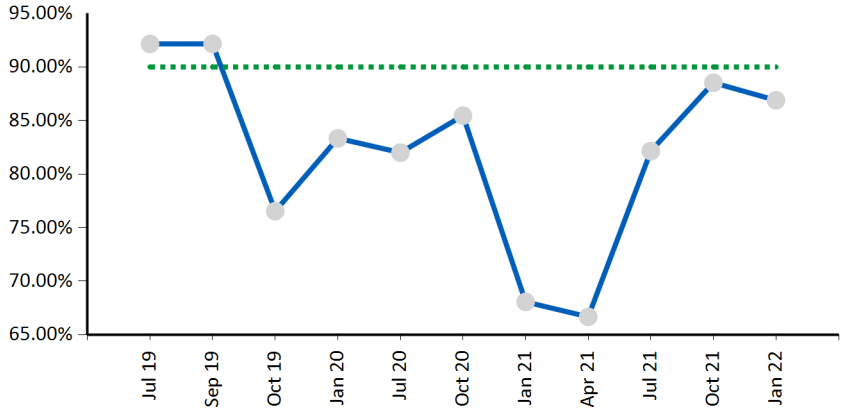
20 - Community patients acquiring pressure damage (category 4)



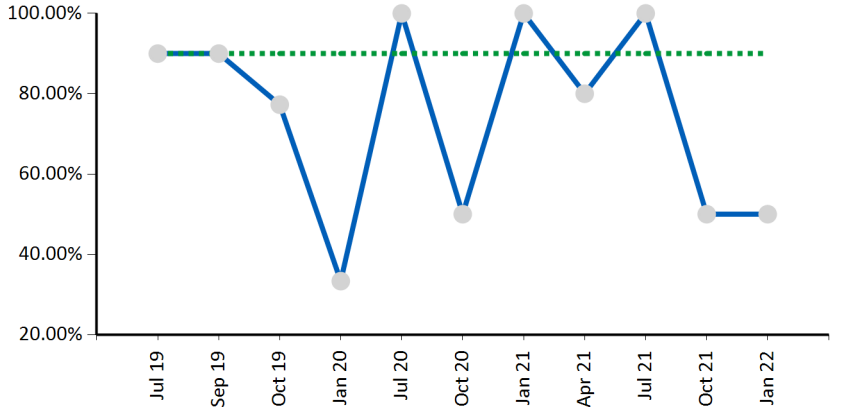
516 - Community patients acquiring pressure damage (unstagable) - SPC data available after 20 data points



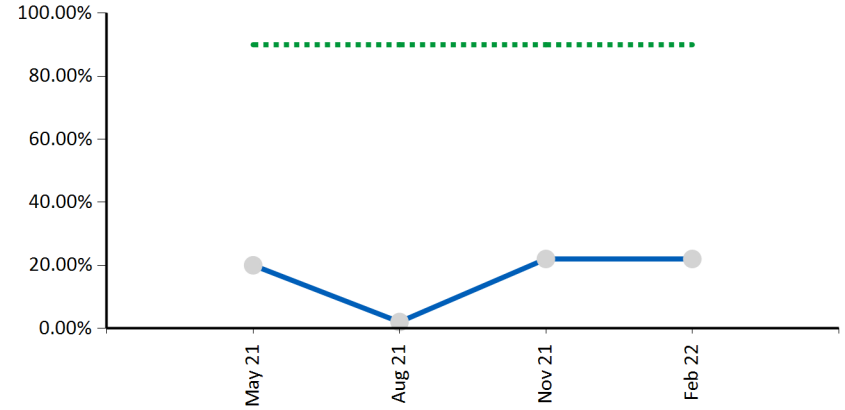
28 - Emergency patients - screened for Sepsis (quarterly) - SPC data available after 20 data points



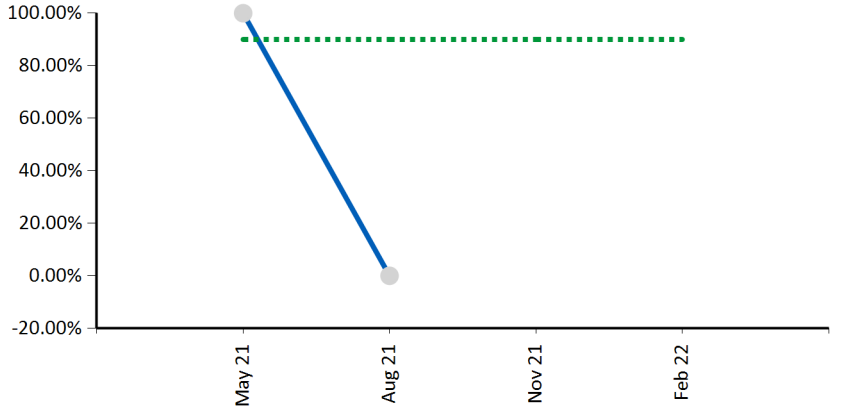
29 - Emergency patients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



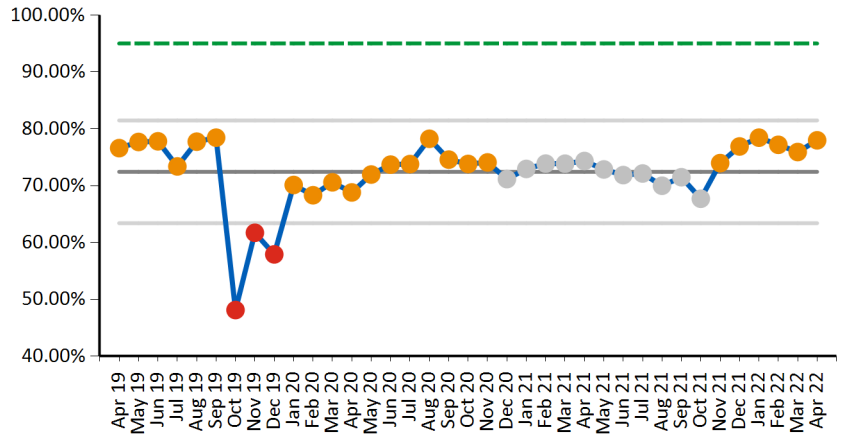
513 - Inpatients - screened for Sepsis (quarterly) - SPC data available after 20 data points



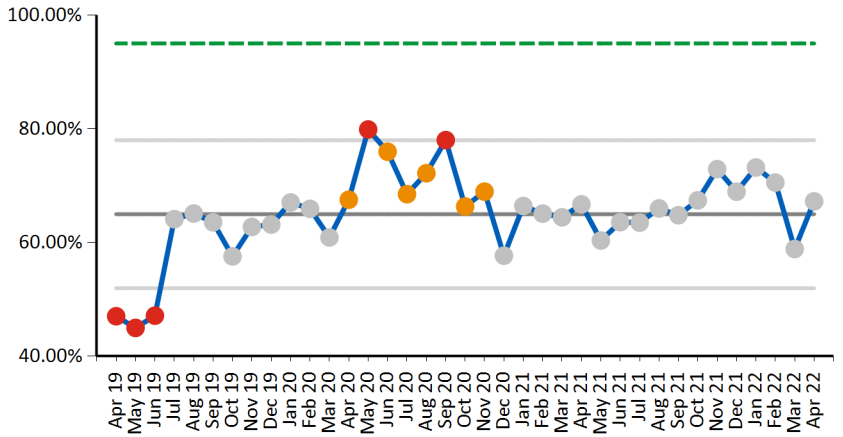
514 - Inpatients - who receive antibiotics <60 minutes of Sepsis diagnosis (quarterly) - SPC data available after 20 data points



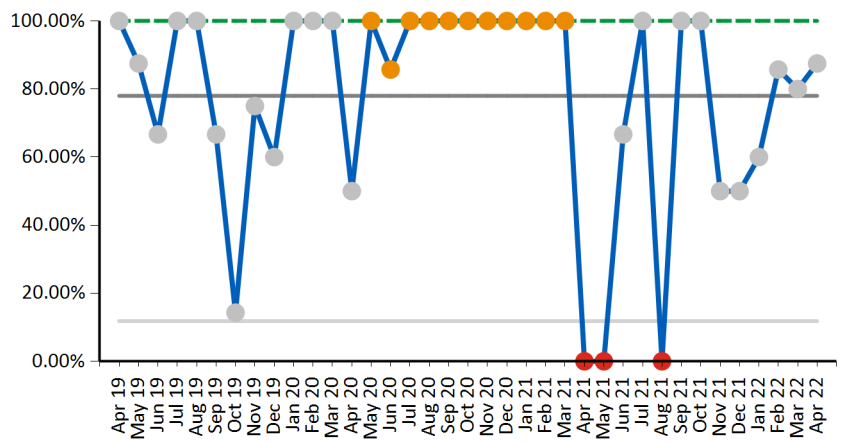
30 - Clinical Correspondence - Inpatients %<1 working day



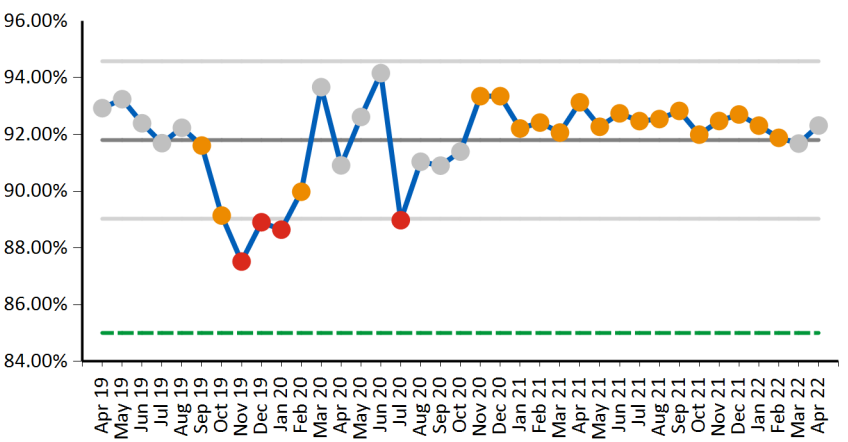
31 - Clinical Correspondence - Outpatients %<5 working days



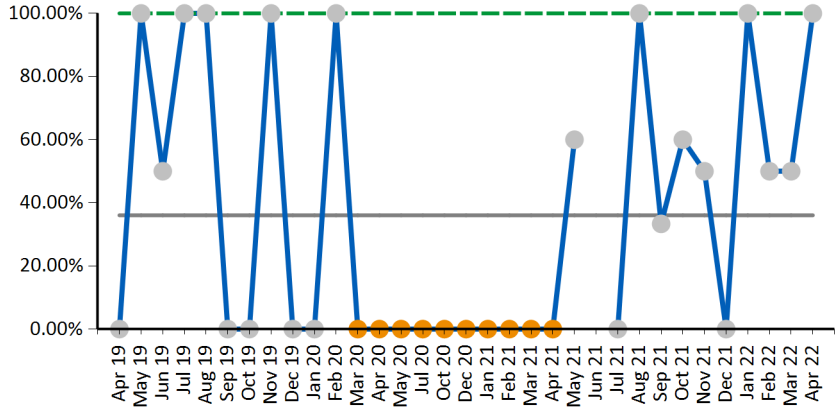
86 - NHS Improvement Patient Safety Alerts (CAS) Compliance



88 - Nursing KPI Audits



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



Infection Prevention and Control

Clostridium difficile infections remain of key concern and a major focus of the divisions supported by the IPC team. During April There have been 15 healthcare associated cases:
• These are currently in the process of being reviewed and will be discussed, challenged and learning shared through the HCAI Harm Free Care panel.
• Five cases were associated with one clinical department and samples sent for ribotyping as part of an investigation into these as a possible outbreak; none of the results have come back as the same ribotype which suggests that these cases were not linked to transmission from patient to patient.
• The microbiology team are in the process of reviewing the prescribing guidelines to further move guidance away from broad spectrum antibiotic use which increases the likelihood of Clostridium difficile infections.
• IPC team have commenced some shop floor micro teaching sessions with clinical staff from the beginning of May to reinforce key points of policy such as SIGHT – especially prompt isolation and sample collection, hand hygiene and use of stool charts.
• An options appraisal is underway for provision of a decant facility to enable environmental improvement to inpatient areas.
• Other priorities include: improved stewardship documented indications for antibiotics, improved sampling when antibiotics are started and additional scrutiny regarding ongoing need for antibiotics. These are being addressed by the acute adult divisions Quality Account for 22/23 for which they have selected antibiotic prescribing and are taking a Trustwide lead on.

iFM have rolled out the revised hospital cleaning standards and it is anticipated that these will have a positive impact on the assurance related to cleaning.

There has been a sustained increase in MSSA bacteraemia and the IPC team is working with the divisions to understand the underlying causes and are developing an series of actions to reduce the likelihood of these. Reviews have identified cannula care as a repeating theme and the IPC team are focussing on cannula care part of ward-level training sessions.

Nosocomial COVID-19 cases continue to reduce and in response, changes have been made to local policy in line with national guidance to be less restrictive on patients in line with the principles of living with COVID. Visiting has been re-introduced on an appointment basis in line with the national guidance.

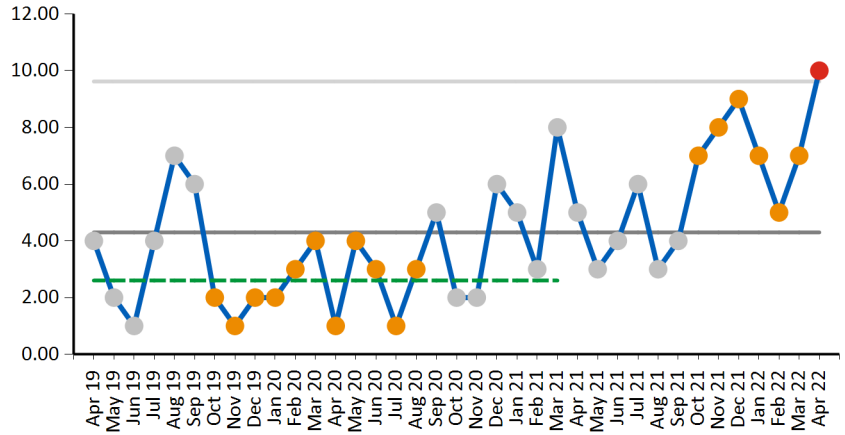
To note:
The measures for 215 and 346 are combined for measure 347 for which there is a plan based on the last published objectives from NHS England for 2019/20.

Chart 217 and 306 - These are SPC G Charts. These are time series charts that plot the time intervals between infrequent events such as MRSA bacteraemias. This chart demonstrates that the Trust is seeing progressively longer gaps between hospital onset MRSA bacteraemias.

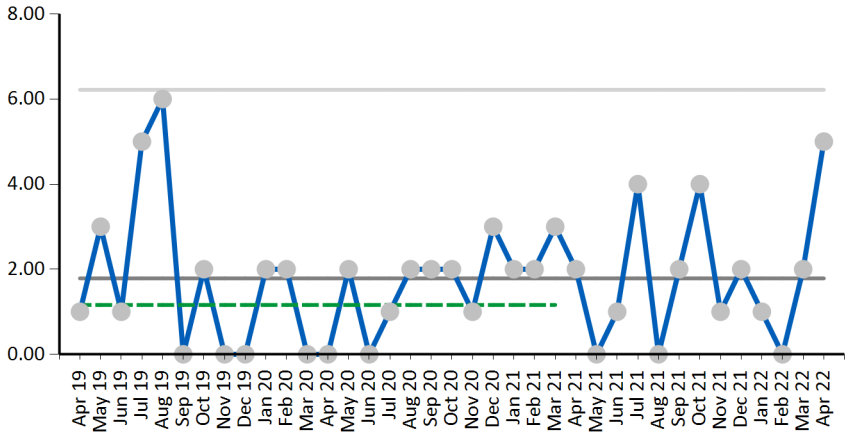
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
215 - Total Hospital Onset C.diff infections		10	Apr-22			7	Mar-22		10	
346 - Total Community Onset Hospital Associated C.diff infections		5	Apr-22			2	Mar-22		5	
347 - Total C.diff infections contributing to objective	<= 3	15	Apr-22		<= 3	9	Mar-22	<= 3	15	
217 - Total Hospital-Onset MRSA BSIs	= 0	0	Apr-22		= 0	0	Mar-22	= 0	0	
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)	<= 2	8	Apr-22		<= 2	1	Mar-22	<= 2	8	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
219 - Blood Culture Contaminants (rate)	<= 3%	2.7%	Apr-22		<= 3%	2.7%	Mar-22	<= 3%	2.7%	
199 - Compliance with antibiotic prescribing standards	>= 95%	74.8%	Q2 2021/22		>= 95%	84.0%	Q1 2021/22	>= 95%		
304 - Total Trust apportioned MSSA BSIs	<= 1.0	4.0	Apr-22	H	<= 1.0	3.0	Mar-22	<= 1.0	4.0	
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)	<= 1	4	Apr-22		<= 1	1	Mar-22	<= 1	4	
306 - Total Trust apportioned Pseudomonas aeruginosa BSIs (HOHA + COHA)	= 0	1	Apr-22		= 0	0	Mar-22	= 0	1	
491 - Nosocomial COVID-19 cases		48	Apr-22			38	Mar-22		48	

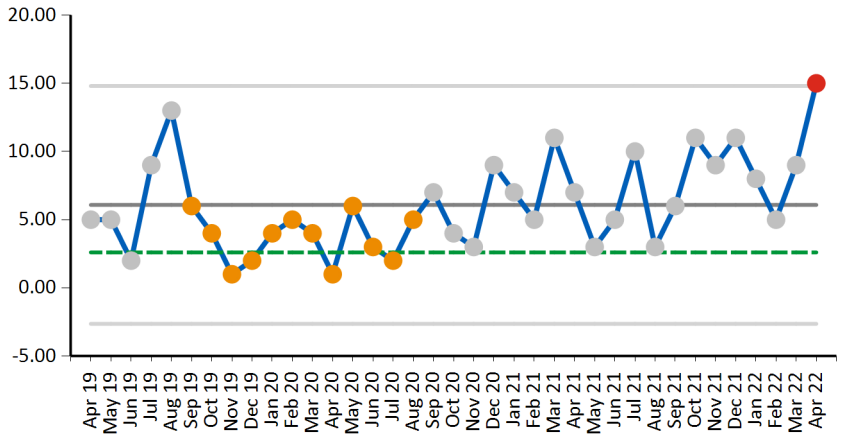
215 - Total Hospital Onset C.diff infections



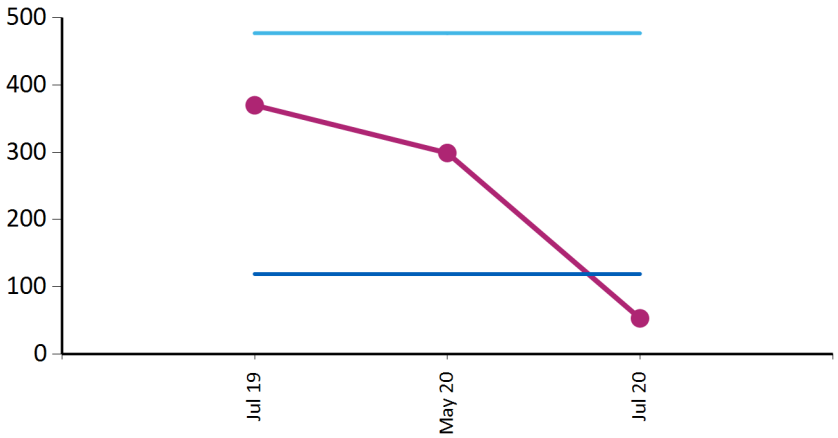
346 - Total Community Onset Hospital Associated C.diff infections



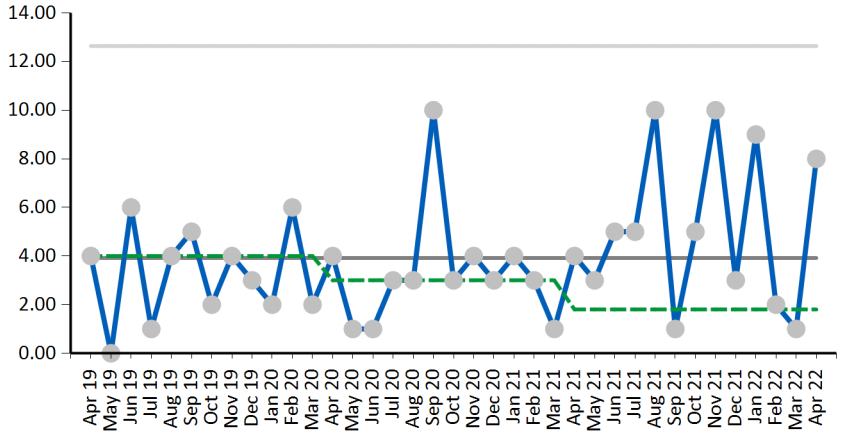
347 - Total C.diff infections contributing to objective



