Board of Directors

26 April 2018, 09:00 to 13:00

Agenda

1. Welcome and Introductions

01. Agenda Board meeting April 2018.pdf (2 pages)

2. Apologies

3. Declarations of Interest

4. Minutes of the meeting held 29th March 2018

04. March 2018 Part One BoD minutes.pdf (9 pages)

5. Action sheet

05. Board actions March 2018.pdf (1 pages)

6. Matters arising

7. Chairman's report

8. CEO report including reportable issues

08. CEO report April 2018.pdf (5 pages)

9. Quality Assurance Committee Chair Report

09. QA Committee Chair report April 2018.pdf (2 pages)

10. Finance and Investment Committee Chair Report

10. F&I Chair Report.pdf (3 pages)

11. Workforce Committee Chair Report

11. Workforce Assurance Committee Chair Report April 2018.pdf (4 pages)

12. Urgent Care Delivery Board Chair Report

Chairs Report of Bolton's Urgent Care Delivery Board April 2018.pdf (2 pages)

13. Use of Resources

13. Use of Resources.pdf (10 pages)

14. Summary Performance Report

14. Board Report_Template v3.0 - Summary V2.pdf (7 pages)

14.1. 2017/18 Data Security and Protection Requirements

Board report cyber security 26-11-18.pdf (1 pages)

IT_SERVICES_RESPONSE_17-18_statement_of_requirements_Branded_template_final_22_11_18.pdf (21 pages)

15. GDPR Assurance and Mitigation

15. GDPR.pdf (11 pages)

16. Operational Plan

16. Operational Plan.pdf (12 pages)

17. Any other business

Bolton NHS Foundation Trust – Board Meeting 26th April 2018

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

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
09:00		Patient Story		Verbal	Patient story and learning points noted
09:20	1.	Welcome and Introductions	Chairman	verbal	
	2.	Apologies for Absence	Trust Sec.	Verbal	Apologies noted
	3.	Declarations of Interest	Chairman	Verbal	To note any declarations of interest in relation to items on the agenda
09:25	4.	Minutes of meeting held 29th March 2018	Chairman	Minutes	To approve the previous minutes
	5.	Action sheet	Chairman	Action log	To note progress on agreed actions
	6.	Matters arising	Chairman	Verbal	To address any matters arising not covered on the agenda
09:35	7.	Chairman's Report	Chairman	Verbal	To receive a report on current issues
09:40	8.	CEO Report including reportable issues	CEO	Report	To receive a report on any reportable issues including but not limited to SUIs, never events, coroner reports and serious complaints
Safety Quality and Effectiveness					
09.50	9.	Quality Assurance Committee – Chair Report 18th April 2018	QA Chair	Report	QA Chair to provide a summary of assurance from the QA Committee escalate any items of concern to the Board
10.00	10.	Finance and Investment Committee – Chair Report 24th April 2018	FC – Chair	Report	FC Chair to provide a summary of assurance from the F&I Committee and to escalate any items of concern to the Board
	11.	Workforce Committee Chair report 18th April 2018	WC Chair	Report	WC Chair to provide a summary of assurance from the Workforce Committee and escalate any items of concern to the Board
10.10	12.	Urgent Care Delivery Board Chair Report -	CEO	Report	To receive a report on the Urgent Care Delivery Board
10.20	13.	Use of Resources	Director of Nursing	Report	
10.30	14.	Summary Performance Report	Exec team	Report	To receive for information

Time		*Topic*	*Lead*	*Process*	*Expected Outcome*
	14.1	Data Security and Protection Requirements	COO	Report	

Coffee

Governance					
11.10	15.	GDPR assurance and mitigation	COO	Report	
Strategy					
11.20	16.	Operational Plan	Director of Nursing	Report	To approve the operational plan and self-certification for submission to NHSI
Reports from Sub-Committees (for information)					
	17.	Any other business			
Questions from Members of the Public					
	18.	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					
11.45	To consider a resolution to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted				

Meeting	Board of Directors Meeting – Part One
Time	09.00
Date	29th March 2018
Venue	Boardroom Royal Bolton Hospital

Present:-

Mr D Wakefield	Chairman	DW
Dr J Bene	Chief Executive	JB
Mrs T Armstrong Child	Director of Nursing	
Mr Allan Duckworth	Non-Executive Director	AD
Mr A Ennis	Chief Operating Officer	AE
Ms A Gavin Daley	Non-Executive Director	AGD
Dr M Harrison	Non-Executive Director	
Steve Hodgson	Medical Director	SH
Ms B Ismail	Non-Executive Director	BI
Mr J Mawrey	Director of Workforce	JM
Andrew Thornton	Non-Executive	AT
Mrs A Walker	Director of Finance	AW

In attendance:-

Mr R Mundon	Director of Strategy WWL	RM
Mrs E Steel	Trust Secretary	ES

Apologies

Apologies were received from Mrs J Njoroge, Non-Executive Director

Welcome and Introductions

The Chairman welcomed all Board members and observers to the meeting.

1. Patient Story

Mr W attended to share the events of his cancer story from diagnosis in October 2015, to the end of treatment in 2016 and ongoing review. Mr W's cancer was identified through routine screening and a follow up colonoscopy. Mr W was out of the country when the biopsy results were received, this necessitated an early

return home and appointments and arrangements were made to accommodate his travel. Further diagnostics identified an abnormal lymph node in Mr W's pelvis, he was offered the choice of surgery or radiotherapy and chemotherapy – he opted for the latter and received a course of treatment at the Christie. Follow up reviews including blood tests and a sigmoidoscopy have been normal.

Reflecting on his treatment Mr W expressed tanks for the care, attention and compassion he received. He would however have appreciated the opportunity for further discussion of treatment options before making his choice. Mr W also advised that one of the practicalities he had not anticipated was the impact on travel insurance costs for future trips abroad – the Director of Nursing agreed to pick this up with the team to ensure that patients receive appropriate advice.

Resolved: Board members thanked Mr W for sharing his story which illustrated the effectiveness of screening in the identification and treatment of cancer.

FT/18/15	Director of Nursing to pick up issues relating to patient information and practical advice

2. Welcome and Introductions

The Chairman welcomed Board members and observers to the meeting.

3. Declarations of Interest

The Chairman advised that he had recently been appointed as Chair of University Hospital North Midlands (UHNB). The appointment would be with effect from 4th April 2018; Mr Wakefield advised that he would continue to chair both Trusts until the end of his term of office and the appointment of a successor in Bolton.

4. Minutes of The Board Of Directors Meetings Held 22 February 2018

The minutes of the meetings held on 22 February 2018 were approved as a true and accurate reflection of the meeting.

5. Action Sheet

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

FT/17/11 The Medical Director provided a verbal update on actions taken to ensure timely prescription and dispensing of discharge medication. Although there is no hard data and no quick solution the Medical Director advised that he was assured that there was a strong focus at all levels. The Elective Division have made good progress on support for discharge however there is still some work to do in the Acute Adult Division, this has been discussed at JLG and Junior Doctors are keen to be part of the solution.