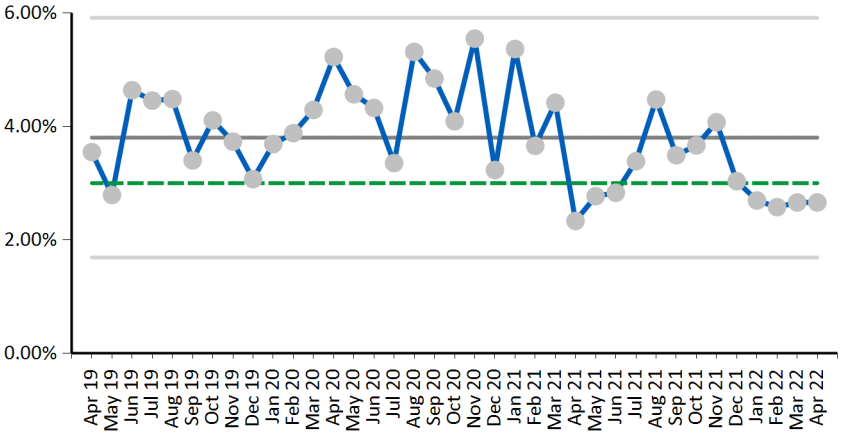
217 - Total Hospital-Onset MRSA BSIs - G Chart (Days Between Cases)



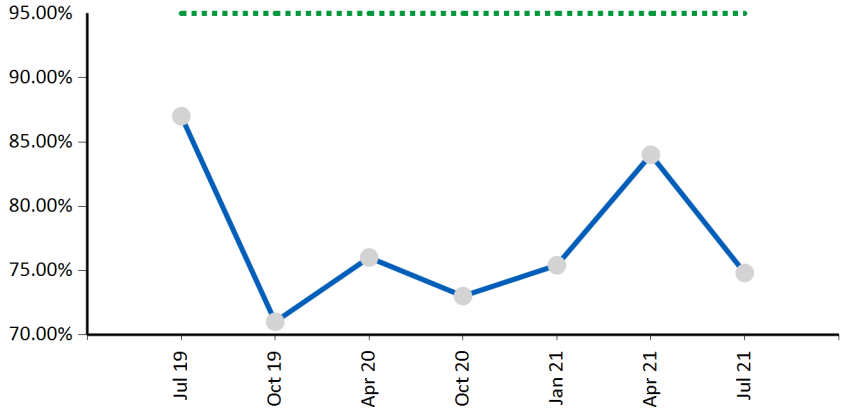
218 - Total Trust apportioned E. coli BSI (HOHA + COHA)



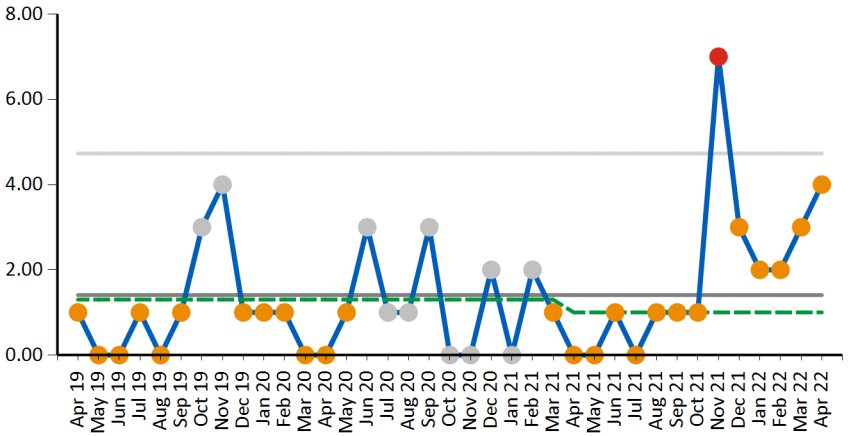
219 - Blood Culture Contaminants (rate)



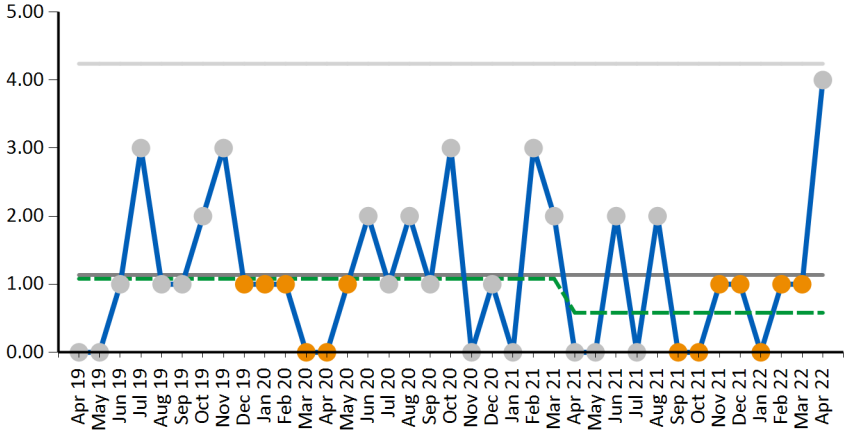
199 - Compliance with antibiotic prescribing standards - SPC data available after 20 data points



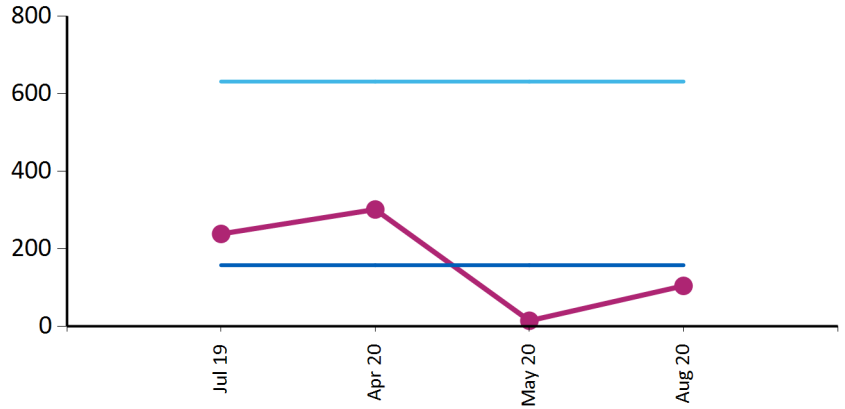
304 - Total Trust apportioned MSSA BSIs



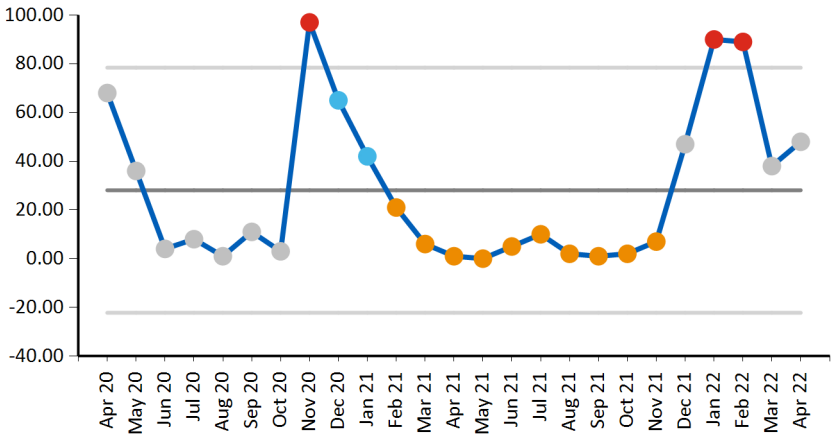
305 - Total Trust apportioned Klebsiella spp. BSIs (HOHA + COHA)



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



491 - Nosocomial COVID-19 cases



Mortality

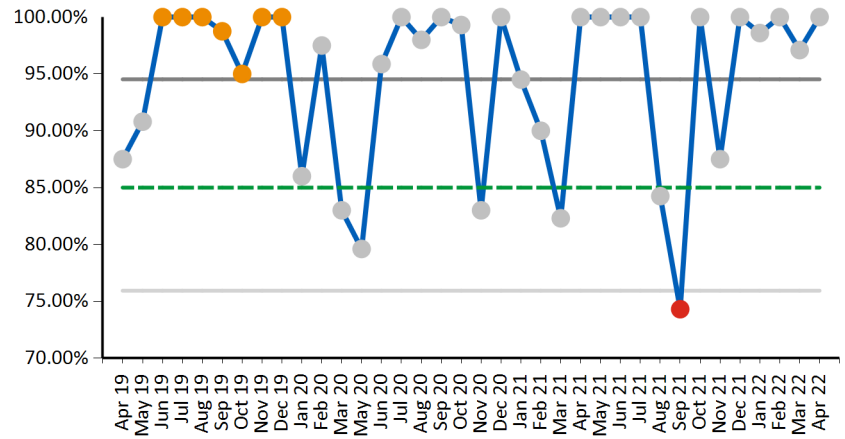
Crude – in month position remains below the average and target for the time period.

SHMI – in month position is higher than the average for the time period. The rolling average for the period December 2020 to November 2021 is 'higher than expected'.

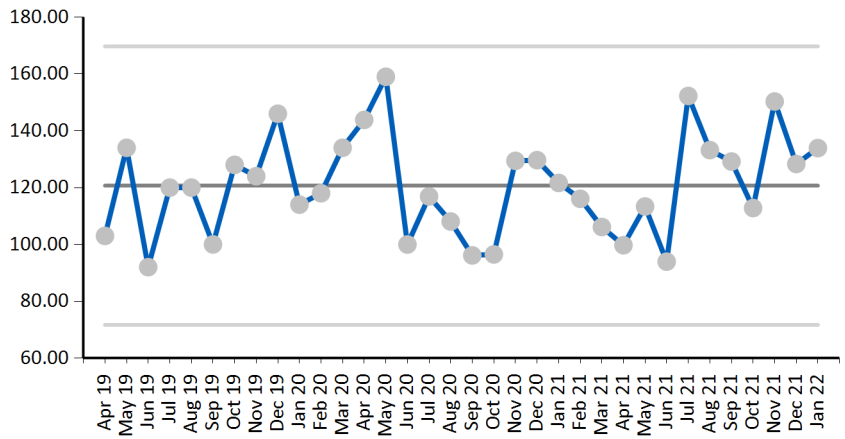
HSMR – in month position is higher than the average for the time period. The rolling average for the period February 2021 to January 2022 is alerting 'red' and is highest amongst peers.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
3 - National Early Warning Scores to Gold standard	>= 85%	100.0%	Apr-22		>= 85%	97.1%	Mar-22	>= 85%	100.0%	
495 - HSMR		133.91	Jan-22			128.31	Dec-21			
11 - Summary Hospital-level Mortality Indicator (SHMI)	<= 100.00	135.70	Nov-21		<= 100.00	125.29	Oct-21	<= 100.00		
12 - Crude Mortality %	<= 2.9%	2.2%	Apr-22		<= 2.9%	2.0%	Mar-22	<= 2.9%	2.2%	

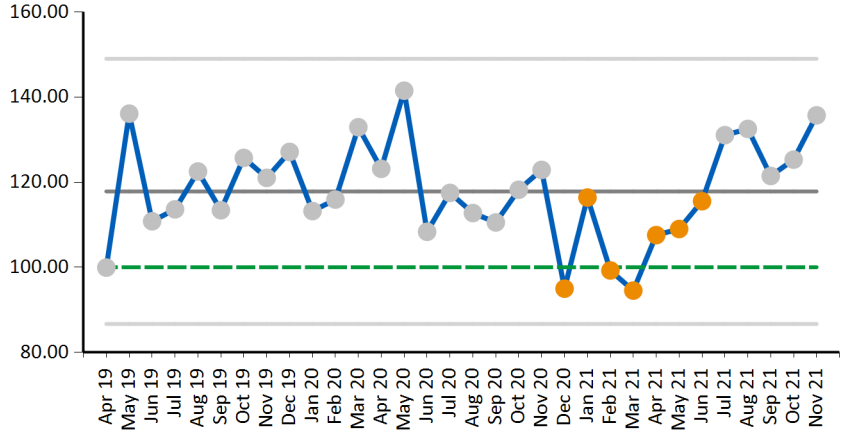
3 - National Early Warning Scores to Gold standard



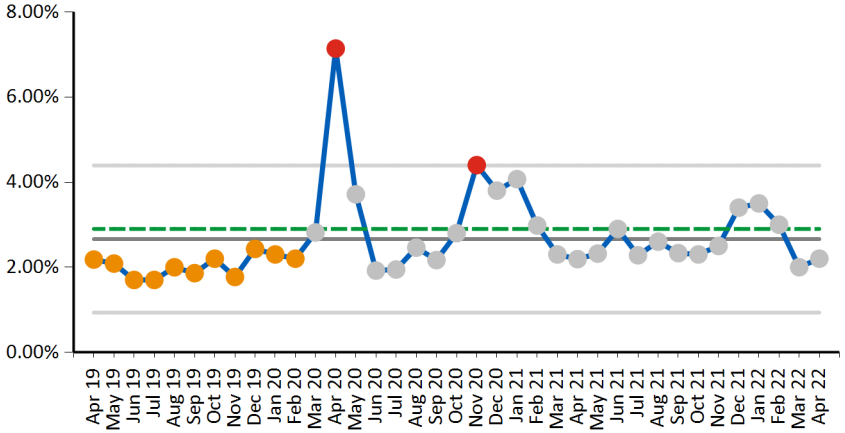
495 - HSMR



11 - Summary Hospital-level Mortality Indicator (SHMI)



12 - Crude Mortality %



Patient Experience

FFT
NHSE continue to publish FFT data on their website and all areas within the Trust have improved their collection methods as safely as possible using QR codes and available devices. The response rates remain varied.

The Patient Experience Team are working with all Divisions to review their collection methods and to identify good practice and work with those areas where improvement is needed. All Divisions have been asked to focus on their recommendation rates as some areas have fallen below 90%. This is monitored in their Divisional Quality Patient Experience Group.

Changes to the Patient Experience Team have been agreed and will take effect over the coming months with a focus on FFT collection and analysis.

Complaints
The Trust rate for acknowledging complaints during April was 100%. The number of formal complaints received has continued to increase with April (28) in comparison to those received in the previous two months March (26) and February (21). Our performance was 35.3% with 11 out of 17 cases breaching. As with all breaches, a review has been undertaken to establish the cause and whether these could have been avoided. The management of complaints is under constant review with collaborative work with the PE team and Divisions.

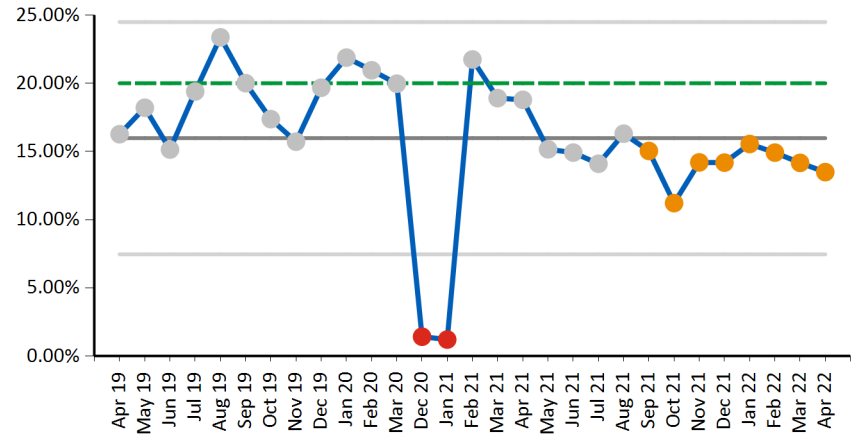
There is currently a focus on quality of responses which is having an impact on timeframes however work continues with divisions regarding the complaints process and timeliness of responses.

Deterioration in Maternity FFT satisfaction rates. The division is working in collaboration with the patient experience team and MVP to triangulate feedback and collate themes. In addition there is a Quality Improvement piece of work underway called 'empowering patients'. This is based on themes from complaints and FFT feedback and is currently in the survey stage. The launch of new 'Helpline' telephone service is planned for 25th May. This will provide direct access to the Family Care Divisional Leadership Team to provide real time intervention and support.

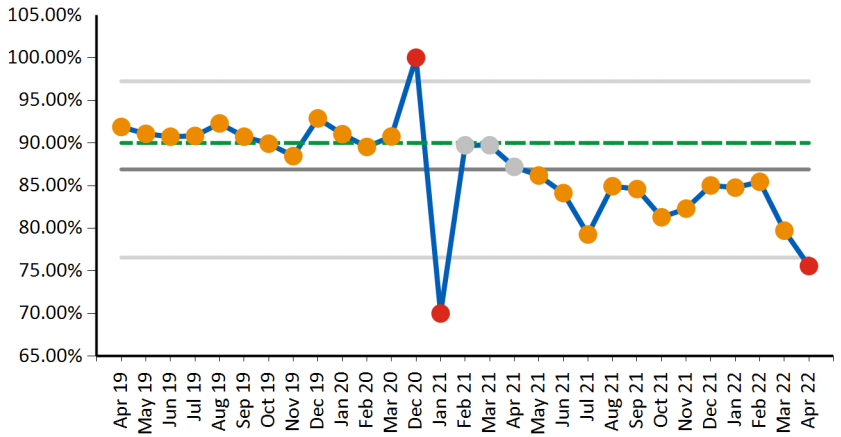
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
200 - A&E Friends and Family Response Rate	>= 20%	13.5%	Apr-22		>= 20%	14.2%	Mar-22	>= 20%	13.5%	
294 - A&E Friends and Family Satisfaction Rates %	>= 90%	75.6%	Apr-22		>= 90%	79.7%	Mar-22	>= 90%	75.6%	
80 - Inpatient Friends and Family Response Rate	>= 30%	20.9%	Apr-22		>= 30%	21.7%	Mar-22	>= 30%	20.9%	
240 - Friends and Family Test (Inpatients) - Satisfaction %	>= 90%	97.0%	Apr-22		>= 90%	95.7%	Mar-22	>= 90%	97.0%	
81 - Maternity Friends and Family Response Rate	>= 15%	19.9%	Apr-22		>= 15%	16.1%	Mar-22	>= 15%	19.9%	
241 - Maternity Friends and Family Test - Satisfaction %	>= 90%	81.5%	Apr-22		>= 90%	82.6%	Mar-22	>= 90%	81.5%	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
82 - Antenatal - Friends and Family Response Rate	>= 15%	17.1%	Apr-22		>= 15%	10.3%	Mar-22	>= 15%	17.1%	
242 - Antenatal Friends and Family Test - Satisfaction %	>= 90%	87.5%	Apr-22		>= 90%	89.1%	Mar-22	>= 90%	87.5%	
83 - Birth - Friends and Family Response Rate	>= 15%	31.6%	Apr-22		>= 15%	29.3%	Mar-22	>= 15%	31.6%	
243 - Birth Friends and Family Test - Satisfaction %	>= 90%	83.1%	Apr-22		>= 90%	79.5%	Mar-22	>= 90%	83.1%	
84 - Hospital Postnatal - Friends and Family Response Rate	>= 15%	16.2%	Apr-22		>= 15%	11.8%	Mar-22	>= 15%	16.2%	
244 - Hospital Postnatal Friends and Family Test - Satisfaction %	>= 90%	69.8%	Apr-22		>= 90%	79.2%	Mar-22	>= 90%	69.8%	
85 - Community Postnatal - Friend and Family Response Rate	>= 15%	11.9%	Apr-22		>= 15%	12.0%	Mar-22	>= 15%	11.9%	
245 - Community Postnatal Friends and Family Test - Satisfaction %	>= 90%	81.8%	Apr-22		>= 90%	87.5%	Mar-22	>= 90%	81.8%	
89 - Formal complaints acknowledged within 3 working days	= 100%	100.0%	Apr-22		= 100%	100.0%	Mar-22	= 100%	100.0%	
90 - Complaints responded to within the period	>= 95%	35.3%	Apr-22		>= 95%	36.4%	Mar-22	>= 95%	35.3%	

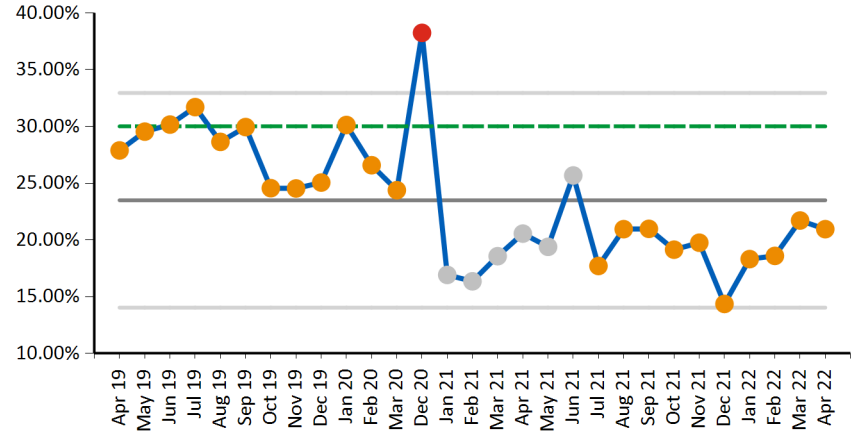
200 - A&E Friends and Family Response Rate



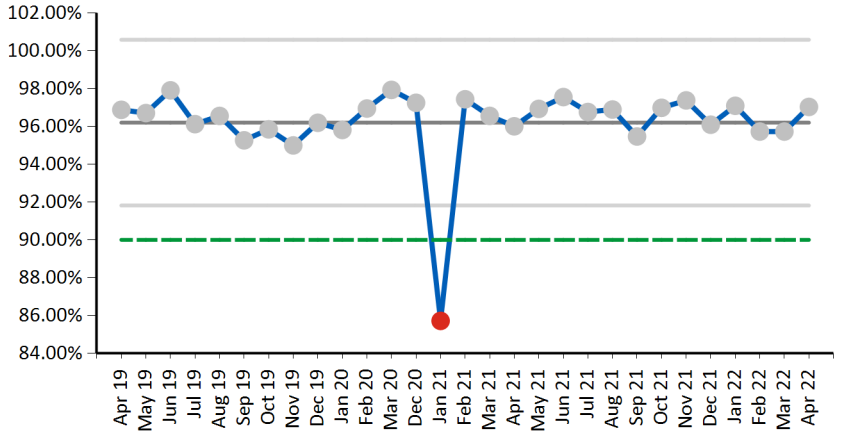
294 - A&E Friends and Family Satisfaction Rates %



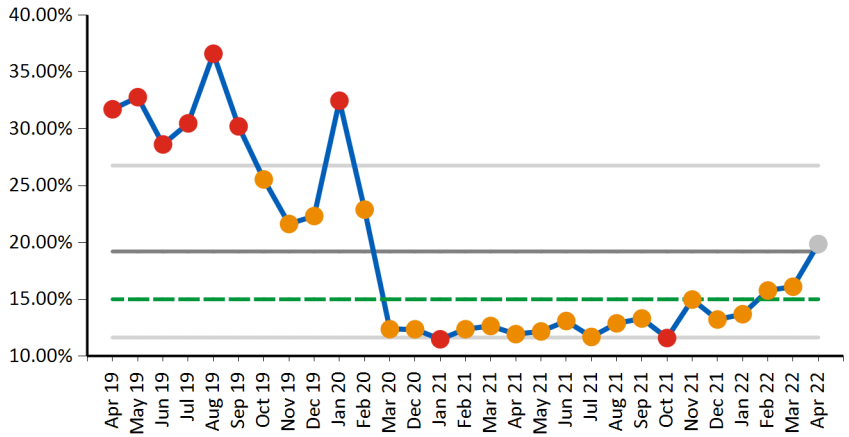
80 - Inpatient Friends and Family Response Rate



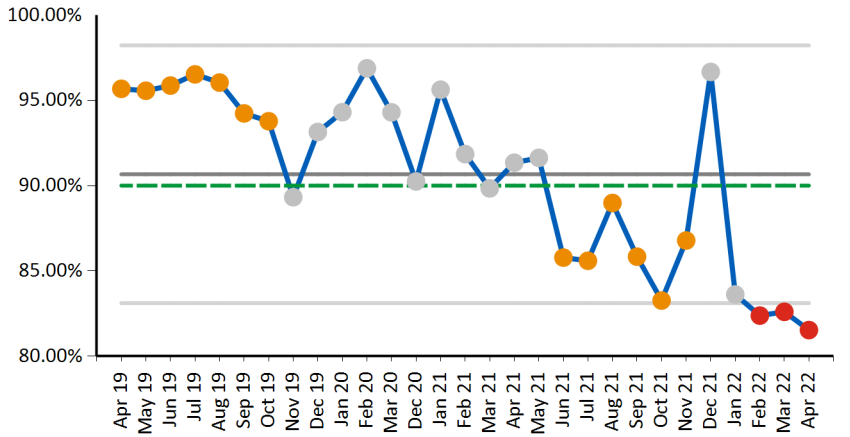
240 - Friends and Family Test (Inpatients) - Satisfaction %



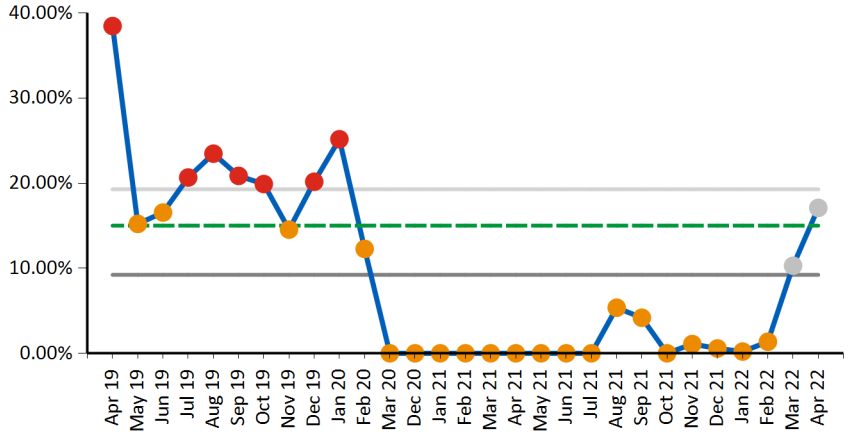
81 - Maternity Friends and Family Response Rate



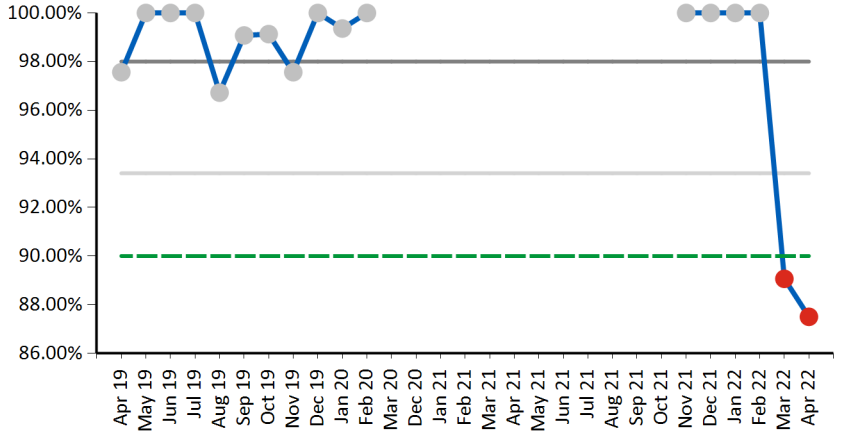
241 - Maternity Friends and Family Test - Satisfaction %



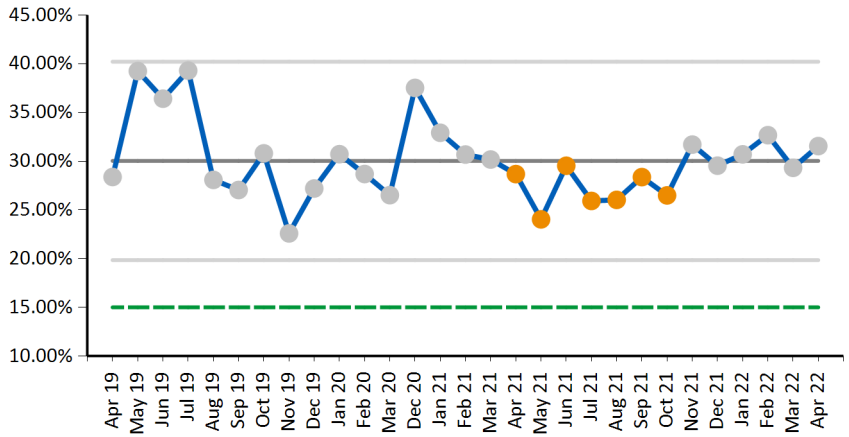
82 - Antenatal - Friends and Family Response Rate



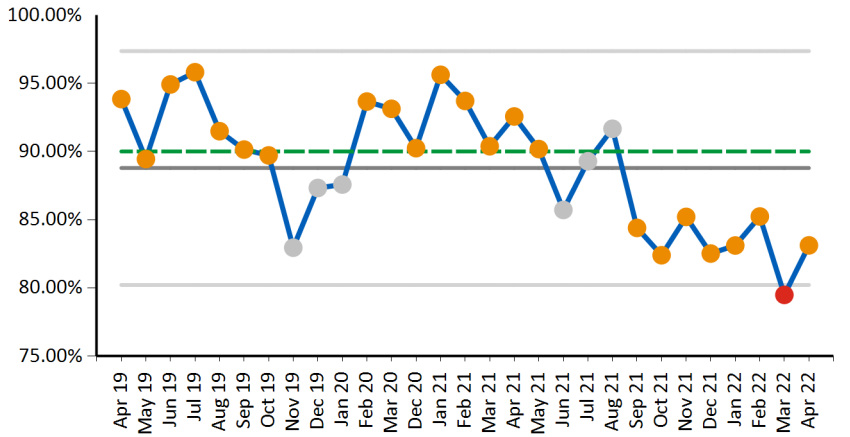
242 - Antenatal Friends and Family Test - Satisfaction %



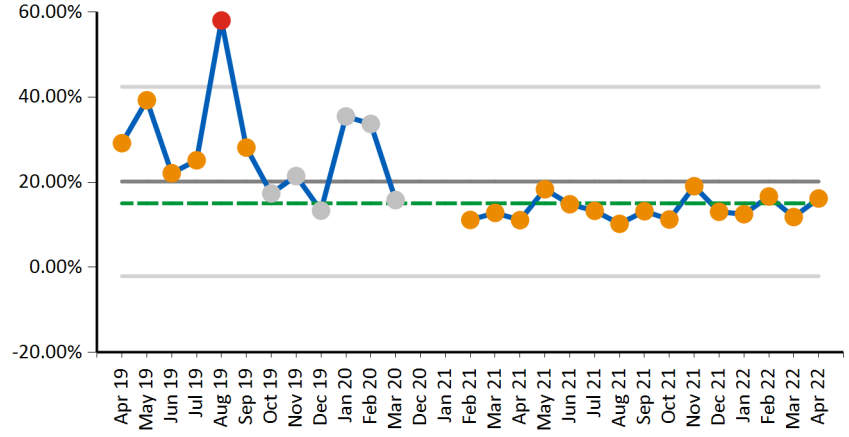
83 - Birth - Friends and Family Response Rate



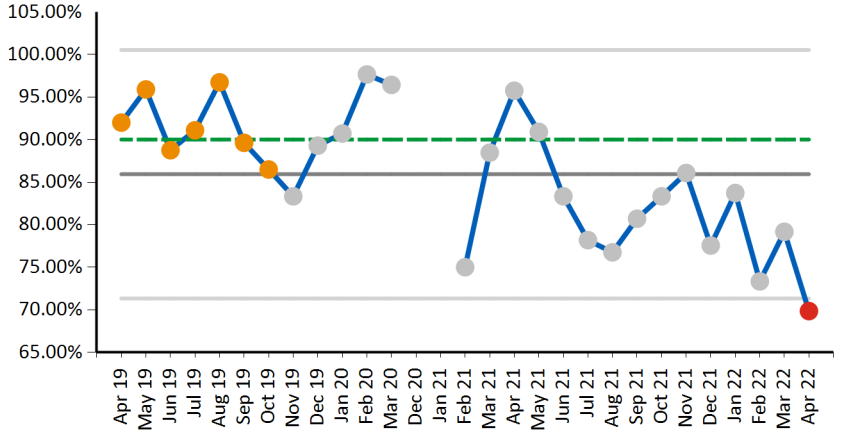
243 - Birth Friends and Family Test - Satisfaction %



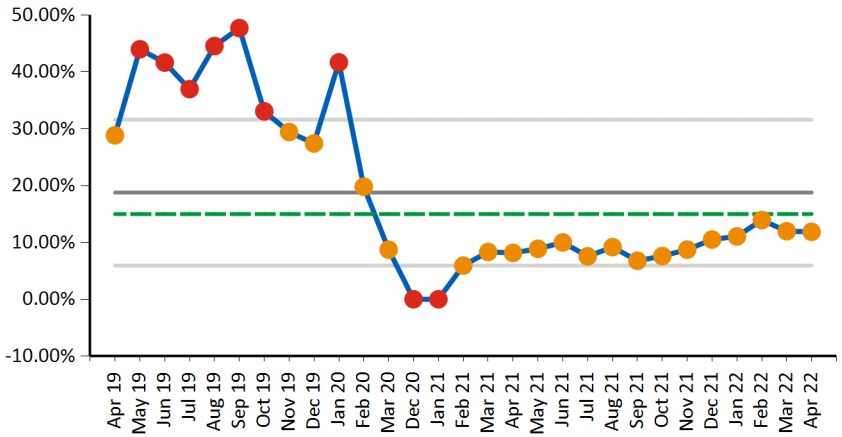
84 - Hospital Postnatal - Friends and Family Response Rate



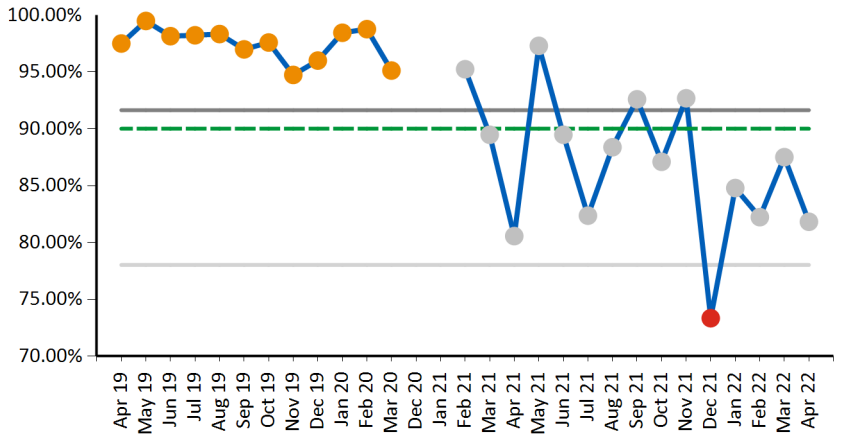
244 - Hospital Postnatal Friends and Family Test - Satisfaction %



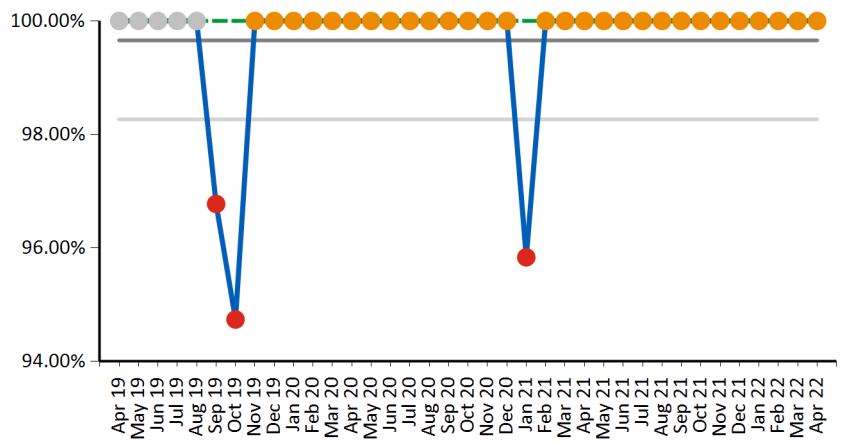
85 - Community Postnatal - Friend and Family Response Rate



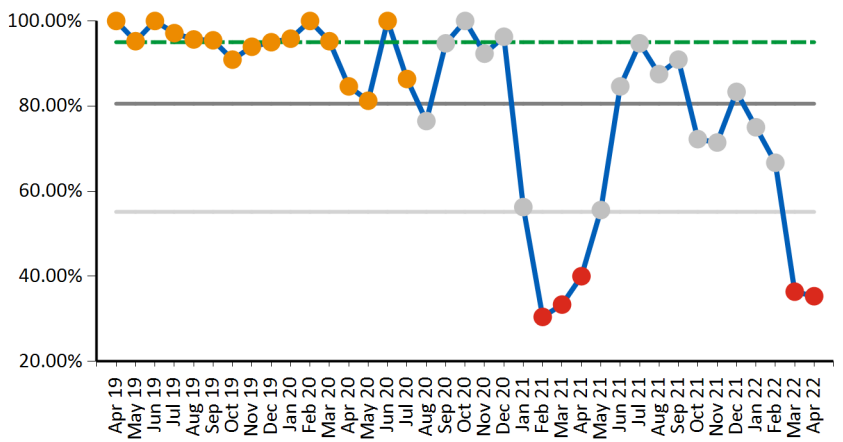
245 - Community Postnatal Friends and Family Test - Satisfaction %



89 - Formal complaints acknowledged within 3 working days



90 - Complaints responded to within the period



Maternity

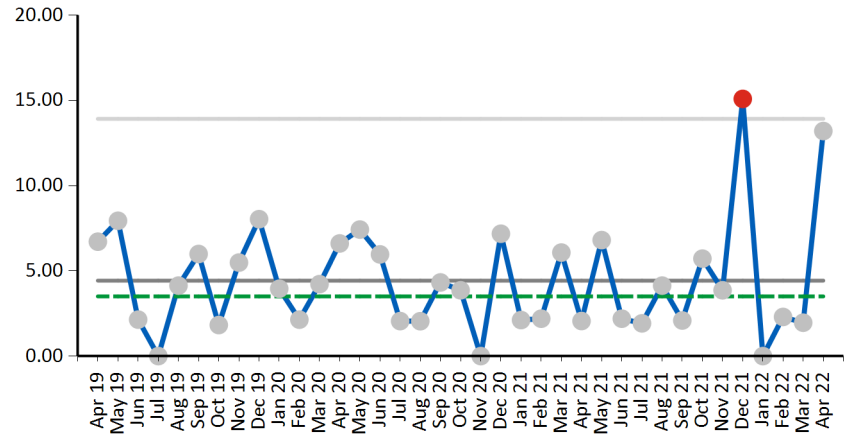
Stillbirth
There were 6 still births in April and 456 live births. The stillbirth rate for April was 1.31% of all births, and 13.15% per 1000 births.
The rolling stillbirth rate is 4.9 per 1000, remaining above the target of 3.5 per 1000. The 6 stillbirths in April included 1 twin pregnancy loss, 1 fetal abnormality, and 1 compassionate termination for known fetal abnormality. A MDT Rapid review has been completed on all cases, with no further action required on all but 1 which was scoped for SI, and the same case referred to HSIB.

% Bookings by 12+6-
Divisional Integrated dashboard figures for April states compliance 88% not 86.1%. Compliance remains lower than target (90%). Breaches consist of 54 late presentations resulting in unavoidable delay, and 41 DNA. Ongoing work led by matrons to improve DNA rate. 10 breaches due to reduced ultrasound capacity. Scan capacity and demand being monitored by Family care and Diagnostic Division. Monitored on the Risk Register- currently 20.