Board members discussed the challenge of measuring the provision of timely discharge medication. Board members agreed that a follow up written report should be provided to the QA Committee

FT/18/16	update report on discharge medication to the QA committee

6. Matters Arising

There were no matters arising.

7. Chairman's Report

The Chairman joined other members of the Board in congratulating the Chief Executive on the receipt of her OBE on 15th March 2018. He advised that Governors had also passed on their congratulations with spontaneous applause at the Governor meeting held that day.

Thanks were extended to the divisional and directorate teams who had supported the Board development day, the work commenced during the "market place" sessions would be followed up formally within future Board strategy sessions.

Achievement of the A&E four hour target remains a challenge despite the ongoing efforts of all staff which is recognised by the Board.

Board changes

The Chairman reminded Board members that the meeting was Mark Harrison's last meeting as a Non-Executive Director of the Trust. The process for Governors to appoint a new Non-Executive Director had commenced alongside a Board led process to appoint a new Executive Chair to lead the Board of iFM Bolton. At the Governor meeting on 15th March 2018, the Governors had supported the appointment of Andrew Thornton as Vice Chairman of the Trust. Bilkis Ismail would be the nominated NED for whistleblowing.

The Chairman reflected on Mark's achievements and contribution since his appointment initially as a Non-Executive in 2012 and as Vice Chair from 2013 onwards. Mark was a member of the Board during the difficult times when the Trust was in breach of its authorisation and he played a key role in providing assurance to Monitor that the Non Executives understood the issues and challenges.

The Board joined the Chairman in thanking Mark for his contribution, his insightful challenges and his trusted judgement.

Mark thanked the Chairman and the Board for their comments adding that he had learnt a great deal from the incredible professionalism and rigour shown by the leadership of the Trust.

8. CEO report

The CEO highlighted the following items from the written report provided within

the Board pack:

- D4 have been shortlisted in the Student Nursing Times – Student Placement of the Year – this recognises their work on the Synergy project.
- The Director of Nursing and the Learning Disability Link Nurse Jainab Desai attended a reception at Buckingham Palace celebrating front line nurses.
- The draft operational plan for 2018/19 was submitted, the final version will be shared with the Board at the April meeting
- A&E performance remains a concern for the Trust and regulators, Greater Manchester have received a regulatory notice for performance. Improvement trajectories have been requested and the level of oversight has increased. It is not yet clear whether there will be implications for individual trusts.

Resolved: The Board noted the CEO report.

9. Quality Assurance Committee Chair Report

The Chair of the Quality Assurance Committee presented his report from the meeting held on 21st March 2018:

The patient story provided a further example of integrated interventions from the acute pain team and pharmacy to significantly improve the quality of life for a patient with post herpetic pain

The Chair report from the Clinical Governance and Quality Committee escalated a challenge in relation to the monitoring of actions from serious incidents and an increase in the number of outstanding actions

The divisional reports from both the Elective and Family Care division provided a good level of assurance with regard to the quality of care with appropriate flagging of key issues and risks within divisions. The Elective division have done particularly well with regard to BOSCA assessments, the Committee were advised that the process is consistently applied. An update on the BOSCA process is scheduled for the next meeting – this will provide assurance with regard to the process.

The Family Care division have commissioned an independent review of systems and processes to include a review of still births and to provide assurance that themes and actions are identified in a culture of continuous improvement.

An update was provided on progress against the national sepsis CQUIN, the Committee had some concerns with regard to sampling and performance and after some discussion agreed that this should remain as one of the Quality Account priorities in 2018/19. Sepsis is also the locally selected indicator for external assurance review in the 2017/18 Quality Account – a full report including the outcome of this review will be presented to the Committee in three months' time.

The Committee noted the success in increasing the number of organ donations.

The Committee reviewed the new CQC insight report and expressed concerns about the lack of supporting narrative which did not provide assurance on actions to address indicators where the Trust is an outlier. A further report has been requested to set the context for each indicator and explain the actions to address.

The Committee noted that a large number of risks had been added to the iFM risk register.

Resolved: The board noted the QA committee Chair report.

10. Finance and Investment Committee Chair Report

The Chair of the Finance and Investment Committee presented his report from the meeting held on 20th March 2018.

The Committee focused their debate on the 17/18 financial performance and the 2018/19 financial plan.

There has been some improvement in the current year position and although there is still an element of risk the position has improved and there is a degree of confidence that the revised tactical plan and existing ICIP schemes will be achieved. Ongoing discussions with GM and the CCG have been positive and NHSI have been fully briefed.

The underlying cash position has improved and assurance has been provided that intensive cash management and monitoring programmes are in place.

Concerns were raised about the quality and accuracy of capital expenditure, planning and forecasting and the Committee have asked for a review of project delivery and forecasting.

The Committee received three papers on planning for 2018/19, the financial plan, the Capital Plan and the ICIP programme. The executive provided reasonable assurance that the 2018/19 is deliverable. This assurance is enhanced by improved process management capability and recent changes to senior management.

The Committee considered the plan in the context of risks and rewards and debated the challenging control total.

The Committee concluded that given the potential for receiving significant additional rewards based on full or partial delivery of control total targets it remains in the best overall interest of the Trust to agree a financial plan based on such targets.

The Committee therefore recommended that the Board should approve the proposed financial plan for 2018/19, whilst recognising the associated risks, and should also reconfirm acceptance of the 2018/19 control totals.

In response to a question about the capital slippage, the Director of Finance advised that the investment is delayed rather than lost; the original five year plan is effectively delayed by one year- the bigger concern is the operational impact on the Trust's resources to deliver quality health care. The Strategic Estates Board will review the prioritisation of the programme to assess projects for the delivery of quality objectives. There was a potential risk on loan/PDC funding – this has now been mitigated.

The Board agreed the need to be mindful of the impact of slippage on the resource required to maintain the older elements of the estate

Resolved: the Board noted the report from the Chair of the Finance and Investment Committee and in line with the Finance and Investment Committee recommendation, approved the 2018/19 financial plan.

11. **Workforce Assurance Committee Chair Report**

The Chief Executive presented her report from the meeting held on 15th March 2018.

Recruitment and retention – the Committee requested further detail on actions taken to include forecasting and trajectories and link to divisional workforce plans.

Job planning remains a significant concern, some progress has been made within Acute Adults with support from the Family Care Division but further work is required.

There has been a slight improvement in sickness absence rates – this will continue to be a focus for the Committee and an update on actions has been requested for the April meeting

In response to a question about time to recruit to posts which had been expressed as a concern by operational teams at the recent Board Development day, the Chief Executive advised that the Workforce Director had identified this as a key objective.

Resolved: the Board noted the report from the chief Executive in her capacity as Chair of the Workforce Committee.