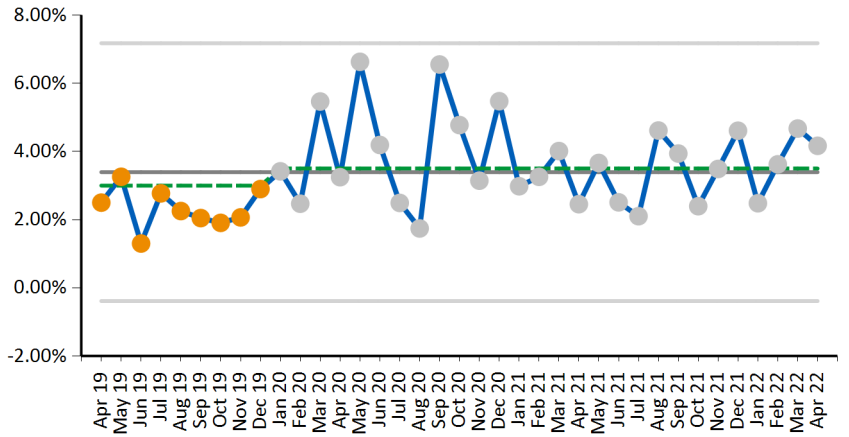
3rd and 4th Degree tears- Rate reduced from March 2022, however rolling rate (3.5%) remains above target (3%). Implementation of OASI training in March 2022 and Commencement of Pastoral support practice educators on the Delivery suite will continue to reduce the incidence of OASI. Monthly audits continue for all incidence of OASI.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
322 - Maternity - Stillbirths per 1000 births	<= 3.50	13.20	Apr-22		<= 3.50	1.96	Mar-22	<= 3.50	13.16	
23 - Maternity -3rd/4th degree tears	<= 3.5%	4.2%	Apr-22		<= 3.5%	4.7%	Mar-22	<= 3.5%	4.2%	
202 - 1:1 Midwifery care in labour	>= 95.0%	97.3%	Apr-22		>= 95.0%	98.5%	Mar-22	>= 95.0%	97.3%	P
203 - Booked 12+6	>= 90.0%	86.1%	Apr-22	L	>= 90.0%	87.2%	Mar-22	>= 90.0%	86.1%	
204 - Inductions of labour	<= 40%	36.1%	Apr-22		<= 40%	36.5%	Mar-22	<= 40%	36.1%	
208 - Total C section	<= 33.0%	41.5%	Apr-22	H	<= 33.0%	37.1%	Mar-22	<= 33.0%	41.5%	
210 - Initiation breast feeding	>= 65%	65.92%	Apr-22	L	>= 65%	66.60%	Mar-22	>= 65%	65.92%	
213 - Maternity complaints	<= 5	10	Apr-22	H	<= 5	0	Feb-22	<= 5	10	
319 - Maternal deaths (direct)	= 0	0	Apr-22		= 0	0	Mar-22	= 0	0	
320 - Rate of Preterm births (rate <37 weeks as a percentage of all births)	<= 6%	9.9%	Apr-22		<= 6%	6.5%	Mar-22	<= 6%	9.9%	

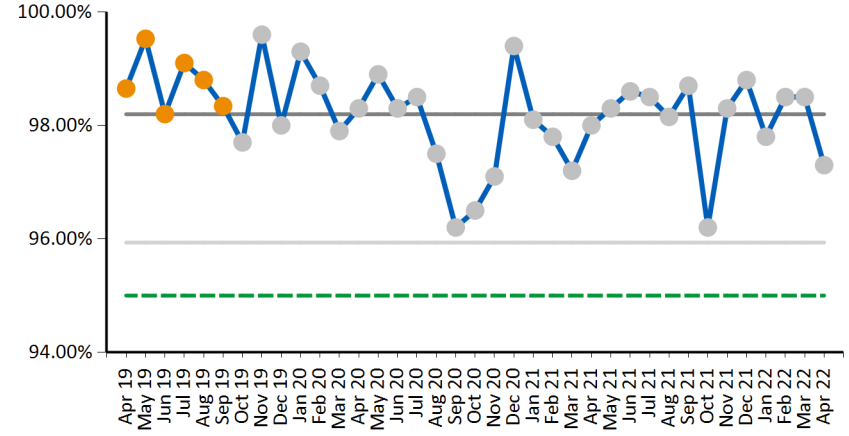
322 - Maternity - Stillbirths per 1000 births



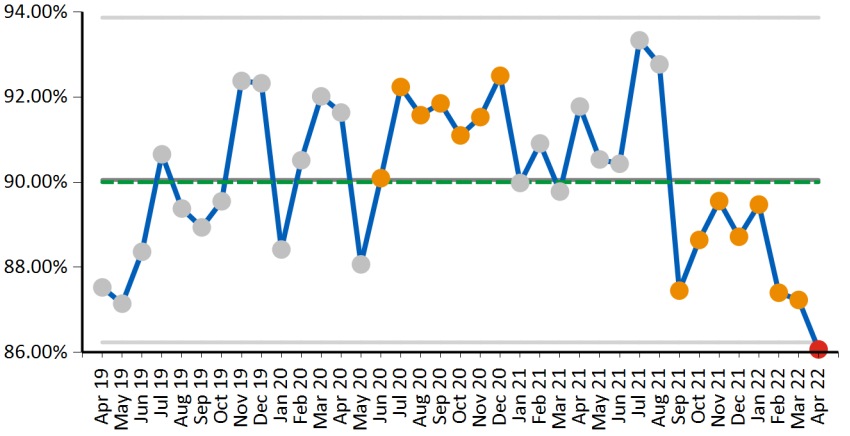
23 - Maternity -3rd/4th degree tears



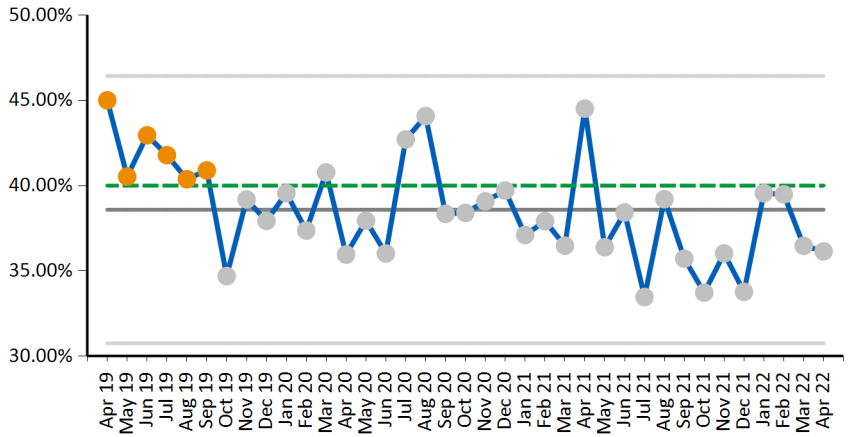
202 - 1:1 Midwifery care in labour



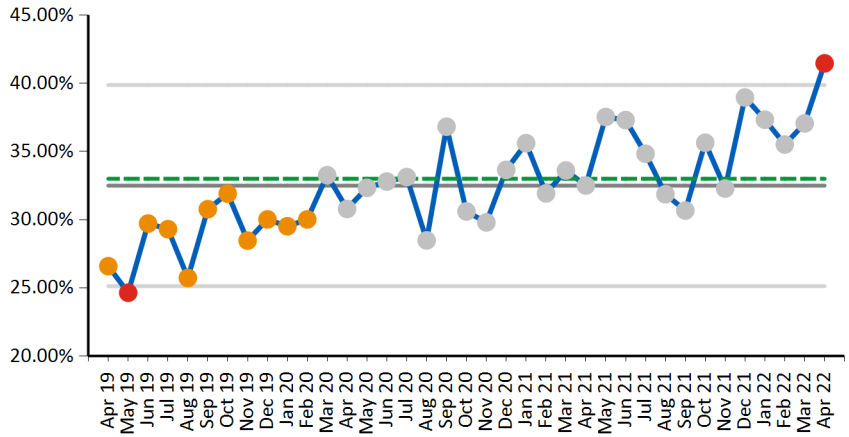
203 - Booked 12+6



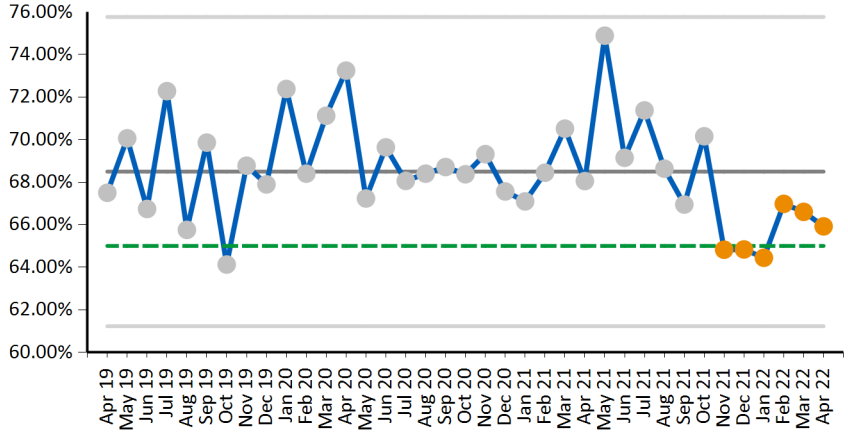
204 - Inductions of labour



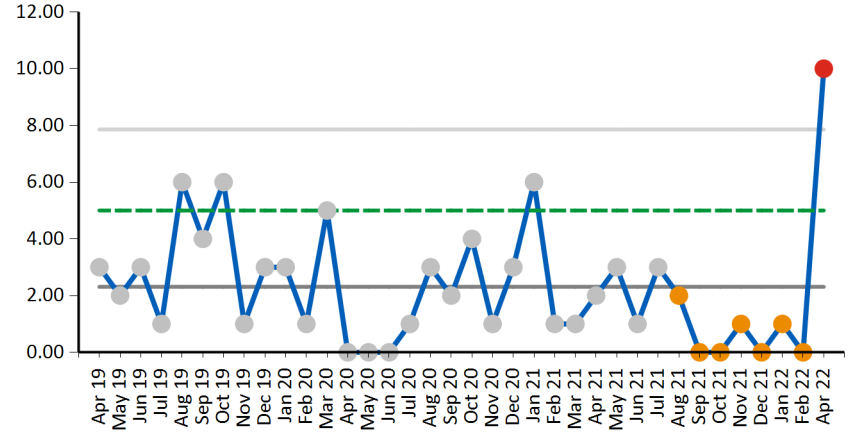
208 - Total C section



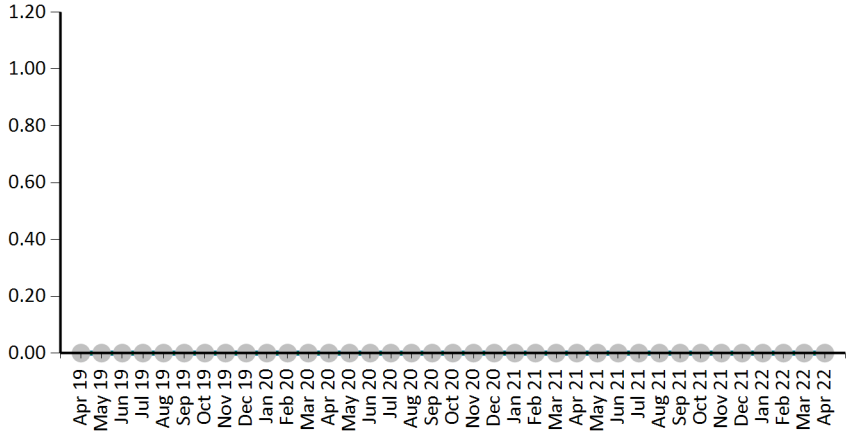
210 - Initiation breast feeding



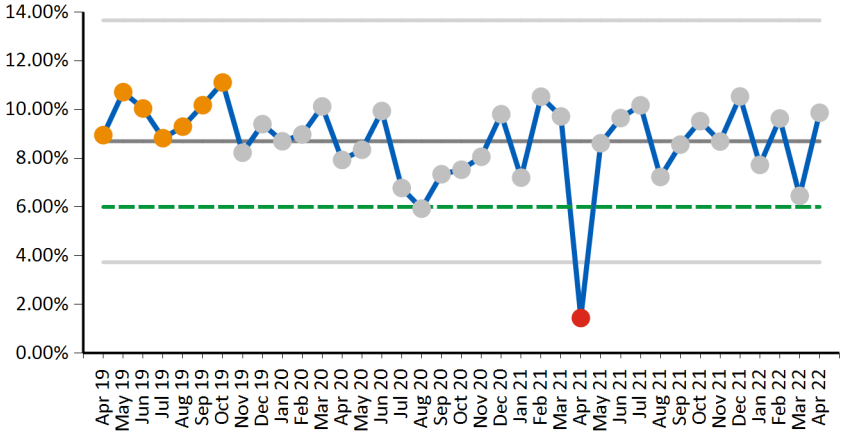
213 - Maternity complaints



319 - Maternal deaths (direct)



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



Operational Performance

Access

Urgent Care
Urgent Care remains a major challenge for the Trust with particular challenges in relation to the 12 hour standard and ambulance handovers over 30 and 60 minutes.

A task and finish group is in place with the intention of launching new same day emergency care pathways in by the end of June 2022. This will be delivered in a staged approach ahead of winter and will see CDU return to a medical admissions unit. Medical staffing recruitment remains a risk to the delivery of this, however a skill mix approach is being explored.

There has been a decline in performance in relation to ambulance turnaround times and 4 hour performance in month1 though some improvement is being seen in month 2.

Work is underway to develop the clinical strategy for urgent care and meetings with Archus will take place over the coming months.

NHSE have visited in May and the a key area of focus will be ensuring that the system addresses the 10 outstanding national criteria in relation to urgent treatment centre in Bolton

RTT
104 week waits continue to reduce and the trust remains on track to reduce all 104+ week waits to zero by 1st July.
RTT performance and 52 week waiting patients remains static as the focus continues to be on ensuring that all specialties reduce their 104 week waits chronologically.
The 18 week waiting list is increasing, this continues to be related to reduced outpatient activity in Ophthalmology, an action plan to improve this is in progress.

DM01
The Trust position for DM01 decreased by 2.3% in April to a final position of 64.6% compliance.

Performance for MRI, CT, Fluoroscopy, Flexi Sigmoidoscopy and Gastroscopy has recovered and these modalities are now compliant with national DM01 targets.

Cardio Echo position improved in month as a result of additional locum support to facilitate extra lists.

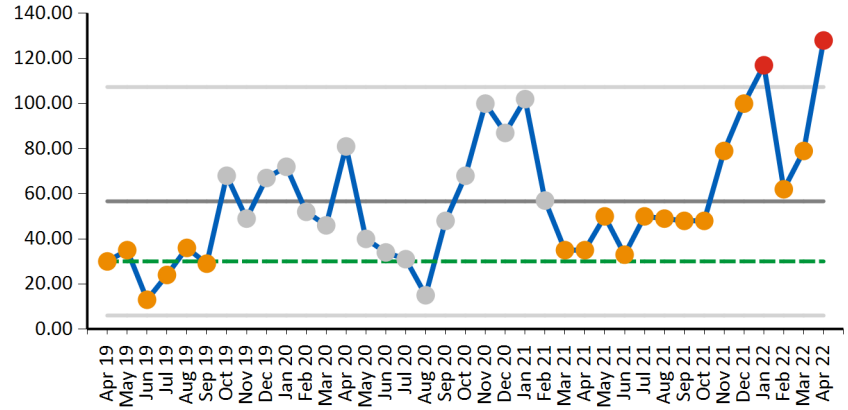
Cystoscopy compliance decreased in month. Additional support from an extra consultant will commence in June.
Urodynamic Screening (UDS) performance decreased in month, additional sessions are scheduled in May to recover this position.

Ongoing staffing pressures in Ultrasound and both Adult and Paediatric Audiological services mean that recovery for these service will take some time.

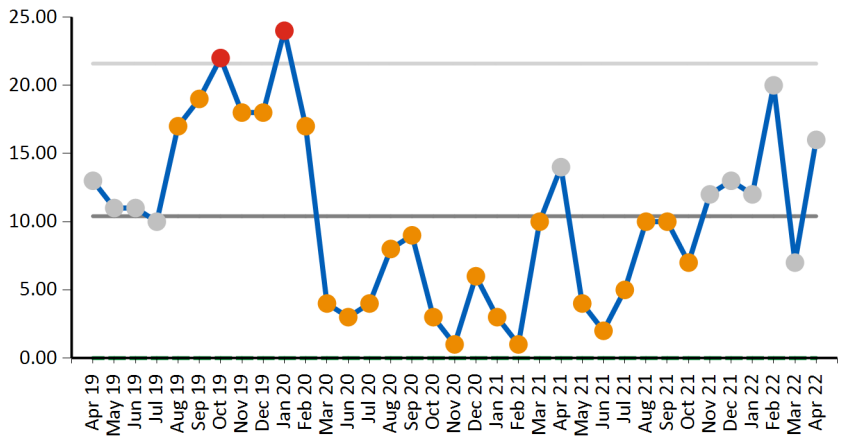
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)	<= 30	128	Apr-22		<= 30	79	Mar-22	<= 30	128	
8 - Same sex accommodation breaches	= 0	16	Apr-22		= 0	7	Mar-22	= 0	16	

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur	>= 75%	47.1%	Apr-22		>= 75%	51.1%	Mar-22	>= 75%	47.1%	
41 - RTT Incomplete pathways within 18 weeks %	>= 92%	65.3%	Apr-22		>= 92%	65.4%	Mar-22	>= 92%	65.3%	
42 - RTT 52 week waits (incomplete pathways)	= 0	1,660	Apr-22		= 0	1,588	Mar-22	= 0	1,660	
314 - RTT 18 week waiting list	<= 25,530	33,598	Apr-22		<= 25,530	32,659	Mar-22	<= 25,530	33,598	
53 - A&E 4 hour target	>= 95%	58.4%	Apr-22		>= 95%	59.8%	Mar-22	>= 95%	58.4%	
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)	= 0.0%	14.4%	Apr-22		= 0.0%	14.2%	Mar-22	= 0.0%	14.4%	
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)	= 0.00%	15.37%	Apr-22		= 0.00%	14.24%	Mar-22	= 0.00%	15.37%	
72 - Diagnostic Waits >6 weeks %	<= 1%	35.4%	Apr-22		<= 1%	33.1%	Mar-22	<= 1%	35.4%	
27 - TIA (Transient Ischaemic attack) patients seen <24hrs	= 100%	87.5%	Apr-22		= 100%	100.0%	Mar-22	= 100%	87.5%	

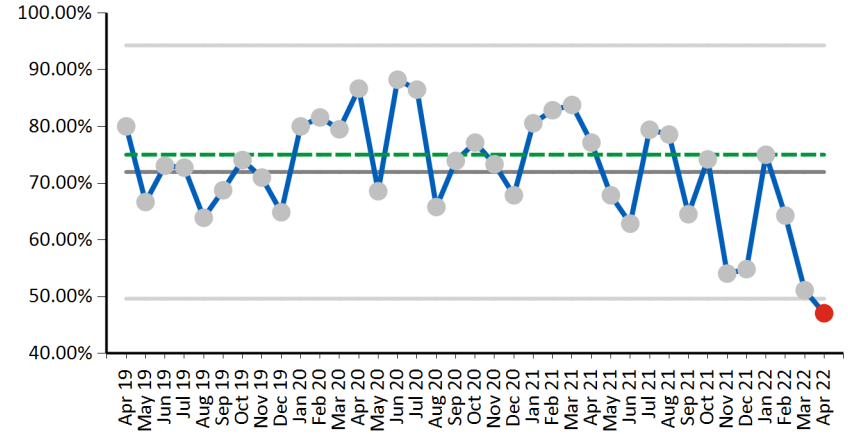
7 - Transfers between 11pm and 6am (excluding transfers from assessment wards)



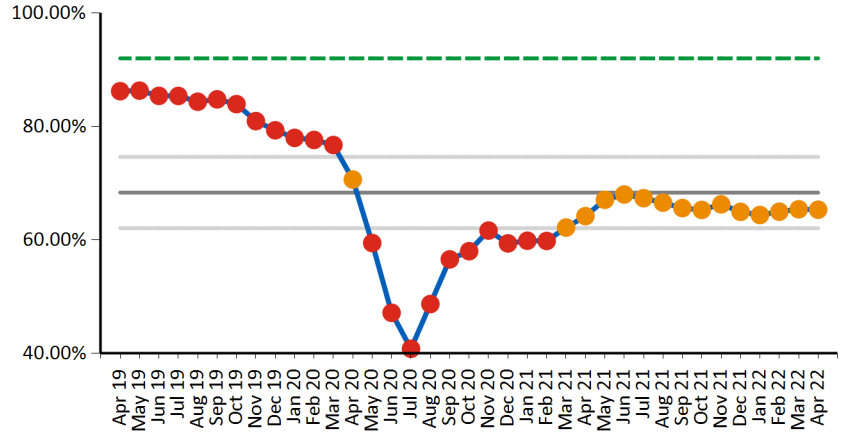
8 - Same sex accommodation breaches



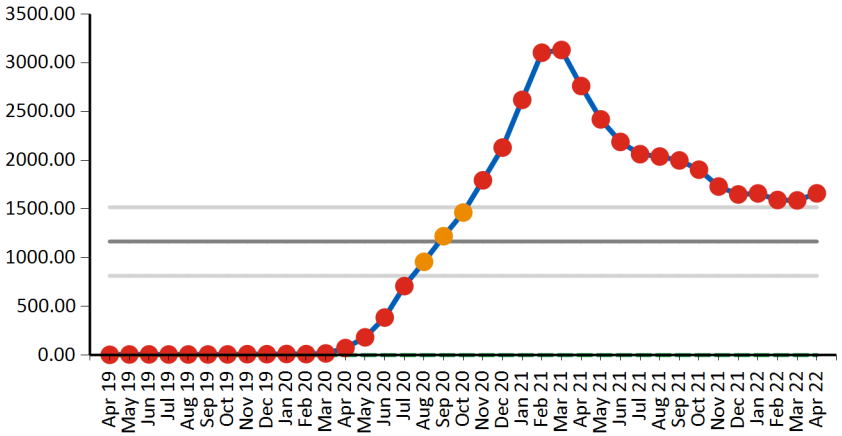
26 - Patients going to theatre within 36 hours of a fractured Neck of Femur



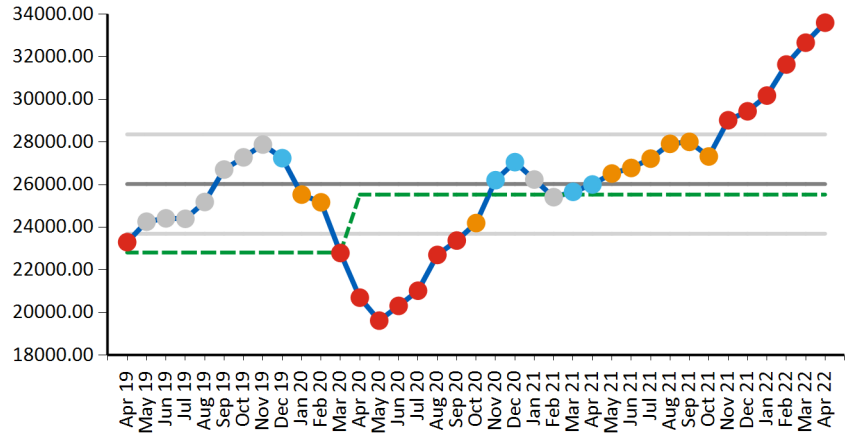
41 - RTT Incomplete pathways within 18 weeks %



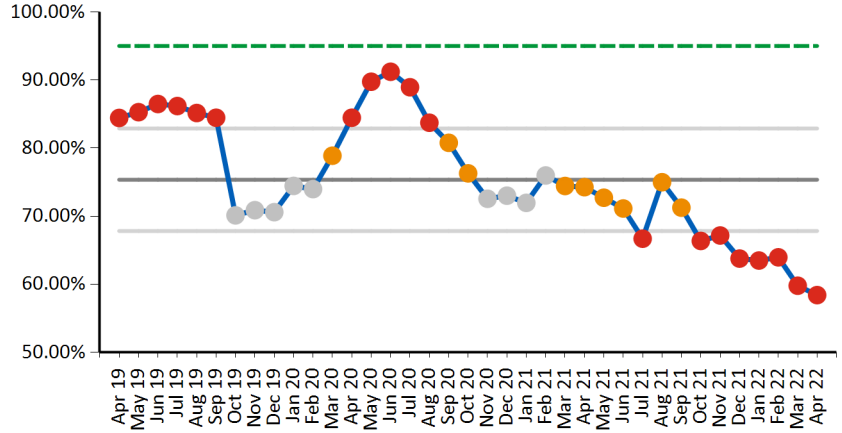
42 - RTT 52 week waits (incomplete pathways)



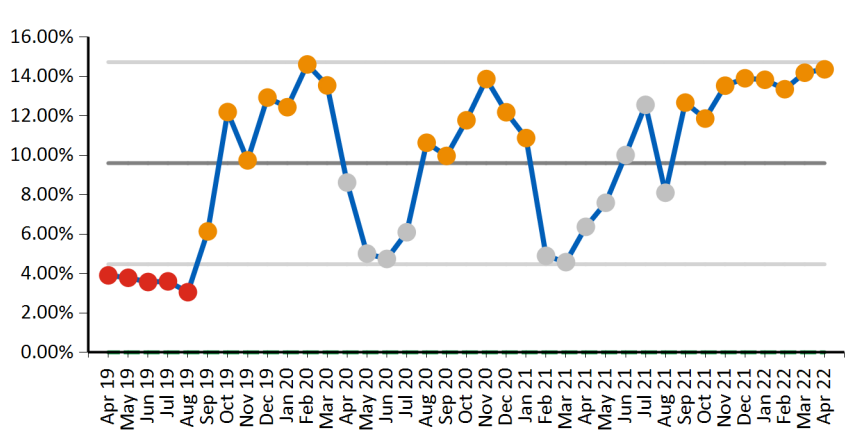
314 - RTT 18 week waiting list



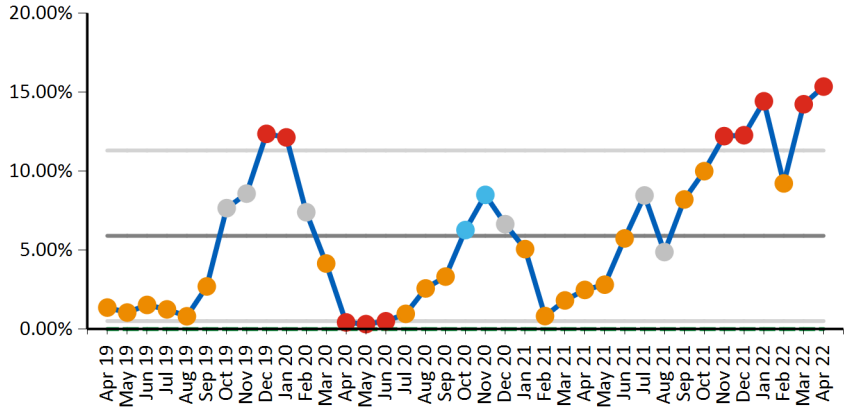
53 - A&E 4 hour target



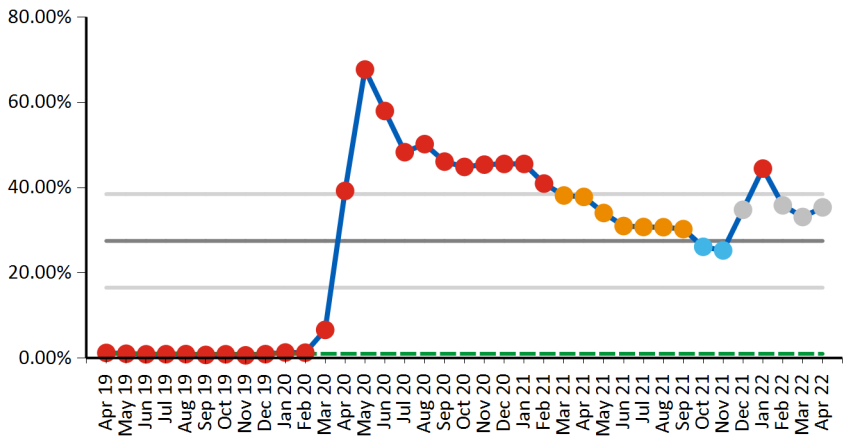
70 - Ambulance handovers to take place within 15 minutes (no of patients waiting > 30 mins<59 mins)



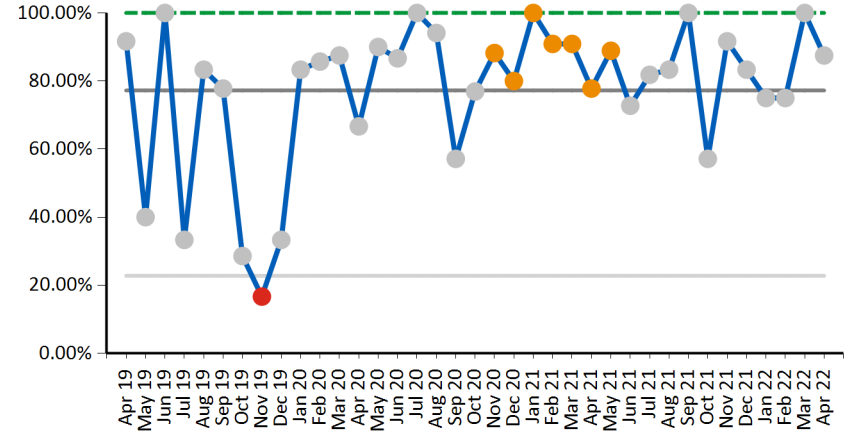
71 - Ambulance handovers must take place within 15 minutes (no of patients waiting > 60 mins)



72 - Diagnostic Waits >6 weeks %



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



Productivity

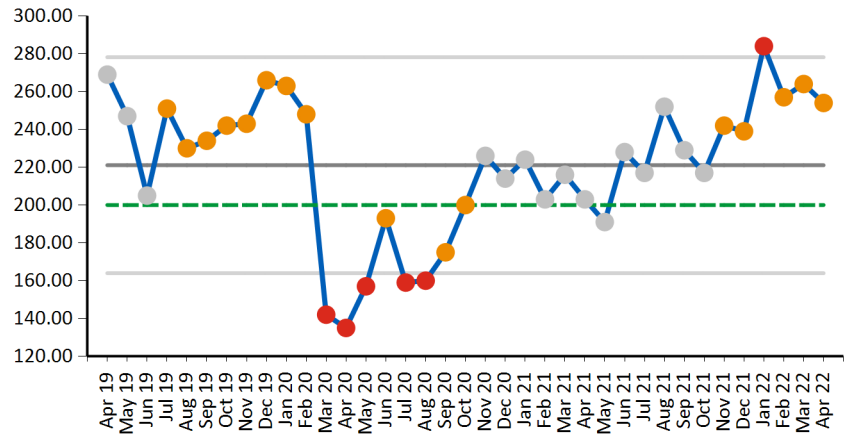
The proportion of cancelled operations re-booked within 28 days significantly improved in month. The Access Booking and Choice team continue to focus on improving this position.

The Trust continues to experience pressure around reducing the number of patients at any one time with no Criteria to Reside (NCTR), and the length of time these patients remain in hospital. We are working with system partners to support the improvement of this indicator, and have implemented a number of recommendations from the Emergency Care Improvement Support Team (ECIST), with further support from them planned. The Integrated Care Partnership (ICP) has also commissioned AQuA to work with us to review whole system flow and implement any required new service models; this is currently in the diagnostic phase.

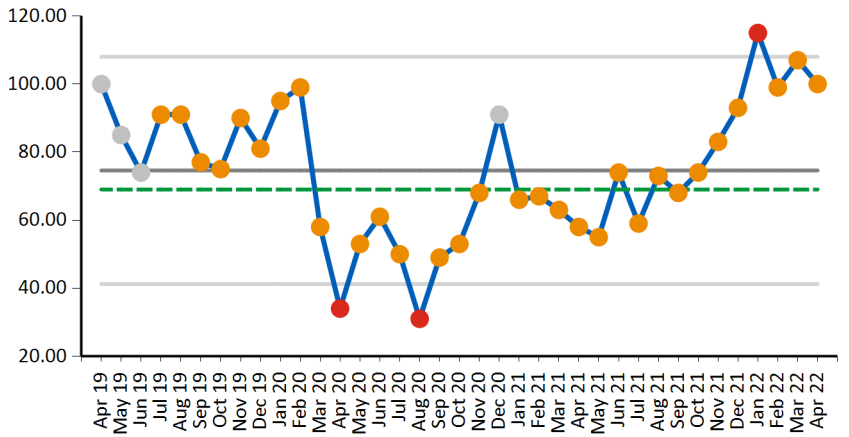
	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
56 - Stranded patients	<= 200	254	Apr-22	H	<= 200	264	Mar-22	<= 200	254	?
307 - Stranded Patients - LOS 21 days and over	<= 69	100	Apr-22	H	<= 69	107	Mar-22	<= 69	100	?
57 - Discharges by Midday	>= 30%	20.3%	Apr-22		>= 30%	19.2%	Mar-22	>= 30%	20.3%	F
58 - Discharges by 4pm	>= 70%	59.2%	Apr-22	L	>= 70%	55.2%	Mar-22	>= 70%	59.2%	F
59 - Re-admission within 30 days of discharge (1 mth in arrears)	<= 13.5%	10.8%	Mar-22	L	<= 13.5%	9.6%	Feb-22	<= 13.5%		?
489 - Daycase Rates	>= 80%	89.5%	Apr-22		>= 80%	90.2%	Mar-22	>= 80%	89.5%	P
61 - Operations cancelled on the day for non-clinical reasons	<= 1%	1.7%	Apr-22		<= 1%	1.8%	Mar-22	<= 1%	1.7%	?
62 - Cancelled operations re-booked within 28 days	= 100%	74.3%	Apr-22		= 100%	23.9%	Mar-22	= 100%	25.7%	?
65 - Elective Length of Stay (Discharges in month)	<= 2.00	2.93	Apr-22		<= 2.00	2.99	Mar-22	<= 2.00	2.93	?
66 - Non Elective Length of Stay (Discharges in month)	<= 3.70	4.37	Apr-22		<= 3.70	4.20	Mar-22	<= 3.70	4.37	?
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears)	>= 80%	63.2%	Mar-22		>= 80%	66.7%	Feb-22	>= 80%		?
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision	= 0	41	Apr-22	H	= 0	44	Mar-22	= 0	41	P

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
493 - Average Number of Patients: with no Criteria to Reside	>= 55	110	Apr-22			112	Mar-22	>= 55	110	
494 - Average Occupied Days - for no Criteria to Reside		1,184	Apr-22			1,220	Mar-22		1,184	
496 - Average bed days since patients with LOS >14 days moved onto NCTR list		1,107	Mar-22			1,255	Feb-22	>= 1,380		

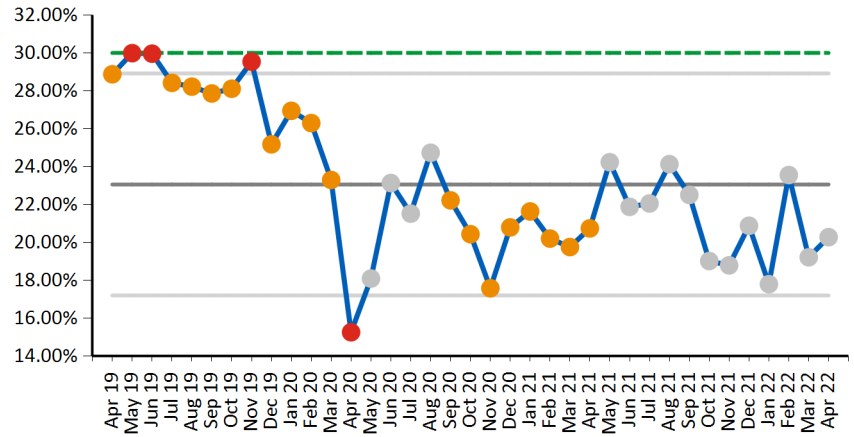
56 - Stranded patients



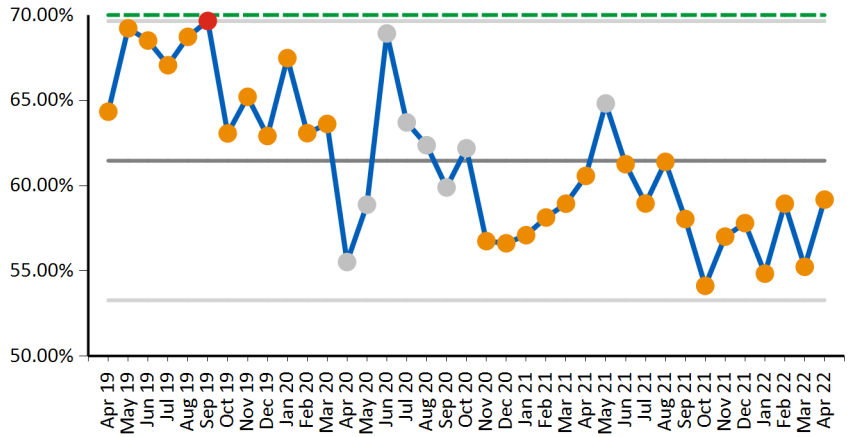
307 - Stranded Patients - LOS 21 days and over



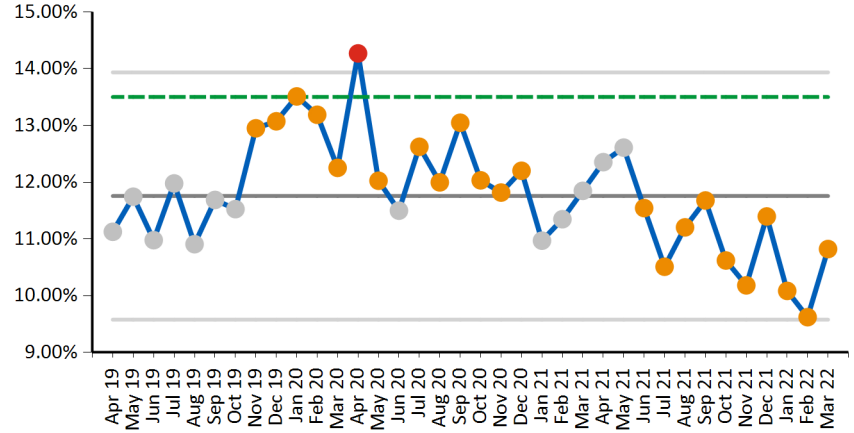
57 - Discharges by Midday



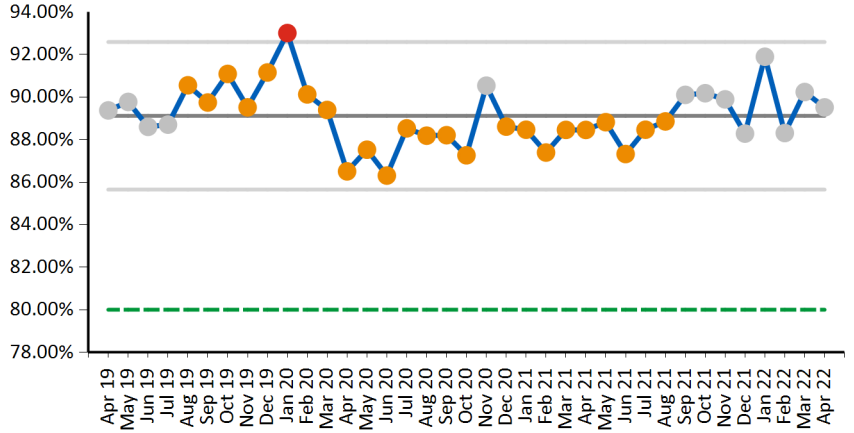
58 - Discharges by 4pm



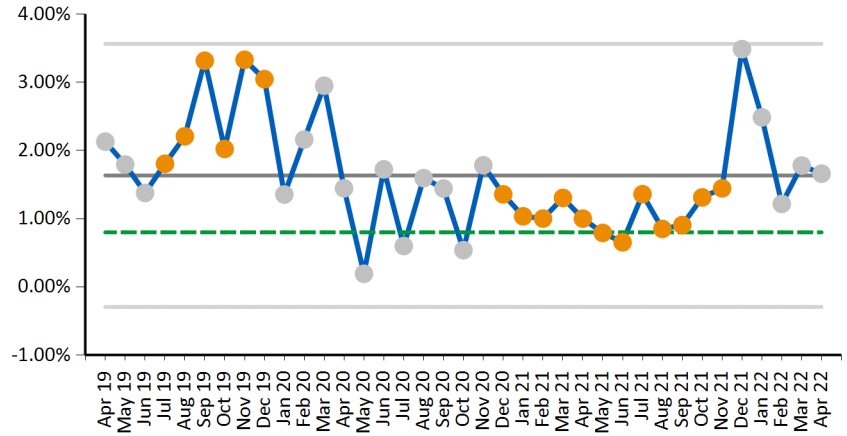
59 - Re-admission within 30 days of discharge (1 mth in arrears)



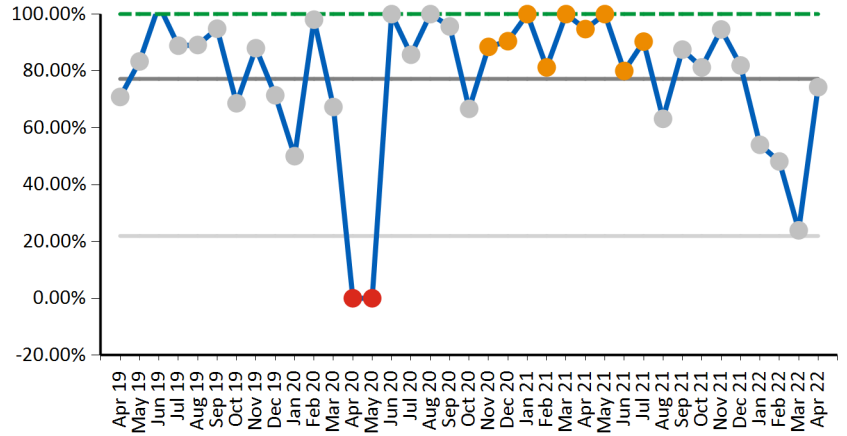
489 - Daycase Rates



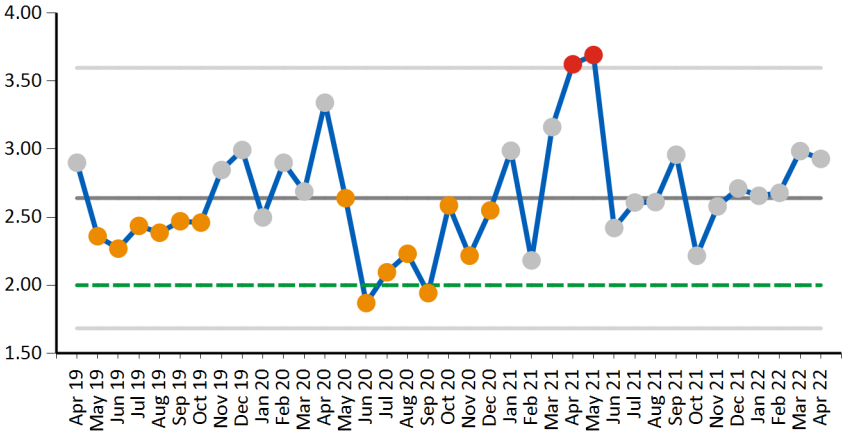
61 - Operations cancelled on the day for non-clinical reasons