12. **Performance Summary**

The Chief Executive presented the summary performance board report; as previously agreed this was a shorter report to allow the BI team time to focus on the development of a new report. The new report had been shared with Directors for comment at the Board Development day and would be in use from month one (May 2018 Board)

Board members discussed the data presented in the report:

C. difficile – Of the 28 reported cases, 15 have been attributed to lapses in care; the Director of Nursing advised that the data provided through the Infection Control Annual Report, the QA committee and the IPC Committee provides some assurance. An external review of infection control processes has been commissioned; the findings will be reported to the QA committee for further assurance. The Director of Nursing advised that as DIPC she is assured that the right policies are in place but recognises that there is more that can be done around adherence to policies. There has been a steady year on year reduction in the number of cases – the trust threshold for 2018/19 is 18 attributable cases.

In response to a question about performance against the 11 day target for urgent cancer referral the Chief Operating Officer reminded Board members that this is an aspirational internal target, the focus has been on delivery the national 14 day target which has been consistently achieved.

Two week symptomatic breast pathway. Work is ongoing to recover performance against this target, cancer patients are prioritised and most low risk patients are seen within 15/16 days. Although there was a significant increase in referrals a year ago this has dropped, there has been some challenge with radiography capacity.

RTT – The Chief Operating Officer advised that he was cautiously optimistic about the plans to recover performance and clear the backlog of patients for the

majority of specialties by the end of the summer. In response to a request for further details, he advised that there are four particularly challenged specialties where it will be more challenging, the CCG have confirmed investment in additional endoscopy capacity – a meeting to discuss this further has been scheduled for the 11th April and an update will be provided to the next Board meeting.

The Trust do not have a significant issue with 52 week breaches but do have two complex pathways where the number of services involved can lead to long waits. There is also a potential issue arising as a result of inaccurate data entry, these cases are identified only when a patient makes contact to request information on their treatment and with no back track in the system it is difficult to get a sense of the scale of the issue - one or two patients per quarter are identified.

EPR will help identify these issues and will give transparency to identify where errors occur. The divisions have been asked to put together a case to support training on data entry to mitigate this issues.

A&E remains a significant challenge; the Chief Operating Officer advised that the year-end target of 85% will not be achieved with current prediction of 79 – 80% at best. There are however some signs of improvement and the support from ECIP has continued. Length of stay has increased by one day since last year, anecdotally acuity has increased and further work is required to understand if the Trust has the right bed base – on the current length of stay 11 additional beds would be required.

The Director of Nursing commented that there are opportunities for improvement within the Trust's control, increasing capacity is not the right way to go, and more work is needed to reduce delays to discharge and stranded patients.

It was clarified that stranded patients are those with a length of stay of seven days or more, some of these are very sick patients with a clinical need but some are within the Trust's control. With 43% of patients classed as "stranded" the Trust benchmarks high against others - a target has been set to reduce this to 35%.

Board members discussed the ongoing improvement programme including actions to focus on early discharges and as a net importer of patients, the challenge of working with social care providers for patients from neighbouring areas. Although ECIP have provided assurance that the right actions are being taken their view is that it will take at least until the summer for changes to be embedded.

Resolved: board members noted the update on the metrics provided within the performance report.

FT/18/17	Report on RTT recovery trajectory to May board meeting
FT/18/18	Winter plan to June board of Directors

13 **Staff Survey**

The Director of Workforce presented the results of the staff survey.

The response rate from the staff sampled was 43% and overall results provided assurance of a good record of staff engagement albeit with some areas for further improvement. Data can be cut by staff group and by division and work is now underway to support the divisions to agree actions relevant to their workforce. Action plans will be discussed at the May Workforce Assurance Committee and will be consolidated into a Trust wide action plan.

The Workforce Director advised that he was working with the team to deliver a refreshed approach to staff engagement to support the ambition to be one of the top performing trusts for staff satisfaction.

Board members discussed the implications of the results and in particular the response to the questions about staff feeling pressure to come to work when unwell and the number of staff experiencing violence.

Board members agreed that while the results are positive there is an opportunity and an aspiration to do things differently to ensure the Trust is somewhere staff would choose/recommend to work or receive treatment

Resolved: Board members approved the proposal to monitor the action plan through the Workforce Operational Committee and to provide ongoing assurance to the Board through the Workforce Assurance Committee.

14. **Gender Pay Gap**

The Director of Workforce presented the Gender Pay Gap report for the Board to note in advance of publication in line with new requirements.

The paper identified the potential reasons and proposed actions to work towards reducing the gender pay gap. Board members discussed the factors contributing to the gender pay gap including unconscious bias and the impact of caring responsibilities and agreed the importance of equality of opportunity for all staff.

Resolved: Board members noted the report and agreed that actions and further work to understand the data would be overseen by the Workforce Assurance Committee.

FT/18/19	Follow up report to Workforce Assurance Committee to clarify data queries and follow up on actions taken

15. **iFM Bolton Board Appointments**

The Trust Secretary reminded the board that in accordance with the iFM Bolton Articles of Association, the Trust Board as the controlling shareholder had sole responsibility for the appointment and removal of directors on the Board of its wholly owned subsidiary.

Further to the governance review undertaken by Deloitte LLP it had been agreed that the membership of the iFM Board should be reviewed. A new Executive Chair would be appointed to replace Mark Harrison and Bilkis Ismail and James Mawrey had been proposed to join the Board of iFM Bolton as Non-Executive Directors representing the Foundation Trust.

Resolved: that having consented to act, Bilkis Ismail and James Mawrey should be appointed as Non-Executive Directors on the Board of iFM Bolton

16. **Any other business**

No other business.

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

No questions raised

Date And Time of Next Meeting

26th April 2018

Resolved: to exclude the press and public from the remainder of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

March 2018 Board actions

Code	Date	Context	Action	Who	Due	Comments
FT/18/03	25/01/2018	Capital programme	Strategic Estates Board to reflect on learning from capital programme	JB	Apr-18	action complete, Estates Strategy Committee are continuing to review and reflect on learning from the capital programme and will report through the F&I committee
FT/18/04	25/01/2018	Workforce Assurance Committee	report back on whistleblowing and Freedom to speak up	TAC	Apr-18	agenda item April Workforce Assurance Committee
FT/18/14	22/02/2018	GDPR	report back to Board to provde assurance with regard to completion of internal audit actions and GDPR mitigation	AE	Apr-18	agenda item
FT/18/21	29/03/2018	SI report 105225	redraft elements of report to reflect concerns - approve by email	SH	Apr-18	some comments received verbal update
FT/17/110	21/12/2017	Infection control review	full report to QA Committee	TAC	May-18	
FT/18/17	29/03/2018	RTT	Report on recovery trajectory to May board meeting	AE	May-18	
FT/18/20	29/03/2018	Pathology reconfiguration	follow up report on risks to May Board	JB	May-18	
FT/18/22	29/03/2018	collaboration with bolton University	Written proposal to be provided in May	JB	May-18	
FT/17/117	21/12/2017	Equality and Diversity	update on E,D&I	TAC	Jun-18	
FT/18/15	29/03/2018	Patient Story	Director of Nursing to pick up issues relating to patient information and practical advice	TAC	Jun-18	through PEIP to QA committee
FT/18/16	29/03/2018	Discharge medication	update report on discharge medication to the QA committee	SH	Jun-18	
FT/18/18	29/03/2018	Winter plan	Winter plan to June board of Directors	AE	Jun-18	
FT/18/19	29/03/2018	Gender pay gap	Follow up report to Workforce Assurance Committee to clarify data queries and follow up on actions taken	JM	Jun-18	
FT/17/92	26/10/2017	Board Assurance Framework	Audit Committee to discuss potential to revise report to include a projected score if actions have desired effect	ES	Jul-18	date changed to align with BAF presentaion to Board
FT/17/96	30/11/2017	Performance report	TAC to provide update on trajectory to achieve recommended fill rate	TAC	Jul-18	
FT/18/05	25/01/2018	Nurse staffing report	next report to include further information on retention/attrition	TAC	Jul-18	