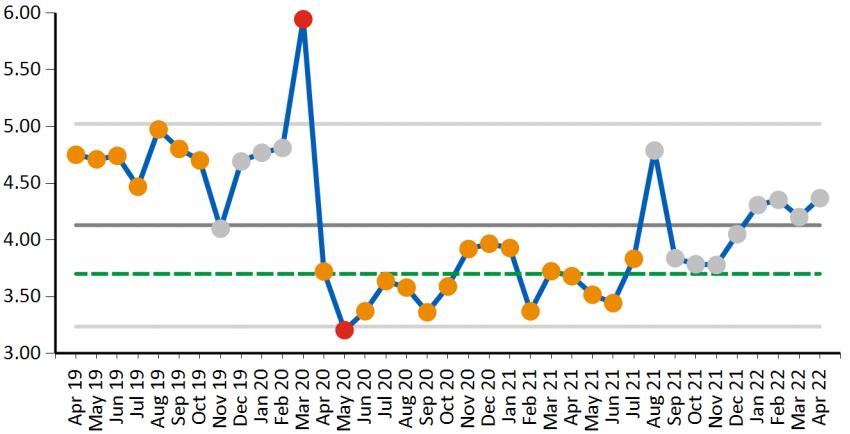
62 - Cancelled operations re-booked within 28 days



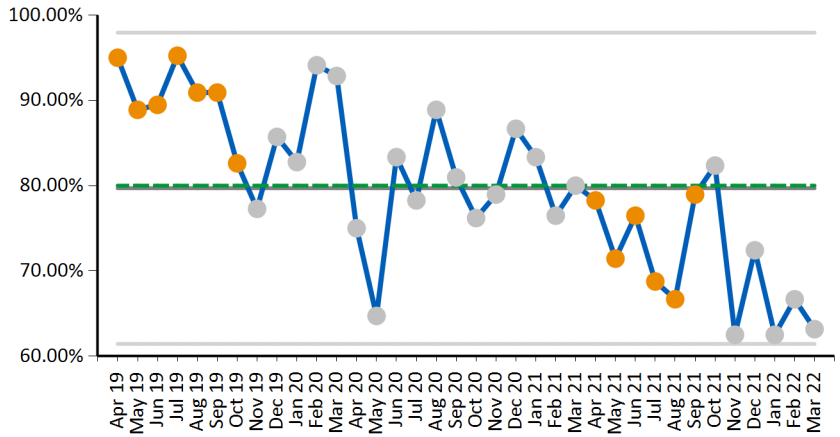
65 - Elective Length of Stay (Discharges in month)



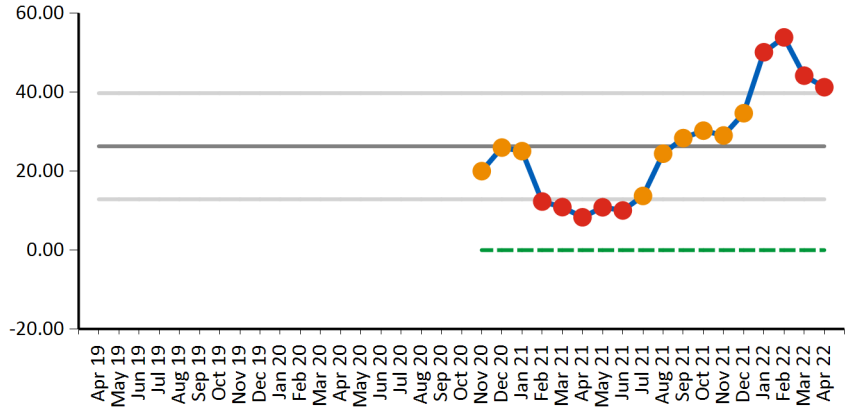
66 - Non Elective Length of Stay (Discharges in month)



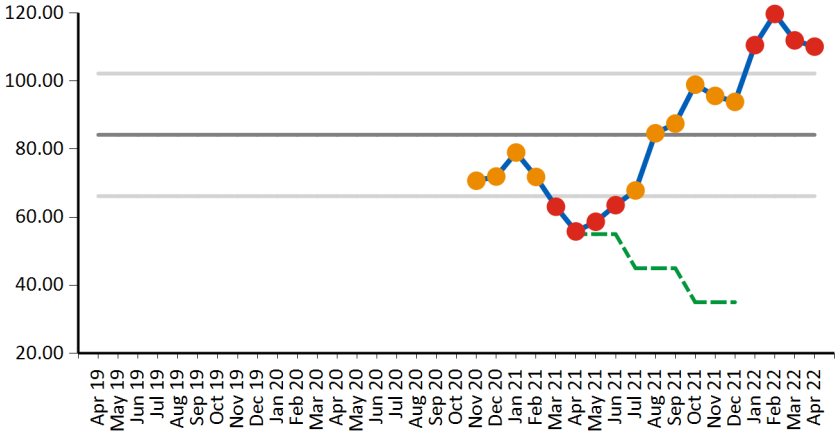
73 - % of patients who spend 90% of their stay on the stroke unit (1 mth in arrears



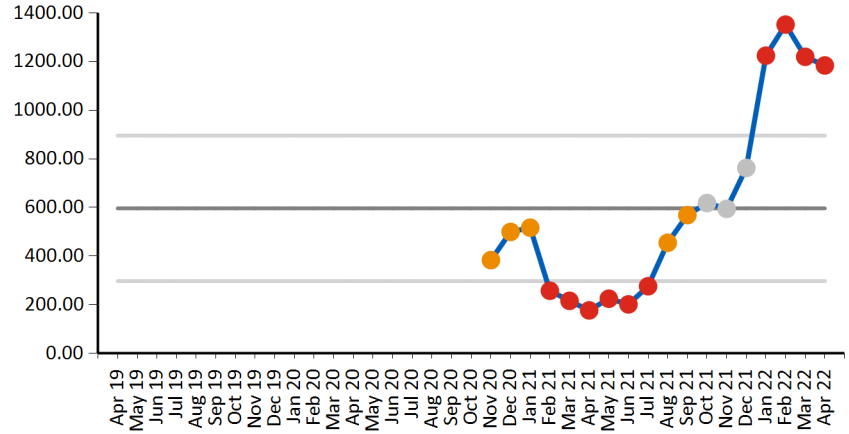
492 - Average Number of Patients: Criteria to Reside number 7+ Days Post Decision



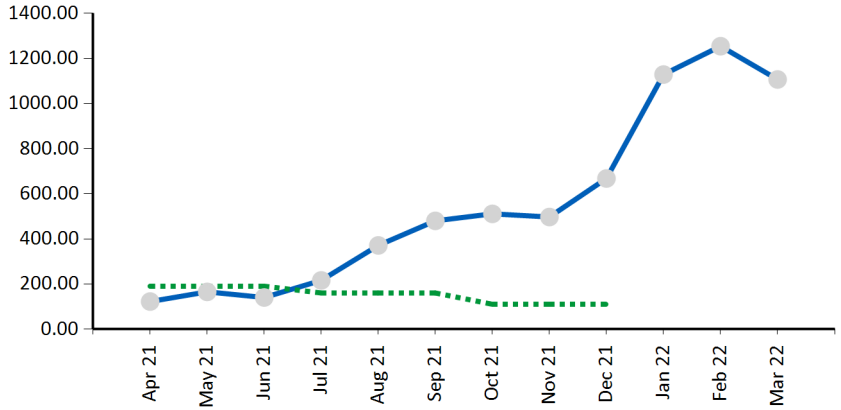
493 - Average Number of Patients: with no Criteria to Reside



494 - Average Occupied Days - for no Criteria to Reside



496 - Average bed days since patients with LOS >14 days moved onto NCTR list - SPC data available after 20 data points

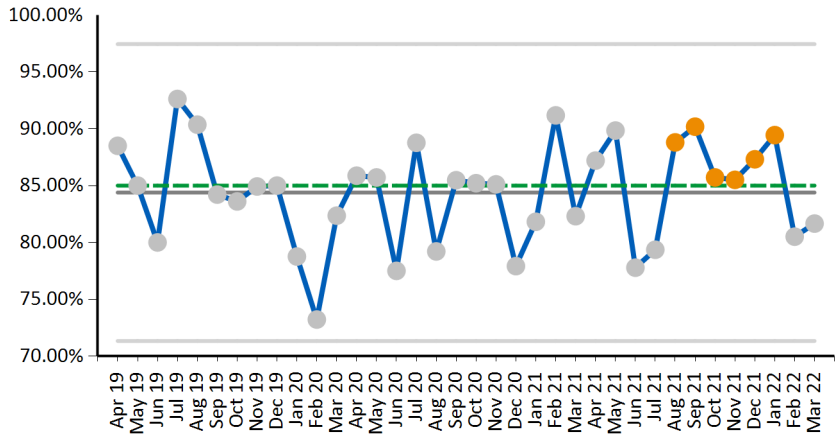


Cancer

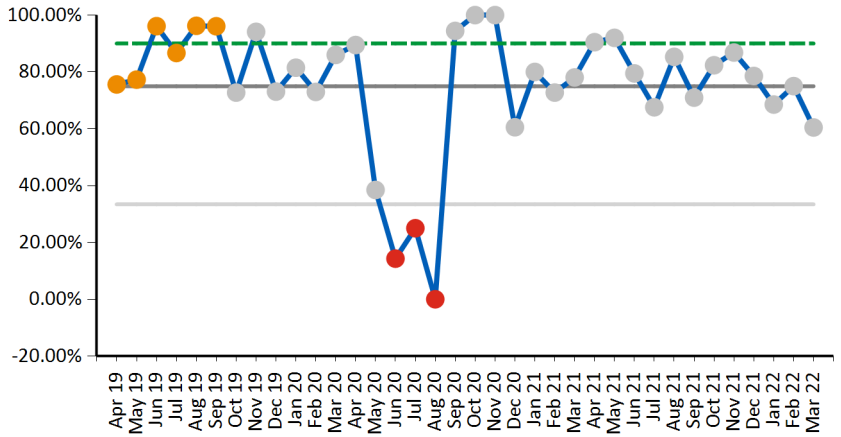
The trust has failed the 62 day performance for March at 81.82% and is predicted to fail in April also. This is related to breaches in Colorectal, Urology and Breast following an increase in referrals and service pressures arising from assessing treating a higher volume of patients.
Each specialty has an improvement action plan in place focusing on pathway efficiency, capacity building and demand management.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
46 - 62 day standard % (1 mth in arrears)	>= 85%	81.7%	Mar-22		>= 85%	80.5%	Feb-22	>= 85%		?
47 - 62 day screening % (1 mth in arrears)	>= 90%	60.5%	Mar-22		>= 90%	75.0%	Feb-22	>= 90%		?
48 - 31 days to first treatment % (1 mth in arrears)	>= 96%	98.6%	Mar-22		>= 96%	97.1%	Feb-22	>= 96%		?
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)	>= 94%	100.0%	Mar-22	H	>= 94%	100.0%	Feb-22	>= 94%		?
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	>= 98%		Mar-22		>= 98%	100.0%	Feb-22	>= 98%		?
51 - Patients 2 week wait (all cancers) % (1 mth in arrears)	>= 93%	78.5%	Mar-22	L	>= 93%	77.5%	Feb-22	>= 93%		?
52 - Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	>= 93%	28.2%	Mar-22	L	>= 93%	18.2%	Feb-22	>= 93%		F

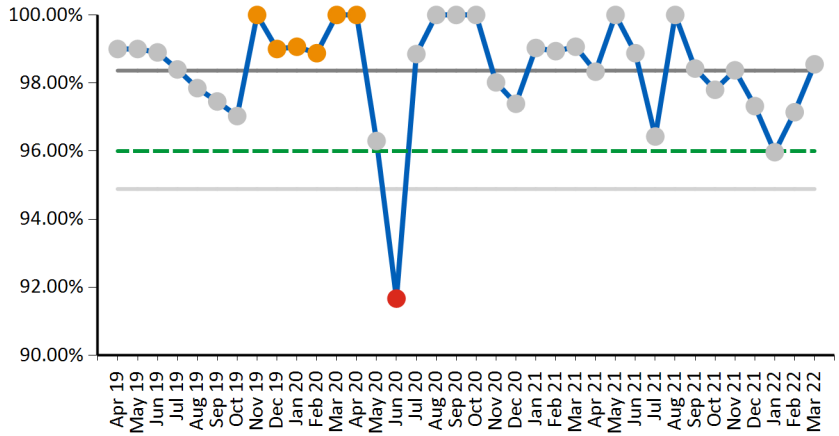
46 - 62 day standard % (1 mth in arrears)



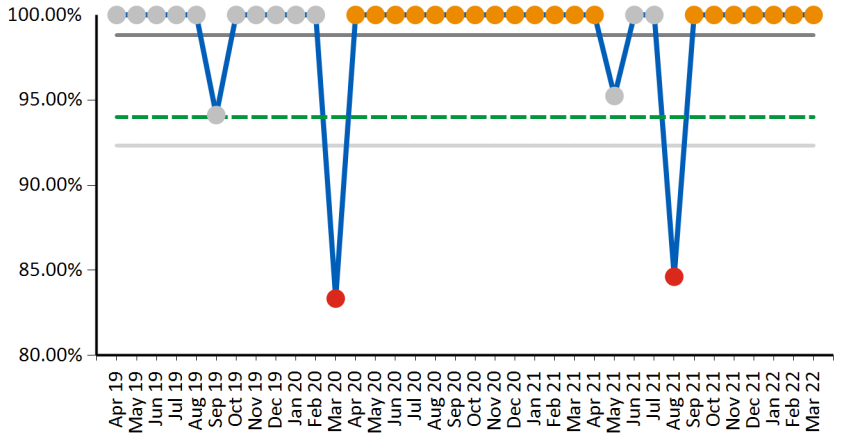
47 - 62 day screening % (1 mth in arrears)



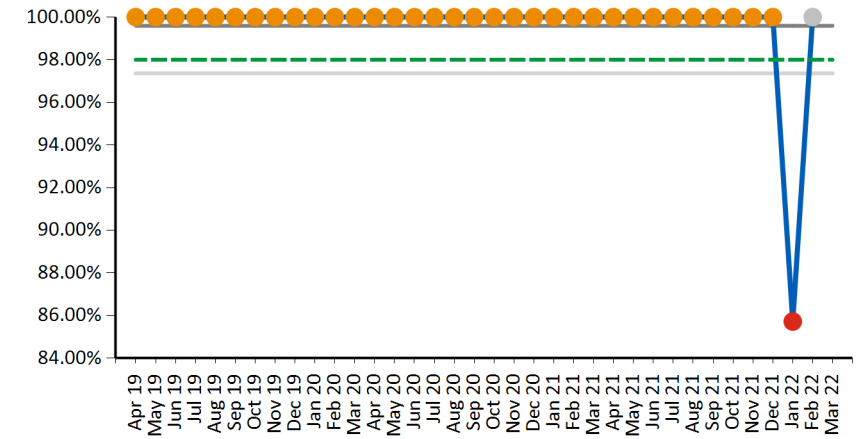
48 - 31 days to first treatment % (1 mth in arrears)



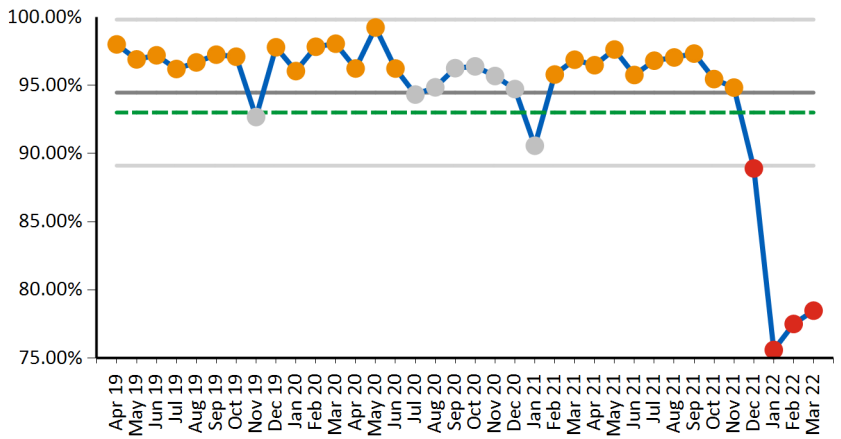
49 - 31 days subsequent treatment (surgery) % (1 mth in arrears)



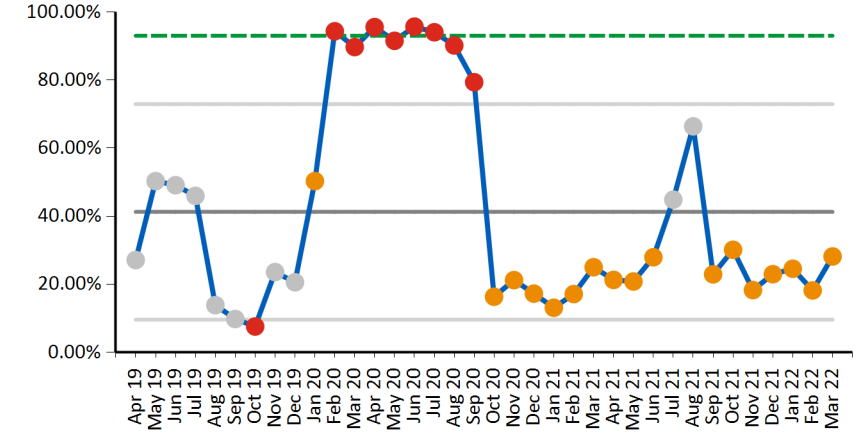
50 - 31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)



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



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

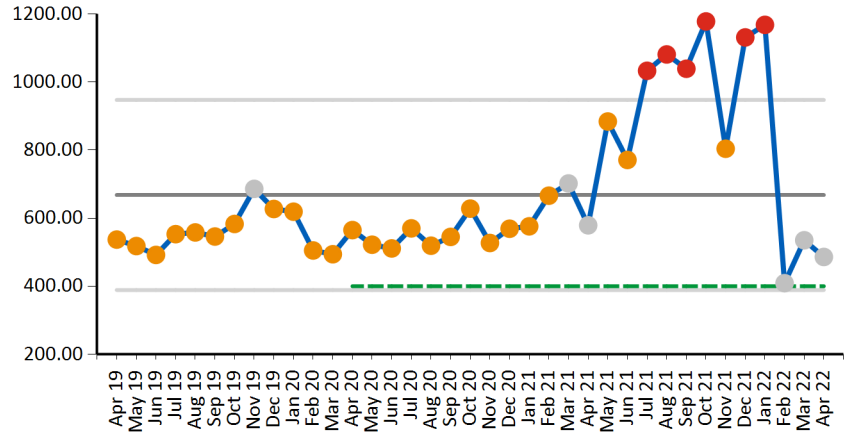


Community

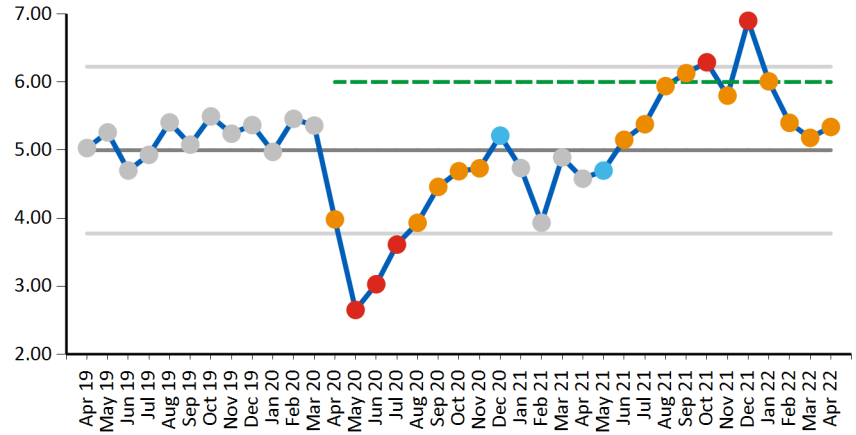
There was a large peak in the number of deflections recorded from ED due to huge volumes of patients on the Covid Oximetry at Home pathway during peak periods of the pandemic. Patients on this pathway are recorded with other pathways which contribute to this deflection metric. Additional staffing capacity to deliver this pathway was diverted from other service areas as part of the pandemic response and has now been stepped back down. Therefore total numbers of patients being deflected from ED has returned to closer to previous levels.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
334 - Total Deflections from ED	>= 400	486	Apr-22		>= 400	535	Mar-22	>= 400	486	
335 - Total Intermediate Tier LOS (weeks)	<= 6.00	5.34	Apr-22		<= 6.00	5.18	Mar-22	<= 6.00	5.34	

334 - Total Deflections from ED



335 - Total Intermediate Tier LOS (weeks)