Key

complete	agenda item	due	overdue	not due

NHS
Bolton
NHS Foundation Trust

Agenda Item No: 08

Meeting	Board of Directors

Date	26 April 2018

Title	Chief Executive Update

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

Previously considered by	

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

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

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

Prepared by	Esther Steel Trust Secretary	Presented by	Jackie Bene Chief Executive

All information provided in this written report was correct at the close of play 18/04/2018 a verbal update will be provided during the meeting if required

1. Awards and recognition

The Trust attracted positive news coverage at a local and national level for a number of stories including, the paediatric audiology service receiving accreditation; and Darley Court's Red2Green campaign work resulting in a reduce length of stay by more than 4.4 days.

The Trust was also highlighted by the Children's Commissioner Anne Longfield OBE for the good work around the implementation of the CP-IS (Child Protection Information System) which adds to our safeguarding measures to keep vulnerable children safe. Her visit to the Trust led to positive coverage locally in the Bolton News and nationally via the Nursing Times.

2. Stakeholders

2.1 NHSI/NHSE

Joint working between NHS England and NHS Improvement

NHS England's board has proposed to increase joint working with NHS Improvement as both organisations look to speak with a single national voice and remove duplication. The first joint Board meeting between NHSI and NHSE will be held in May 2018

Investigation of maternity incidents by the Healthcare Safety Investigation Branch (HSIB)

You may be aware that in November 2017, the Secretary of State for Health announced that the HSIB will commence investigations into certain categories of maternity incidents during the 2018/19 year as part of the National Maternity Transformation Programme.

The HSIB will be rolling out this programme by region commencing in April 2018 with full national coverage to be achieved by April 2019. HSIB will be working alongside Trust staff and will aim to improve the quality and consistency of investigations.

NHS Pay deal

The NHS Staff Council has reached agreement on a refresh of the NHS Terms and Conditions of Service (Agenda for Change).The framework agreement (21 March 2018), forms the basis on which NHS trade unions will now proceed to consult their members. The trade union consultation will run until the 31 May 2018. Should the trade union consultation result in acceptance of the details set out in the framework agreement, this will result in a three year pay deal as well as the reform of the pay scales.

The new pay scales will:

- increase starting salaries
- reduce the number of pay points
- shorten the amount of time it takes to reach the top of the pay band for most staff.

2.2 CQC

The CQC have reviewed their fee structure and for provider trusts have agreed to change from fees based on income bands – (for Bolton NHS FT, this was an annual fee of £245,652) to a fee set at 0.071% of annual turnover.

2.3 Greater Manchester Devolution

Nothing to report

2.4 North West Sector

An Exec to Exec meeting was held with the Exec team from WWL on 14 April 2018. We are continuing to make progress in discussions about future collaboration and will be bringing a paper to our June Board outlining progress so far and proposals for future working.

2.5 Bolton

The Trust and all involved in the Ingleside development celebrated a major milestone with the opening of our new free-standing midwifery-led unit on Tuesday 3rd April (official opening 19th April). The unit, made possible through collaborative work with Salford CCG and Salford Council, means women have more choice of where to give birth, whether it be in hospital, at home, or in midwifery-led unit. Congratulations to Families Division and iFM for all the hard work, getting the service up and running.

Reportable Issues Log

Issues occurring between 21/03/2018 and 18/04/18

3.1 Serious Incidents and Never events

Three SIs have been reported since the last Board meeting, two where there was serious harm following a fall and one avoidable cardiac arrest. The three cases will be investigate in accordance with the SI process.

3.2 Red Complaints

The Trust received one red rated complaint concerning concerns about quality of complaint.

3.3 Whistleblowing

Nothing to report

3.4 Media issues

We had neutral press coverage of a fire in CDU and for the staff survey.

The Communications Department has been working with an external film company Zut to highlight the key achievements of the organisation over the past year and show the future direction of the Trust.

4 Board Assurance Framework

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

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

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

	Trust Wide Objective	Lead	I	L		April	Feb	Jan	Dec	Key Risks/issues	Key action	Oversight
1.1	Reduce healthcare acquired infections	DON as DIPC	4	4	-	16	16	16	16	Sub-optimal of robust clinical engagement with Antimicrobial Stewardship	External review to be completed in March 2018 Development of Business Case for Antimicrobial Stewardship Pharmacist – March 2018	IPC committee
1.2.1a	For our patients to receive safe and effective care (pressure ulcers)	DON	5	2	-	10	10	15	15	No identified risks, sharing, learning arrangements robust.	Maintain current governance arrangements and enhance ward based training (calibrated to releasing staff safely)	QAC and Harm Free Care
1.2.1b	For our patients to receive safe and effective care (falls)	DON	5	3	-	15	15	15	15	Sub-optimal adoption of all preventative falls measures consistently	Implemented updated Falls Action Plan (in line with National Falls Audit results 2017)	QAC and Harm Free Care
1.2.2	For our patients to receive safe and effective care (mortality reduction)	MD	4	3	-	16	16	16	16	Escalation of ill patients, Increase in HSMR/RAMI	Roll out mortality review process Drive further improvement in ward observation KPI's Ensure Patient Track Oversight Group delivers on action plan	Mortality reduction
1.4	Staff and staff levels are supported	DON	4	5	-	20	20	20	20	Recruitment, limited pool of staff Staffing for escalation areas Aligning the organisation to all new and emerging national staffing solutions (e.g. trainee nursing associates)	Recruitment workplan New Workforce Assurance Committee	IPM Workforce Workforce committee
2.1	To deliver the NHS constitution, achieve Monitor standards and contractual targets	COO	4	5	-	20	20	20	20	Late decisions in A/E Beds coming up late Lower discharges at weekends Staffing in key departments Urgent Care pressure and increased demand on Diagnostic and Elective work	Urgent Care programme plan SAFER ECIP support Capacity and Demand Planning WLI to bring waiting times for diagnostics down	Urgent care prog board System Sustainability Board
4.1	Service and Financial Sustainability	DOF	5	4	-	20	20	20	20	Healthier Together Access to Transformation Fund Delivery of cost improvement plans Lack of workforce leading to agency cost pressures	Estates Master Planning Capital process – RIBA implementation Strategic approach to cost improvement Locality plan delivery Joint system savings approach LCO Development Strategic financial planning	IPM F&I comm
4.4	Compliance with NHS improvement agency rules	DoW	4	4	-	16	16	16	16	Sickness absence Workforce shortage Gaps in rotas	Additional admin support for wards. Ongoing recruitment National recruitment plan	IPM Workforce comm
5.4	Achieving sustainable services through collaboration within the NW sector	CEO	5	4	-	20	20	20	20	Estates and IT challenges Healthier Together/GM devolution	Ongoing engagement with partners Agreement on scope of single service Exec to Exec and Board to Board with WWL Q2	Board F&I
5.5	Supporting the urgent care system	COO	5	4	-	20	20	20	20	Intermediate care delays Late bed availability Delayed transfer/discharge of medically well patients Lack of Social Care Capacity	Urgent Care action plan ECIP support	Urgent care prog board