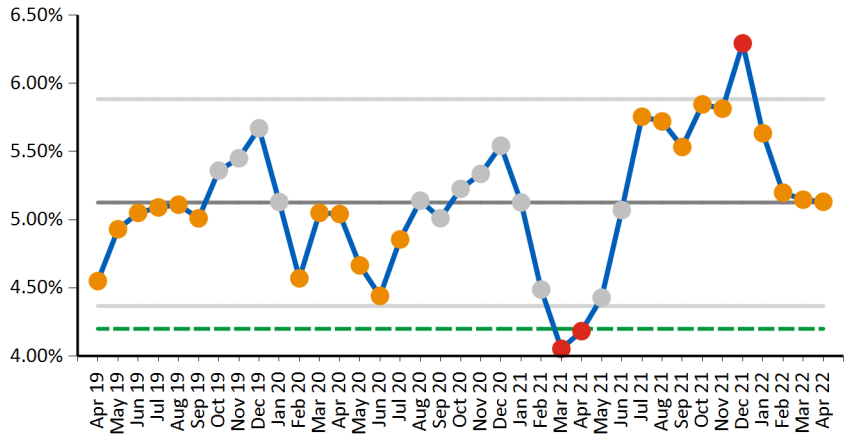
Workforce

Sickness, Vacancy and Turnover

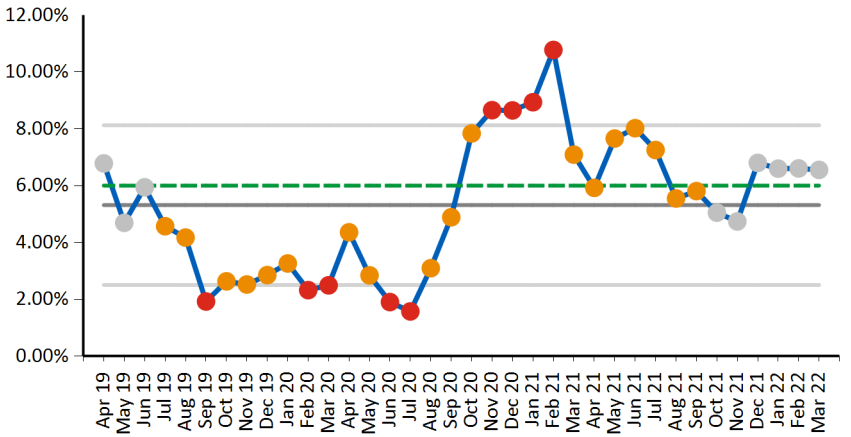
Sickness absence continues to benchmark favourably against GM Trusts and shows an improved position on last month. Vacancy and turnover are also showing an improvement on last month however, the recruitment market remains challenging and the pipeline in for new starters, options for hard to recruit to posts and the impact on agency spend remain a key focus for the People Committee.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
117 - Sickness absence level - Trust	<= 4.20%	5.13%	Apr-22		<= 4.20%	5.15%	Mar-22	<= 4.20%	5.13%	
120 - Vacancy level - Trust	<= 6%	6.55%	Mar-22		<= 6%	6.60%	Feb-22	<= 6%		
121 - Turnover	<= 9.90%	14.06%	Apr-22		<= 9.90%	14.73%	Mar-22	<= 9.90%	14.06%	
366 - Ongoing formal investigation cases over 8 weeks		3	Apr-22			2	Mar-22		3	

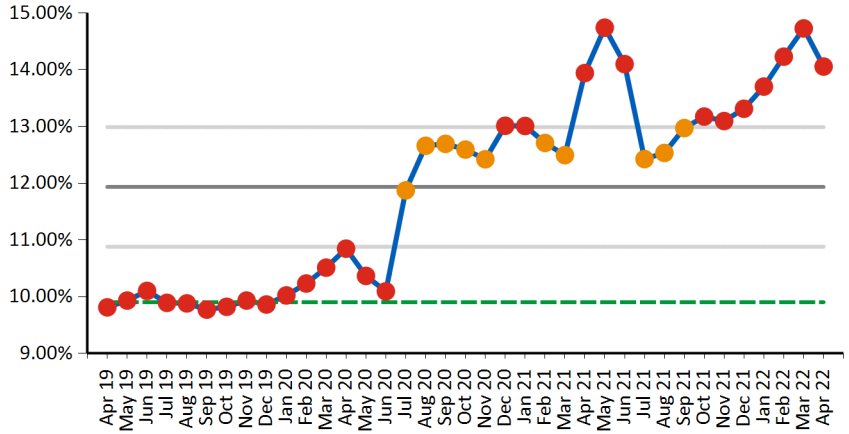
117 - Sickness absence level - Trust



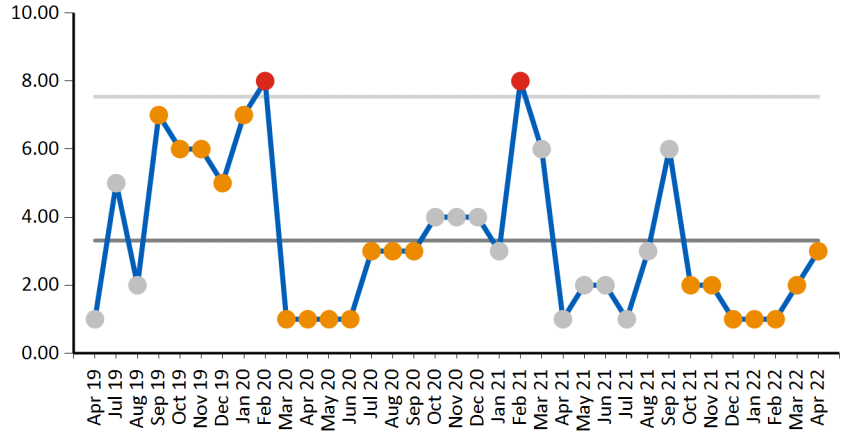
120 - Vacancy level - Trust



121 - Turnover



366 - Ongoing formal investigation cases over 8 weeks

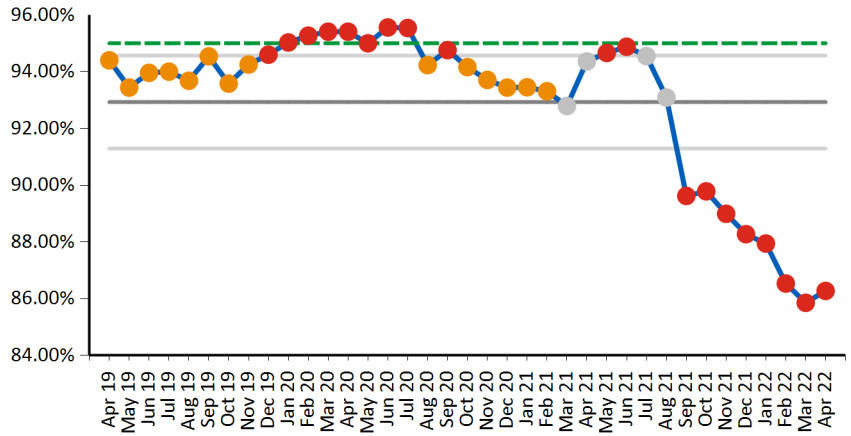


Organisational Development

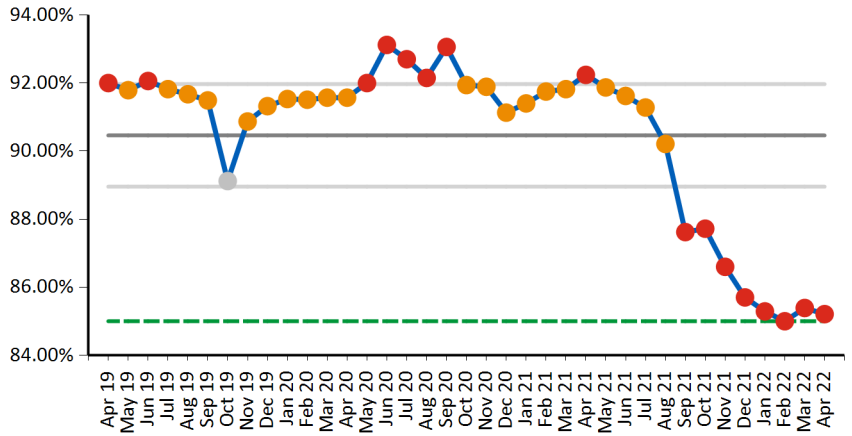
The Divisions and the OD team continue to support the recovery plan for statutory and mandatory training to bring compliance back up to target. The impact of the recovery actions are expected to be reflected in mandatory and statutory training figures from next month and updates against plan will be considered by People Committee.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
37 - Staff completing Statutory Training	>= 95%	86.3%	Apr-22		>= 95%	85.9%	Mar-22	>= 95%	86.3%	
38 - Staff completing Mandatory Training	>= 85%	85.2%	Apr-22		>= 85%	85.4%	Mar-22	>= 85%	85.2%	
39 - Staff completing Safeguarding Training	>= 95%	88.69%	Apr-22		>= 95%	88.37%	Mar-22	>= 95%	88.69%	
101 - Increased numbers of staff undertaking an appraisal	>= 85%	76.9%	Apr-22		>= 85%	78.0%	Mar-22	>= 85%	76.9%	
78 - Our staff tell us they would recommend the Trust as a place to work - (quarterly in arrears)	>= 66%	69.0%	Q4 2021/22		>= 66%	67.0%	Q3 2021/22	>= 66%		
79 - Our staff tell us they would recommend the Trust for treatment - (quarterly in arrears)	>= 80%	61.5%	Q4 2021/22		>= 80%	62.0%	Q3 2021/22	>= 80%		

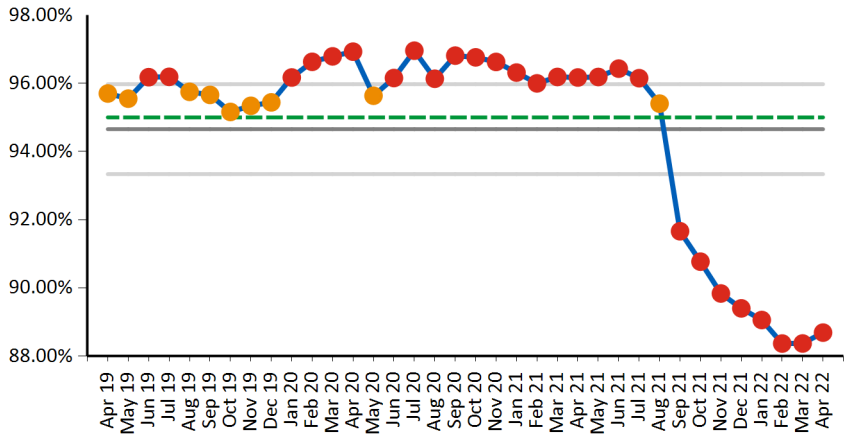
37 - Staff completing Statutory Training



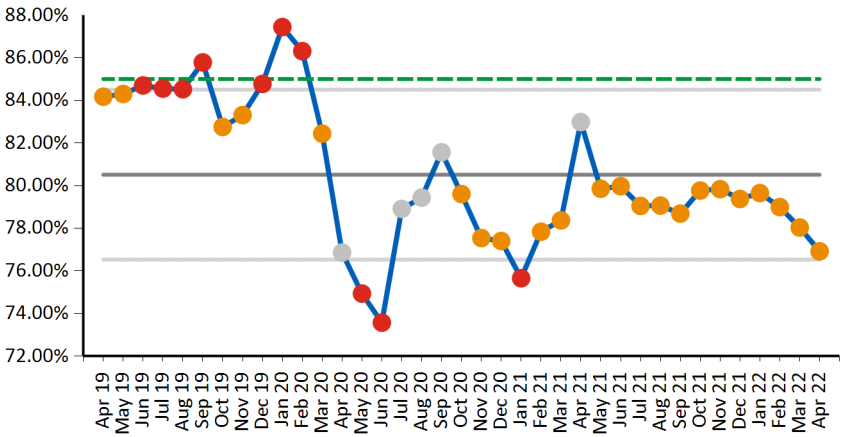
38 - Staff completing Mandatory Training



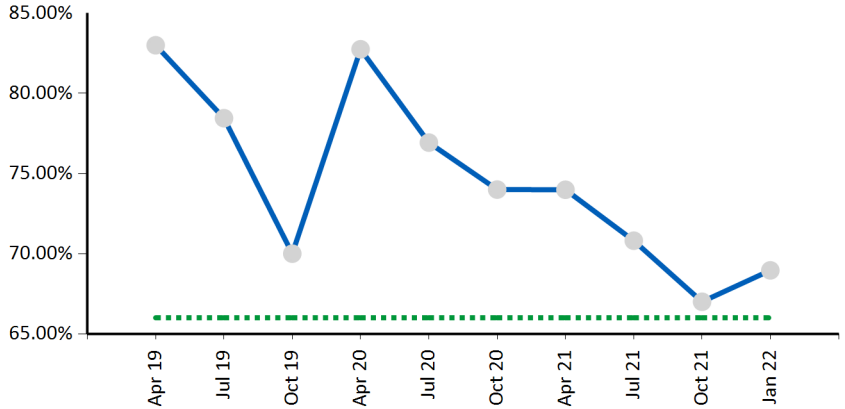
39 - Staff completing Safeguarding Training



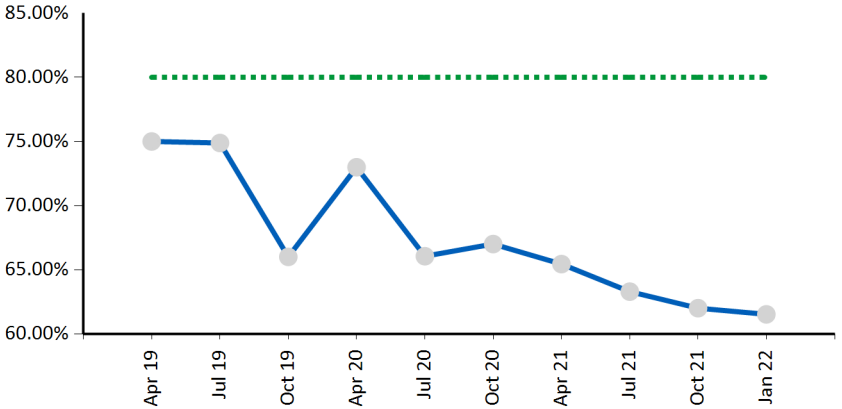
101 - Increased numbers of staff undertaking an appraisal



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

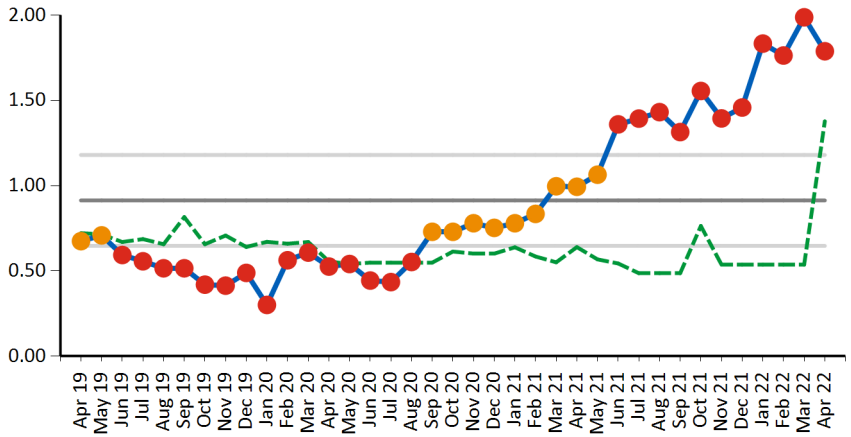


Agency

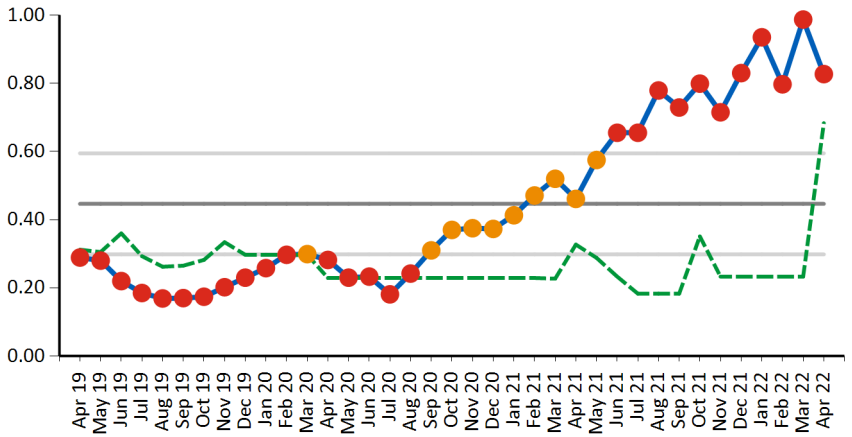
Total agency spend reduced by £199k compared to the previous month, the majority of which (£159k) related to Nursing agency spend. People Committee continue to provide oversight for all staff group agency usage and along with Finance and investment Committee monitoring against forecast.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
198 - Trust Annual ceiling for agency spend (£m)	<= 1.38	1.79	Apr-22		<= 0.54	1.99	Mar-22	<= 1.38	1.79	
111 - Annual ceiling for Nursing Staff agency spend (£m)	<= 0.68	0.83	Apr-22		<= 0.23	0.99	Mar-22	<= 0.68	0.83	
112 - Annual ceiling for Medical Staff agency spend (£m)	<= 0.62	0.82	Apr-22		<= 0.23	0.74	Mar-22	<= 0.62	0.82	

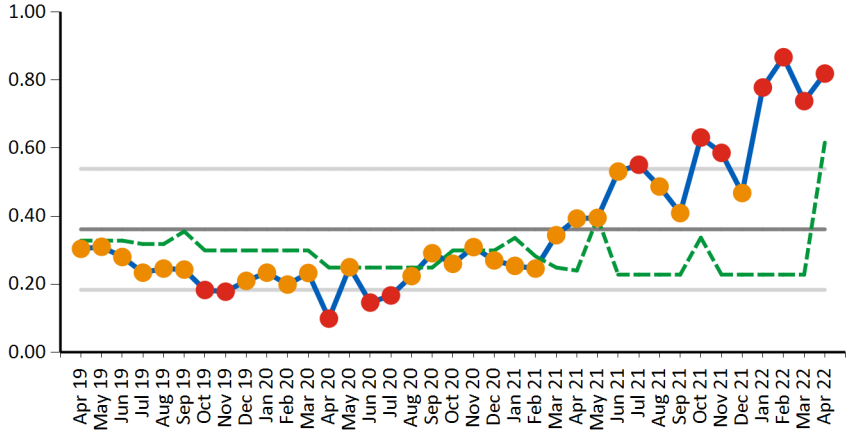
198 - Trust Annual ceiling for agency spend (£m)



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



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



Finance

Revenue Performance Year to Date
• We have a year to date deficit of £2.2m compared with a planned deficit of £1m.
• Revenue performance is currently rated amber as further discussions continue with GM around the 22/23 financial plan.

Revenue Performance Forecast Outturn
• The forecast scenarios range from a deficit of £2m to a deficit of £33.5m, with a likely deficit of £14m.
• Forecast Outturn is currently rated amber as further discussions continue with GM around the 22/23 financial plan

Cost Improvement
• The current trackers indicate that £4.6m of recurrent savings have been identified against a target of £12.4m.
• CIP is currently rated amber

Variable Pay
• We spent £3.9m on variable pay in month 1 compared to an average of £3.5m per month in 21/22.
• Variable pay is rated red as spend is significantly above plan.

Capital Spend
• Year to date spend is £3.7m.
• Capital is rated amber as further discussions continue with GM around the 22/23 plan.

Cash Position
• We had cash of £49.8m at the end of the month.
• Cash is rated green.

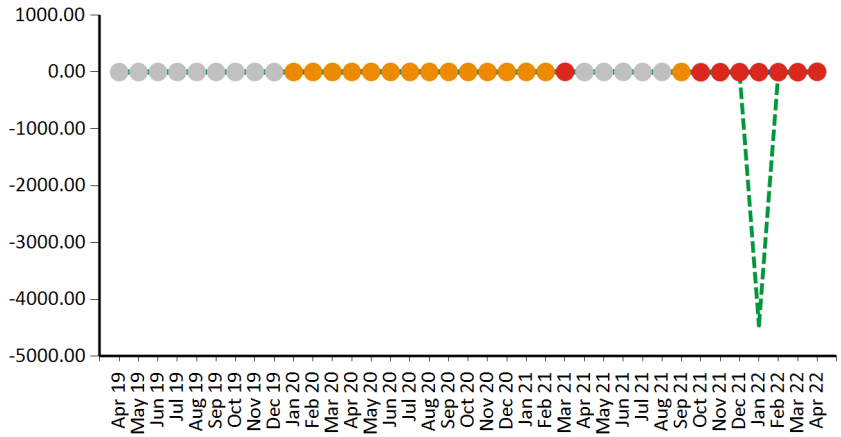
Loans and PDC
• We have loans of £38.9m.
• Rated green as there are no concerns in this area.