All information provided in this written report was correct at the close of play 20/04/18 a verbal update will be provided during the meeting if required

Committee/Group Chair's Report

Name of Committee/Group:	Quality Assurance Committee	Report to:	Board of Directors
Date of Meeting:	18 April 2018	Date of next meeting:	16 May 2018
Chair:	Andrew Thornton	Parent Committee:	Board of Directors
Apologies:	AW, KB	Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Key Points	Action/decision
Patient Story		The division shared a letter received from a new father outlining his positive experience in what could have been a very difficult time. The letter described smooth transition from antenatal through delivery suite, theatres and neonatal department	Story noted
Clinical Governance and Quality Committee		The CG and Q Committee flagged a number of amber issues with a potential underlying theme of capacity and competing pressures.	Report noted and concerns discussed, QA committee agreed the approach taken and the need to continue focus on clinical audit
BOSCA update		Six monthly update on BOSCA process and outcomes provided assurance that a robust process is in place and good progress is being made	Results discussed
Pressure Ulcers quarterly report		Annual performance – 28% reduction in pressure ulcers attributable to a lapse in care. Despite an increase in the number of ulcers reported in Q4, the Committee were assured that this remains an area of focus	Report noted, the Committee requested a presentation from the Tissue Viability Nurse to accompany the next report
Falls Quarterly report		Q4 performance of 5.33 falls per 1000 bed days (increase from Q3 but better than national benchmark Debate focused on harms from falls and need to continue focus on this area. Amber rated because of the harm from falls	Work to continue – next report to include recurrent falls

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee/Group Chair's Report

Ophthalmology Improvement Plan		Comprehensive action provided – committee assured by the plan and the leadership now in place to implement this	Plan noted
Patient Experience, Inclusion and Partnership Committee		The PEIP Committee Chair reported receipt of assurance through a number of comprehensive reports including an early report on the embargoed in patient survey where the Trust has improved in 47 out of 63 indicators	Report noted
Mortality Committee		SHMI down from 107 to 106, RAMI down from 87.5 to 85.4. One red rated area escalated in the number of outstanding RCAs - backlog plan in place	Report noted
Risk Management Committee		The Risk Management Committee Chair report triggered a debate on the security measures in place on NICU and E5. Reports received on Fire, Health and Safety Audits and actions to ensure electricity supply resilience in the data centre (external review commissioned)	Further discussion on security arrangements through Risk Management Committee
Safeguarding Committee		Report advised that the Committee were assured by updates from the Safeguarding team but had some concerns with regard to compliance with Prevent training	
IT and Informatics Committee		Positive feedback on the Bolton Care record but risk escalated with regard to Junior Doctor access to the system – work ongoing to address. Telecoms issue for Ingleside noted but work round in place	
Comments			
Risks Escalated			

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

Committee/Group Chair's Report

Bolton NHS Foundation Trust

Name of Committee/Group:	Finance & Investment Committee	Report to:	Board of Directors
Date of Meeting:	24th April 2018	Date of next meeting:	22nd May 2018
Chair:	Allan Duckworth	Parent Committee:	Board of Directors
Apologies:	D Wakefield, B Ismail	Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Finance Report (Month 12)		Director of Finance	Key points noted from the Finance & Activity Report: • The Trust has a year to date surplus of £2.3m when STF and impairments are excluded from the position; £0.1m better than plan. • Against the NHSI Plan the Trust has a surplus of £8.1m; £2m less than plan due to STF. • The Trust has a year to date actual surplus of £1.8m including STF and impairments. • The final position is not yet known as there is a final tranche of STF available, but this will only be communicated by NHSI on 16th April. • Balance Sheet adjustments of £1.2m were released into the position. • Agency costs are at £10.3m against a year to date plan of £6.2m. • ICIPs at £20.8m are on plan for the year. • The month end cash balance is £8.1m which is worse than plan by £3.1m this month due to underachievement of STF. • Year to date capital spend is £18.7m which is £15.0m below the capital plan. • The Trust Use of Resource Rating is 3 as at the end of Month 12 which is below plan. The rating was a 2 prior to the agency trigger being applied.	Control totals delivered. Discussions with Bolton CCG and GM yielded positive results in terms of providing the additional support required albeit with consequences in future years. Because control totals were achieved, additional STF was confirmed following the year end, the indicative value of this being £3.8m. The net reported surplus will however be reduced due to impairments. The underlying cash position continues to give cause for concern but assurance has been provided that intensive cash management and monitoring programmes are in place, including appropriate and escalating contingency plans. This will be closely monitored through the following year.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Capital Programme Update (Month 12)		Director of Finance	The Committee received a paper which reported final spend for the year of £18.7m, and which confirmed further slippage from the previous forecast of £21.8m. The Committee was disappointed to note that further delays were reported for certain Estates schemes going into the following year. These further delays plus the additional slippage in 2017/18 may impact upon the capital programme for 2018/19 and this will therefore be reviewed by the Executive.	Ongoing concerns were noted regarding the quality and accuracy of capital expenditure planning and forecasting and the ability of the Trust to deliver projects on time. The Executive are currently reviewing processes and will make appropriate recommendations for improvements. This risk to be escalated. Report noted.
Chair Report from the Strategic Estates Board		Chief Executive	The Committee received the Chair's report from the Strategic Estates Board held on 11th April. The general view is that the Strategic Estates Board should help to provide further assurance in future with regard to capital expenditure planning and delivery.	Chair's report noted.
Income and Cost Improvement Programme 2018/19 Assurance		Director of Finance	The Committee discussed in some detail the size and phasing of the ICIP programme for 2018/19. The FD confirmed that this programme still represented medium to high risk and will be escalated as such. NHSI have given positive feedback with regard to process. It was confirmed that it may be possible to reduce the overall level of ICIP to meet the control total for 2018/19 due to final levels of income and costs being better than were included in the draft plan. The FD will confirm the revised numbers in time for the Board meeting to enable approval.	Delivery of ICIPs along with Divisional performance/pay costs continues to represent the key material risks for 2018/19 and will be escalated as such. The Finance Committee Chair will also ask the Board to consider reducing the ICIP target for 2018/19, subject to the FD's confirmed revised numbers. Report noted.

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Committee/Group Chair's Report

Key Agenda Items:	RAG	Lead	Key Points	Action/decision
Permanent Injury Benefit Claim		Director of Finance	The FD reported that high level legal opinion has been obtained from a barrister which indicates that the Trust should have no liability for this claim therefore there is no need to raise a provision or show it as a contingent liability. This is on the basis that the person involved was not employed by the Trust. The External Auditors, KPMG, have now agreed this position.	It was agreed that following legal/audit opinion that there is no need to raise a provision or show a contingent liability.
Procurement KPI Report		Director of Finance	The Acting Head of Procurement attended for this item. It was agreed that the KPIs would be revisited and that future reports should aim to place more emphasis on identifying specific opportunities for Bolton, using available tools such as the purchase price index and benchmarking (PPIB) and whilst more general broader reporting for GM collaboration would also continue.	More focus on identifying specific opportunities and tracking achievement against identified plans.
Tender Update		Director of Finance	The Committee received and noted an overview of the competitive tender exercises that the Trust is presently engaged in.	Report noted.

Comments

Risks escalated

- Cash and Balance Sheet Strength
- Divisional Performance/ICIP Delivery/Pay Costs
- iFM Bolton Performance
- Delivery of Capital Expenditure Programme
- National Pay Award – potential risk

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Committee/Group Chair's Report

NHS Bolton NHS Foundation Trust

Name of Committee/Group:	Workforce Assurance Committee	Report to:	Board of Directors
Date of Meeting:	18 April 2018	Date of next meeting:	17th May 2018
Chair:	Jackie Bene, Chief Executive	Parent Committee:	Board of Directors
Apologies:		Quorate (Yes/No):	Yes

Key Agenda Items:	RAG	Key Points	Action/decision
Sickness/Absence Management		• Update provided on Sickness Absence Action plan as set out in recent Trust Board paper • February sickness dated reported a 1% reduction from January data and this reduction was sustained. • Divisions re-assured the Committee of the refreshed rigour that is in place to support colleagues back to work / remain in work. • Recognising the ongoing high absence levels in the Acute Division then agreement reached on additional support that will be put in place. • Whilst increased investment has been made in supporting our staff who suffer from Anxiety / stress it was recognised that a refreshed and proactive approach to Health & Wellbeing is critical.	Agreed actions: • Agreement reached that this would be a standing item on the Committee until further improvements demonstrated. • Receive an annual report from our Occupational Health providers, seeking assurance that we receive a quality and value for money service. • Receive an update on the Trust adopting an employee assistance programmes.

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Recruitment and Retention		• The Trust received an update on the Recruitment & Retention plan that will be initiated within the Trust. The focus of this being developing a Bolton Brand that works towards achieving Bolton as the employer of choice for prospective staff members. The Committee noted the ambition in this plan and supported the direction of travel detailed. • The actions noted in the plan will be monitored via the Workforce Operational Group with regular assurance reports to the Committee • Discussion took place (and actions agreed) on innovative approaches that could be taken to help fill vacancies. • Committee recognised that our Education & Leadership is critical to this agenda and suggested that a refreshed offering be considered.	Agreed actions: • Agreement reached that update on the actions being taken would be provided to the Committee on a quarterly basis. • Education and Leadership framework to be reviewed at the next Workforce Operational Group with update being provided to the Committee In June
Preceptorship		• Committee received assurance on the Preceptorship and Care Certificate activity within the Trust..	Agreed actions: • Undertake a systematic review to understand the experience through the eyes of a preceptee

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Committee/Group Chair's Report

Guardian of Safeworking		• In line with Statutory guidance the Committee received the Guardian of Safe Working report for Quarter 1 and Quarter 2. • Whilst no immediate concerns were raised in the report regarding the safeworking of our Junior Doctors it was noted that there were gaps in the report due to the Guardian of Safeworking not having access to data required in a timely manner.	Actions agreed:- • Monthly meetings be diarised with the Guardian of Safeworking, Medical Director and Director of Workforce. Basis of this meeting for the GSOH to highlight any concerns and to ensure that appropriate tools provided to support the Guardian of Safeworking in undertaking role
Freedom to Speak up		• Freedom to Speak Up Guardian provided quarterly report to the Committee. • It was noted that she had received a low number of concerns raised within the quarter (2). This led to discussions as to whether it would be timely to review the Freedom to Speak Up Guardian process within the Trust to ensure maximum awareness of this role. • Whilst the number of concerns raised were low the Committee did note that in the recent NHS Staff Survey the Trust benchmarked positively in this area. Specifically NHS Staff Survey shows our staffdo feel able to raise concerns (better that sector average).	Actions agreed:- • Review of the Freedom to Speak up process be presented to the Committee in June.
Workforce Operational Group		Red items escalated: • Recruitment and vacancies – proposals included in agenda paper • Temporary staffing usage and spend – monthly report to include actions taken to mitigate usage and spending	Actions agreed: • Workforce operational group review the Workforce Dashboard to ensure it delivers Divisional requirements.

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

Committee/Group Chair's Report

Medical Workforce Group		• Reports received from March and April meeting – actions to address variable pay spend flagged as a red	Actions agreed: • PMO support to reduce variable pay spend.

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

Bolton NHS
NHS Foundation Trust

Committee/Group Chair's Report

Name of Committee/Group:	Bolton Urgent Care Delivery Board	Report to:	Bolton FT Trust Board
Date of Meeting:	10th April 2018	Date of next meeting:	8th May 2018
Chair:	Jackie Bene	Parent Committee:	Bolton System Resilience Board
Apologies:		Quorate (Yes/No):	Y

Key Agenda Items:	Assurance Yes/No	Lead	Key Points	Action/decision
Letters from GM Strategic Partnership regards accuracy of DTOC data	Yes	CCG & BFT	There have been discrepancies between local, GM and nationally reported DTOC data for Bolton	Further data reconciliation has corrected the discrepancies
Q1 Locality Improvement Plan	Yes	Bolton System	System aims to achieve at least 90% performance by end of June Chosen focus options : • Home First • Patient Flow • Discharge	Plan submitted to GM Partnership
Exception reports :				
• Frailty Update	No	CCG	Links to care planning being further explored	Upload Frailty Index Scores to Bolton Care Record and link to INTs
• Immedicare work in NH's	No	CCG	Scaling up plans from current 6 care home coverage requested	Await outcome
• Implementation of SAFER	Yes	BFT	Improving performance discussed	Continue progress

Committee/Group Chair's Report

Performance Dashboard	Partial	BFT	Main issue of concern was the LOS in admissions avoidance caseload – relates to resources /sickness in reablement but should improve next month. Also ambulance turnaround and delays in access to Mental health beds	.Further assurances sought regards capacity NWAS not in attendance MH to add further metrics to dashboard to help assre

NHS
Bolton
NHS Foundation Trust

Agenda Item No : 13

Meeting	Board of Directors

Date	26th April 2018

Title	Governance arrangements for monitoring all Use of Resources metrics

Executive Summary	• The Trust has robust oversight of those UoR (Use of Resources) metrics that influence the financial score rating • The Trust needs to enhance its oversight arrangements of those metrics that do not feature in the arithmetic that create the UoR score • The Trust needs to factor into these arrangements the NHSI/CQC August 2017 Use of Resources: assessment framework

Previously considered by *Name of Committee/working group and any recommendation relating to the report*	• Approved at the QA Committee March 2018

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

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

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

Prepared by	Richard Sachs & Jo Bolger	Presented by	Richard Sachs, Director of Quality Governance

Governance arrangements for monitoring all Use of Resources metrics

1. PURPOSE

The paper seeks to outline arrangements for the monitoring of all UoR (Use of Resources) metrics for the start of 2018/19. Mindful of the need to discuss and debate in appropriate forums the metric performance and assurance that this ultimately provides to the Board of Directors.