Better Payment Practices Code
• Year to date we have paid 87.3% of our invoices within 30 days.
• Non NHS performance is 87.3%.
• This is below the target of 95%, hence rated amber.
• Action to improve performance is underway

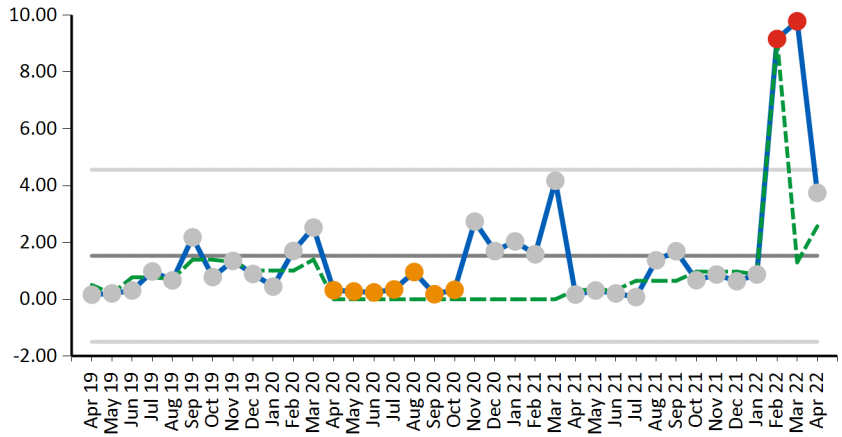
Use of Resources Rating
• This is not being reported following the suspension of normal financial reporting arrangements due to Covid.

	Latest				Previous			Year to Date		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
220 - Control Total (£ millions)	>= 1.0	2.2	Apr-22		>= -4.3	-4.2	Mar-22	>= 1.0	2.2	
222 - Capital (£ millions)	>= 2.6	3.7	Apr-22		>= 1.3	9.8	Mar-22	>= 2.6	3.7	
223 - Cash (£ millions)	>= 48.2	49.8	Apr-22		= 0.0	56.8	Mar-22	>= 48.2	49.8	

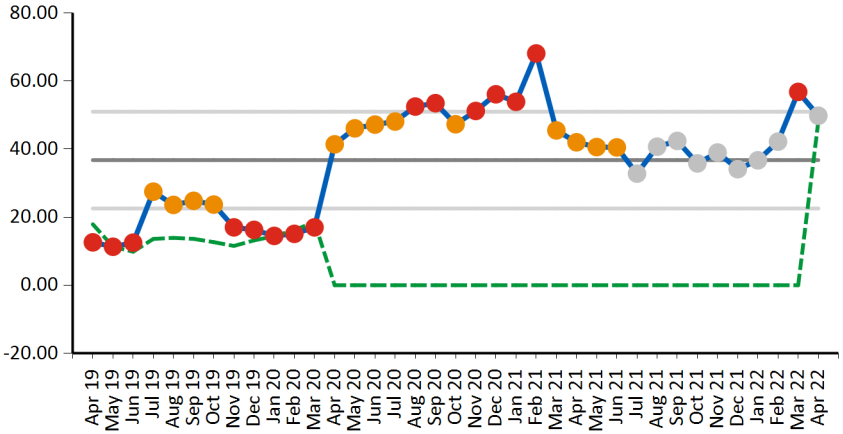
220 - Control Total (£ millions)



222 - Capital (£ millions)



223 - Cash (£ millions)



oard Assurance Heat Map - Hospital

			Council	Acute Division																													Families Division									
	Indicator	Target	Lab Lodge	AED-Adults	AED-Paeds	A4	ACU	B1 (Frailty Unit)	B2	B3	B4	BCAU	C1	C2	C3	C4	CCU	CDU	D1 (MAU1)	D2 (MAU2)	D3	D4	DL	EU (daycare)	H3 (Stroke Unit)	Critical Care	DCU (daycare)	E3	E4	F3	F4	F6	G3/TSU	G4/TSU	H2 (daycare)	R1	UU (daycare)	CDS	E5	F5	Ingleside	M2 (AN)	M3 (Birth)	M4 (PN)	M5 (PN)	M6	NICU	Overall
	Average Beds Available per day	*N/a*	32	0	0	22	10	23	26	19	24	19	25	26	26	22	10	13	24	22	25	27	12	5	22	18	25	25	25	25	23	16	25	24	11	9	4	15	38	9	4	26	5	22	22	17	38	828
Infection Prevention Control	Hand Washing Compliance %	*Target = 100%*	100.0%	85.0%	100.0%	100.0%	95.0%	N/R	100.0%	100.0%	100.0%	90.0%	95.0%	80.0%	100.0%	85.0%	100.0%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	90.0%	100.0%	100.0%	65.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	97.6%
	IPC Rapid Improvement Tool % (Gen)	*Target = 95%*	94.2%	100.0%	96.7%	94.4%		95.0%	70.0%	95.0%	89.5%		89.5%	95.0%	83.3%	70.0%	94.7%	89.5%	90.0%	90.0%	100.0%	89.5%	100.0%	94.7%	N/R	85.0%	93.3%	94.7%	95.0%	89.5%	94.7%	92.1%	94.7%	88.9%	93.8%		95.0%	95.0%	97.2%	97.2%	100.0%	95.0%		95.0%	95.0%	94.7%	93.8%	
	IPC Rapid Improvement Tool % (Med)	*Target = 95%*		90.5%	97.5%	90.9%		100.0%	N/R	91.3%	91.3%		95.5%	92.0%	83.3%	78.3%	100.0%	82.6%	90.5%	85.0%	97.9%	90.9%	N/R	93.3%	N/R	81.8%	95.0%	91.7%	100.0%	87.0%	69.6%	100.0%	91.3%	95.7%	93.8%		95.5%	95.2%	92.1%	92.1%	86.2%	96.0%		96.0%	96.0%	95.8%	94.4%	
	Mattress Audit Compliance %	*Target = 100%*	100.0%			66.7%		100.0%	97.4%	100.0%	100.0%		100.0%	97.4%	100.0%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	96.5%		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%	98.6%
	C - Diff	*Target = 0*	0	0	0	1	0	1	0	1	3	0	0	2	0	0	0	0	1	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	10
	MSSA BSIs	*Target = 0*	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
	E.Coli BSIs	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	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	1	4
	MRSA acquisitions	*Target = 0*	0	0	0	0	0	0	0	1	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	0	0	0	2
Harm Free Care	All Inpatient Falls (Safeguard)	*Target = 0*	0	7	0	2	0	4	9	3	3	1	4	7	3	3	0	3	6	3	1	2	0	0	4	0	0	5	1	2	1	1	5	1	0	2	0	0	0	0	0	0	0	1	0	84	
	Harms related to falls (moderate+)	*Target = 1.6*	0	0	0	0	0	0	1	0	1	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	0	0	0	3
	VTE Assessment Compliance	*Target = 95%*					91.4%	0.0%	0.0%	30.6%	0.0%	89.9%	90.9%	100.0%	100.0%	81.3%	96.4%	94.2%	94.3%	96.3%	83.3%	77.3%		99.9%	100.0%	100.0%	96.7%	100.0%	94.2%	100.0%	95.8%	100.0%	100.0%	100.0%	98.9%	71.4%	94.2%	96.6%	0.0%			100.0%		90.6%	89.3%	100.0%		95.3%	
	New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	2	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	9
	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
	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
	New pressure Ulcers (unstageable)	*Target = 0*	0	0	0	0	0	1	0	0	0	0	0	3	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	5
Audit	Monthly KPI Audit %	*Target = 95%*	99.0%	90.1%	97.5%	N/R	N/R	92.1%	82.2%	93.6%	87.1%	N/R	87.6%	85.3%	N/R	69.8%	95.1%	97.1%	95.2%	92.9%	86.6%	87.3%	100.0%	N/R	N/R	83.3%	98.4%	75.4%	84.7%	91.0%	82.5%	86.2%	91.3%	83.2%	96.7%		100.0%	98.4%	100.0%	100.0%	94.7%	98.3%		97.1%	98.4%	97.0%	98.3%	93.7%
	BoSCA Overall Score %	*w=<55,b=55, s>75,g>90*							59.4%	56.8%			76.8%	63.4%	72.7%	71.7%	84.2%		61.2%	73.7%					75.3%	85.3%		71.0%	72.8%	81.1%	67.1%			75.1%	67.0%												71.4%	
	BoSCA Rating								bronze	bronze			silver	bronze	bronze	bronze	silver		bronze	bronze					silver	silver		bronze	bronze	silver	bronze			silver	bronze												Bronze	
Patient Experience	FFT Response Rate	*Target = 30%*	100.0%	18.7%	0.3%	42.9%	0.0%	21.7%	0.0%	21.6%	66.7%	0.0%	75.8%	4.5%	42.1%	0.0%	66.7%	78.6%	18.5%	14.1%	16.2%	42.9%		29.0%	20.6%	0.0%	31.0%	2.5%	35.8%	22.0%	4.4%	39.0%	25.0%	25.0%	23.5%	0.0%	28.8%	31.6%	12.6%	0.6%	31.6%	17.1%		16.2%	16.2%	0.0%	57.1%	20.9%
	FFT Recommended Rate	*Target = 97%*	91.7%	75.6%	71.4%	100.0%		93.3%		87.5%	83.3%		95.7%	100.0%	87.5%		96.4%	100.0%	94.1%	92.3%	91.7%	92.6%		97.5%	100.0%		97.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.5%		100.0%	83.1%	98.6%	0.0%	83.1%	87.5%		69.8%	69.8%		100.0%	97.0%
	Number of complaints received	*Target = 0*	0	3	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	1	0	0	5	0	0	1	0	0	18
Governance	Serious Incidents in Month	*Target = 0*	0	2	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	0	0	0	0	0	0	1	1	0	0	0	0	1	0	6	
	Incidents > 20 days, not yet signed off	*Target = 0*	0	28	4	2	1	15	0	8	5	4	0	39	3	7	0	5	5	6	13	8	0	0	3	0	0	4	3	0	1	0	3	1	1	2	0	72	2	0	0	1	2	15	10	4	4	281
	Harm related to Incident (Moderate+)	*Target = 0*	0	2	2	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	1	0	0	0	0	3	1	0	0	0	0	0	0	0	10
Staff Development	Appraisals	*Target = 85%*		94.6%			75.0%	73.0%	50.0%	70.0%	64.0%	68.4%	66.7%	63.6%	94.7%	62.2%	76.9%	70.6%	61.7%	87.5%	68.4%	92.1%	66.7%	81.4%	65.9%	88.3%	85.7%	56.3%	56.7%	85.7%	90.9%	93.8%	79.5%	82.9%	80.0%		100.0%	75.6%	21.1%		100.0%	48.3%	62.5%	61.8%	62.1%		76.5%	73.4%
	Statutory Training	*Target = 95%*		76.01%			85.59%	76.85%	52.82%	71.69%	82.85%	80.8%	82.90%	79.12%	83.00%	77.81%	92.24%	86.27%	84.65%	88.74%	89.34%	86.13%	89.58%	89.51%	80.75%	93.72%	91.08%	77.62%	88.32%	89.59%	76.29%	86.96%	81.80%	81.41%	94.94%		97.22%	77.0%	82.4%		85.7%	67.2%	71.6%	78.8%	66.5%		81.81%	82.2%
	Mandatory Training	*Target = 85%*		81.32%			81.9%	82.7%	62.8%	77.6%	81.0%	80.0%	78.8%	76.5%	76.2%	77.5%	89.8%	87.5%	82.3%	84.7%	89.0%	85.9%	87.9%	89.5%	81.4%	92.4%	91.1%	83.6%	79.3%	94.2%	78.6%	84.9%	80.6%	76.4%	88.9%		94.2%	75.0%	85.9%		100.0%	72.9%	79.6%	77.5%	65.2%		80.2%	82.4%
Staffing & Workforce	% Qualified Staff (Day)							97.2%	96.8%	88.1%	91.7%		90.9%	95.2%	96.8%	98.7%	100.9%				96.5%	102.2%			90.7%	80.9%		99.3%		118.7%	95.0%		106.5%					90.7%	90.3%	100.0%		91.7%		82.1%	79.1%			
	% Qualified Staff (Night)							101.7%	118.0%	101.7%	101.7%		110.2%	108.0%	141.7%	137.2%	100.0%				107.8%	114.4%			100.0%	78.5%		149.4%		110.5%	150.0%		95.7%					68.4%	88.9%	100.0%		89.9%		78.7%	67.5%			
	% un-Qualified Staff (Day)							107.0%	150.1%	76.5%	84.0%		101.8%	108.8%	87.4%	68.6%	84.1%				88.3%	104.9%			92.3%	105.5%		94.6%		116.6%	96.8%		107.5%					80.2%	93.1%	100.0%		90.6%		42.9%	48.4%			
	% un-Qualified Staff (Night)							163.2%	245.8%	101.1%	105.8%		116.1%	111.3%	103.4%	110.9%	96.7%				116.7%	108.9%			97.8%	93.5%		112.3%		142.1%	142.4%		115.8%					104.6%	99.3%	100.0%		99.6%		54.3%	39.6%			
	Budgeted Nurse: Bed Ratio (WTE)		13.21	-9.38	-9.38	4.64	0.00	1.20	7.38	0.00	3.58	0.00	9.36	1.29	-1.81	3.72	10.17	2.76	7.50	3.25	3.27	0.29	0.00	2.12	-0.86	-1.64	-3.19	3.26	1.37	-2.25	17.11	2.83	2.55	6.10	0.00	0.00	-3.75	5.78	1.69	1.69	12.82	-1.31	12.48	-2.36	3.22	-4.95	29.96	120.49
	Current Budgeted WTE (Ledger)		50.34	73.28	73.28	43.34		38.03	60.58	0.00	26.50		40.57	33.71	41.23	42.69	60.93	19.97	50.82	40.30	40.01	39.97		40.70	36.15	95.36	32.75	35.52	30.21	37.79	35.49	18.07	44.50	44.49			16.01	86.31	33.42	33.42	66.93	22.00	22.12	26.34	26.34	46.87	123.71	1730.03
	Actual WTE In-Post (Ledger)		37.13	82.66	82.66	38.70		36.83	53.20	0.00	22.92		31.21	32.42	43.04	38.97	50.76	17.21	43.32	37.05	36.74	39.68		38.58	37.01	97.00	35.94	32.26	28.84	40.04	18.38	15.24	41.95	38.39			19.76	80.53	31.73	31.73	54.11	23.31	9.64	28.70	23.12	51.82	93.75	1596.33
	Actual Worked (Ledger)		45.85	96.19	96.19	61.63		51.55	54.88	0.00	24.19		50.59	43.56	53.67	43.47	51.86	24.15	54.68	47.49	43.84	46.57		54.14	39.30	92.09	35.77	47.12	29.40	50.60	35.24	21.52	59.68	51.49			21.53	86.43	33.85	33.85	56.80	24.67	7.35	33.90	29.51	55.97	93.54	1884.09
	Sickness (%)	*Target < 4.2%*		5.82%			4.87%	18.21%	8.07%	13.10%	10.38%	0.93%	11.96%	14.08%	5.02%	10.81%	10.64%	0.18%	6.49%	0.93%	6.64%	8.25%	17.11%	4.91%	5.88%	5.37%	3.05%	17.76%	2.78%	4.87%	4.87%	8.41%	7.86%	6.19%	2.04%		4.17%	9.48%	4.73%		0.00%	5.16%	7.26%	6.97%	11.93%		8.39%	7.32%
	Current Budgeted Vacancies		-8.72	-13.53	-13.53	-22.93	0.00	-14.72	-1.68	0.00	-1.27	0.00	-19.38	-11.14	-10.63	-4.50	-1.10	-6.94	-11.36	-10.44	-7.10	-6.89	0.00	-15.56	-2.29	4.91	0.17	-14.86	-0.56	-10.56	-16.86	-6.28	-17.73	-13.10	0.00	0.00	-1.77	-5.90	-2.12	-2.12	-2.69	-1.36	2.29	-5.20	-6.39	-4.15	0.21	133.70
	Pending Appointment																																														0.00
	Substantive Staff Turnover	*Target < 10%*		6.8%			3.9%	12.2%	52.6%	10.5%	25.0%	16.7%	28.6%	19.4%	14.6%	16.2%	3.5%	5.4%	22.2%	35.1%	18.2%	20.0%	13.3%	13.14%	2.4%	9.7%	7.1%	17.7%	17.6%	10.9%	72.0%	0.0%	7.9%	18.9%	11.8%		10.3%	11.6%	9.2%		66.7%	16.1%	34.3%	20.5%	16.4%		11.9%	18.20%

Data Legend

No data returned	N/R
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 & ICS Services

			ICS Services														DN Teams										Treatment Rooms		
	Indicator	Target	Admission Avoidance	Acute Therapies	Anti-coagulant Team	Asylum & Refugee/ Homeless & Vunerable	Bladder & Bowel Service	Community IV Therapy	Diabetes & Endo	Dietetics	Falls	Neurology & LTC	Podiatry	Rheum-atology	SLT	Stroke	Wheel-chair Service	Avondale	Breightmet & Little Lever	Crompton	Farnworth	Great Lever	Horwich	Pikes Lane	Waters Meeting	West-houghton	Evening Service	North	South	Overall
Infection Control & Harm Free	Hand Washing Compliance %	*Target = 100%*	N/R		100.0%	N/R	N/R	N/R				N/R		100.0%				100.0%	N/R	N/R	N/R	100.0%	N/R	N/R	N/R	N/R	N/R	N/R	N/R	100.00%
	Monthly New pressure Ulcers (Grade 2)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2	2	1	1	1	1	2	0	0		12
	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
	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
	Monthly New pressure Ulcers (Unstageable)	*Target = 0*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	0	0	0	1	0	0	1		5
Audit	Monthly KPI Audit %	*Target = 95%*	98.4%			97.3%	97.1%	100.0%		N/R			N/R		N/R		98.8%	98.0%	98.2%	98.2%	98.8%	98.2%	98.4%	98.7%	98.8%	98.4%	99.6%	98.4%	98.2%	97.94%
	BoSCA Overall Score %	*w=<55%, B>55%, S>75%, G>90%*																94.74%	91.01%	94.22%	85.51%	93.60%	94.33%	97.23%	83.06%	97.11%	94.79%	95.60%	89.86%	93%
	BoSCA Rating																	platinum	platinum	platinum	silver	platinum	platinum	platinum	silver	platinum	platinum	gold	silver	platinum
Patient Experienc	Friends and Family Response Rate %	*Target = 30%*	45.0%		50.0%	0.0%	20.0%	40.0%	4.0%	3.0%	100.0%	20.0%	5.1%	5.9%	6.4%	100.0%	57.1%					40.9%							65.0%		
	Friends and Family Recommended Rate %	*Target = 97%*	100.0%		100.0%		100.0%	100.0%	79.5%	100.0%	97.3%	88.9%	92.3%	95.8%	100.0%	100.0%	100.0%					100.0%							100.0%		
	Number of Complaints received	*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	1		1
Staff Development	Sickness (%)	*Target is < 4.2%*	9.5%	6.4%	1.0%	16.95%	1.7%	1.7%	3.4%	0.00%	3.0%	0.6%	6.4%	0.0%	6.1%	13.3%	1.5%	4.1%	0.0%	2.6%	3.6%	5.4%	8.5%	5.1%	18.9%	0.7%	3.0%	11.4%		5.2%
	Total WTE with 19.81% Headroom (Sickness, Training etc)																													
	Substantive Staff Turnover Headcount (rolling average 12 months)	*Target is < 10%*	7.2%	12.7%	20.0%	0.0%	0.0%	7.7%	13.6%	21.7%	7.5%	33.3%	7.6%	18.2%	11.1%	12.3%	12.5%	24.2%	6.5%	0.0%	0.0%	16.7%	0.0%	15.4%	13.3%	8.3%	6.2%	10.5%		11.00%
	12 month Appraisal	*Target = 85%*	93.3%	91.2%	100.0%	87.5%	100.0%	84.6%	68.0%	95.2%	81.8%	65.6%	97.3%	88.2%	88.2%	96.4%	100.0%	73.3%	93.8%	88.9%	82.4%	100.0%	81.8%	83.3%	100.0%	100.0%	81.3%	95.5%		89.10%
	12 month Statutory Training	*Target = 95%*	96.0%	93.7%	98.4%	96.0%	100.0%	98.9%	86.4%	94.2%	90.3%	96.6%	92.7%	93.9%	89.1%	91.6%	95.5%	97.1%	88.7%	92.8%	98.7%	96.3%	89.8%	97.8%	92.3%	94.8%	94.6%	89.9%		94.10%
	12 month Mandatory Training	*Target = 85%*	95.7%	92.8%	92.3%	97.0%	87.5%	93.2%	85.7%	95.4%	91.9%	98.2%	86.3%	88.5%	93.8%	93.3%	94.1%	93.0%	86.7%	83.8%	94.6%	98.2%	92.3%	92.4%	85.1%	90.0%	94.0%	91.5%		91.80%

Data Legend

No data returned	N/R
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