2. BACKGROUND

The CQC and NHSI publicised their guidance on UoR in August 2017 and offered guidance to non-specialist acute Trusts on the 5th March 2018:

https://improvement.nhs.uk/resources/use-resources-assessment-framework/#h2-implementing-use-of-resources-assessments

It is imperative that the Trust give due consideration to:

Implementing Use of Resources assessments: The assessments are designed to improve understanding of how effectively and efficiently trusts are using their resources – including their finances, workforce, estates and facilities, technology and procurement – to provide high quality, efficient and sustainable care for patients.

And:

Brief guide for non-specialist acute trusts' – a brief guide to help Trusts understand the Use of Resources assessments. It includes the agenda for the on-site visit and other useful information.

3. CURRENT POSITION

The current arrangements ensure that metrics which impact on the UoR score are overseen by the Finance & Investment Committee – however governance of the remaining metrics needs to be galvanised.

Area	Initial metrics	Rationale	Governance & oversight	Rating
Finance	Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.	Board and F&I	
	Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.	Board and F&I	
	Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.	Board and F&I	
	Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.	Board and F&I	

Red: Not Monitored	Amber: Monitored but outside of Committee auspices	Green: Monitored and discussed at a Committee of the Board

In addition to ensuring that these arrangements remain in place, a new Trust Board of Directors Performance Report/Dashboard will display all UoR metrics in a single table for ease of reference from the beginning of the financial year 2018/19.

Area	Initial metrics	Rationale	Governance & oversight	Rating
Clinical services	Pre-procedure non- elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.	Available from Model Hospital for 16/17 and used for improvement work however not routinely monitored at IPM or board level	
	Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.	Available from Model Hospital for 16/17 and used for improvement work however not routinely monitored at IPM or board level	
	Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. Better performers will have a lower rate of readmission.	IPM scorecards & Board	
	Did not attend (DNA)	A high level of DNAs indicates a system that might be making unnecessary appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.	IPM scorecards not routinely monitored at board level	

Area	Initial metrics	Rationale	Governance & oversight	Rating
People	Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.	IPM scorecards & Board	
	Sickness absence	High levels of sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.	IPM scorecards & Board	
	Pay cost per weighted activity unit (WAU, a unit of clinical output)	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.	Available from Model Hospital not measured internally or routinely monitored at board level	
	Doctors cost per WAU	This is a doctor-specific version of the above pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.	Available from Model Hospital not measured internally or routinely monitored at board level	
	Nurses cost per WAU	This is a nurse-specific version of the above pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.	Available from Model Hospital not measured internally or routinely monitored at board level	
	AHP cost per WAU	This is an AHP-specific version of the above pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.	Available from Model Hospital not routinely monitored at board level	

Area	Initial metrics	Rationale	Governance & oversight	Rating
Clinical support services	Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. A low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.	Available from Model Hospital 15/16. Avaialble and monitored internally however not routinely monitored at board level	
	Top 10 medicines	As part of the top 10 medicines project, trusts are set trust-specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines (complex medicines that are clinically comparable to the branded product), the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).	Available from Model Hospital 15/16. Available and monitored internally however not routinely monitored at board level	

Area	Initial metrics	Rationale	Governance & oversight	Rating
Corporate services, procurement, estates and facilities	Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.	Available from Model Hospital not routinely monitored at board level	
	HR cost per £100 million turnover	This metric shows the annual cost of the HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered	Benchmarked corporately and reported by NHSI 16/17 not routinely monitored at board level	
	Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.	Benchmarked corporately and reported by NHSI 16/17 not routinely monitored at board level	
	Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score for five individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.	Available from Model Hospital 15/16 not routinely monitored at board level	
	Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.	Available and on Model Hospital not routinely monitored at board level	

Red: Not Monitored	Amber: Monitored but outside of Committee auspices (or opportunity to scrutinise outside of BoD or IPM)	Green: Monitored and discussed at a Committee of the Board

4. PROPOSAL

The Following metrics (as described in section 3) will be overseen and scrutinized by the following proposed committee from 1st April 2018:

- **Action:** That 'Finance' related metrics continue to be routinely discussed (Quarterly) at the **Finance & Investment Committee** and discussed in the context of the NHSI/CQC advice and guidance

- **Action:** That 'Clinical Service' related metrics are routinely discussed (Quarterly) at the **Quality Assurance Committee** and discussed in the context of the NHSI/CQC advice and guidance
- **Action:** That 'People' metrics are routinely discussed (Quarterly) at the **Workforce Assurance Committee** and discussed in the context of the NHSI/CQC advice and guidance
- **Action:** That 'Clinical Support Services' metrics are routinely discussed (Quarterly) at the **Quality Assurance Committee** and discussed in the context of the NHSI/CQC advice and guidance
- **Action:** That 'Corporate services, procurement, estates and facilities' metrics are routinely discussed (Quarterly) at the **Finance & Investment Committee** and discussed in the context of the NHSI/CQC advice and guidance (The QAC might wish to consider advising that F&I remit this section to the Estates Strategy Board)

  Each committee has a responsibility to escalate to the Board of Directors if the performance threatens the UoR Dashboard overall and provide explanation and remedial action to address. The table below offers guidance in respect of committee responsibility:

Process and management of Use of Resources assessments to assure evidence	
1	Sub-committee responsible for managing use of resource area will ensure on agenda
2	Sub-committee responsible will ensure the following are assessed and monitored:
Initial metrics	How is the trust performing on each initial metric?
	Is the trust an outlier on any of the initial metrics?
	Explanation of why the Trust is an outlier and any corrective action should be evidenced.
Additional evidence	Is the trust an outlier on any of the wider set of metrics (eg Model Hospital, Getting It Right First Time (GIRFT), data supplied by the trust)?
	Is there any data or information, shared with us by the trust, which is used internally to assess productivity?
Local intelligence	Are there any areas of finance and productivity not covered by the metrics where the trust's performance is notable? Are there any areas of unrealised efficiencies?
	What do we know about the trust's performance more generally, eg cost improvement programmes, private finance initiatives, local health and care economy context?
Qualitative assessment	Sub-committee will refer to key lines of enquiry and prompts
3	Sub-committee will provide exception report on any area on RED.
4	Board will receive monthly report from model hospital with metrics and narrative summary of what action is being taken to move from RED to GREEN.

Committees will also need to consider:

Use of resources area	Key lines of enquiry (KLOEs)
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

5. CONCLUSION and RECOMMENDATIONS

The current governance oversight arrangements of UoR metrics needs to be enhanced to reflect recent advice and guidance from NHSI.

It is therefore recommended that the Quality Assurance Committee recommend to Board of Directors the above suggested delegation of oversight of the metrics described above to be enabled from 1st April 2018.

6. ACKNOWLEDGEMENTS

Between January and March 2018 the following persons contributed to the discussion and dialogue about the oversight of the Use of Resources:

Andrea Bennett – Deputy Director of Finance
Jo Bolger – Programme Manager
Rachel Hurst – Associate Director of Finance

Agenda Item No	
Meeting	Board of Directors
Date	
Title	Summary Performance Report – March 2018

Executive Summary	The purpose of this report is to summarise performance for the year against the Trust's business plan. Whilst areas of good performance are noted in the report the main emphasis is highlighting for the Board those material issues where improvement is required.
Previously considered by	It is recommended that the Board note the report

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

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

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

Prepared by	Business Intelligence	Presented by	Jackie Bene, Chief Executive

Contents

Balanced Scorecard - Summary Performance

Trust Objective	Full Year Performance
1: Quality of Care	
2: Operational Performance	
3: Leadership and Improvement	
4: Finance and Use of Resources	
5: Fit for the Future	

Performance Summary Exceptions

Areas where further work on performance is needed are:

- Total Hospital acquired infections
- RTT Incomplete Pathways within 18 weeks
- Diagnostic waits
- Cancer
- A&E
- Sickness absence levels are appropriately managed
- Headline financial performance

Total Hospital acquired Infections

C-Diff (CDT) infections

There were two Clostridium Difficile toxin positive cases in March 2018 which both had lapses in care. The themes related to a delay in stepping down IV to oral antibiotics and a delay in sending a specimen once symptoms started.

Year to date the Trust has reported 30 cases compared with 37 cases for the previous year. Of these, 17 had lapses in care and are considered as performance cases against the trust threshold of 19 cases.

MRSA Bacteraemia Infections

There were no cases assigned to the Trust in February.

RTT

Performance of this constitutional indicator has remained below the target for the seventh month with performance in month of 88.3%, although this month saw an improvement from February. The largest challenges to this at a specialty level are observed in General Surgery, Trauma and Orthopaedics and Ophthalmology. A paper has been put together with a number of options open to the Trust to recover performance. This has been to both CCG and FT executive teams and work is underway to implement backlog recovery.

Cancer

62 day screening % (1 mth in arrears)

Cancer Screening remains a concern on the year to date performance, February was significantly below the threshold at 55.6%. Capacity issues in

both breast treatment and endoscopy have impacted the breast and bowel cancer screening pathways. Performance is being managed through the twice weekly cancer performance meetings.

Meetings are taking place this week between the Cancer Clinical Lead and Breast Team, and between the Endoscopy team, Clinician Lead and Gastroenterology team. Both meetings are to look at operational performance against the key standards.

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

Work is ongoing to recover the breast symptomatic standard. (Also covered by meetings above). The position at the end of February was below the standard of 93% at 88.9% but an improvement of 9.1% on January's performance.

A&E

A&E performance in March 2018 was 78.9%; an reduction of 0.7% on the previous month and 4.7% worse than the same month last year.
Work continues on the urgent care plan with oversight from the Emergency and Urgent Care Delivery Board co-chaired by the Trust Chief Executive

The joint work with the Emergency Care Improvement Programme (ECIP) is starting to show traction. Stranded patients are reducing and DTOC was 3.4% for March 2018.

Diagnostic Waits

The 17 breaches at month end have been validated, giving a final position of 0.6% of the Diagnostic Waiting List waiting more than 6 weeks at the end of March. Last month there were 141 patients waiting over 6 weeks (decrease of 124 this month). The main areas of pressure continue to be Colonoscopy which accounts for 5 of the 17 patients who were waiting over six weeks and Audiology and Urodynamics with three patients for each. The Diagnostic 6 week performance standard (DMO1) has been recovered in line with the action plan. Agreement has also been reached with the CCG to fund substantive capacity for Endoscopy.

Sickness absence levels are appropriately managed

Sickness levels were 5.2% in March compared to the Trust target of 4.2% which is a small increase of 0.1% on last month's position. It is higher than the same time last year (4.2%).

Headline financial performance

- The Trust has a year to date surplus of £2.3m excluding STF and impairments, £0.1m better than plan.
- Against the NHSI Plan the Trust has a surplus of £8.1m; £2m less than plan due to STF.

Performance Summary Exceptions

- The Trust has a year to date actual surplus of £1.8m including STF and impairments.
- The final position is not yet known as there is a final tranche of STF available, but this will only be communicated by NHSI w/c 16th April.
- Balance Sheet adjustments of £1.2m were released into the position.
- Agency costs are £10.3m against a full year plan of £6.2m.
- ICIPs at £20.8m are on plan for the year.
- The month end cash balance is £8.1m which is worse than plan by £3.1m as a result of underachievement of STF.
- Year to date capital spend is £18.7m which is £15.0m below the capital plan.
- Use of Resource Rating is three as Month 12 which is below plan. The rating was a two prior to the agency trigger being applied.

Summary Indicators

Key Performance Indicators

Trust Objective	Outcome Measure	Financial Year	Annual Plan	Plan YTD	Actual YTD	Monthly Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Reduce healthcare acquired infections	Total Hospital acquired C-Diff infections	2016/17	19	19	37	1.6	3	2	1	2	5	4	5	3	4	4	1	3
		2017/18	19	19	30	1.6	4	2	1	6	3	5	2	1	2	1	1	2
	Total Hospital acquired MRSA infections	2016/17	0	0	2	0	0	0	0	0	0	1	0	1	0	0	0	0
		2017/18	0	0	2	0	0	1	0	0	0	0	0	0	1	0	0	0
To Deliver the NHS Constitution, achieve Monitor standards and contractual targets	RTT Incomplete pathways within 18 weeks %	2016/17	92.0%	92.0%	92.6%	92.0%	95.5%	95.4%	94.9%	94.4%	93.1%	92.9%	93.5%	93.7%	92.5%	92.1%	92.1%	92.6%
		2017/18	92.0%	92.0%	88.3%	92.0%	92.1%	92.9%	93.0%	92.5%	92.2%	91.4%	91.1%	90.0%	88.8%	87.2%	87.8%	88.3%
	RTT 52 week waits (incomplete pathways)	2016/17	0	0	11	0	0	0	0	0	0	3	2	1	0	3	2	1
		2017/18	0	0	24	0	5	1	1	4	3	2	1	1	2	2	2	0
	RTT 52 week waits (Admitted pathways)	2016/17	0	0	3	0	1	0	0	0	0	1	1	1	0	0	0	1
		2017/18	0	0	10	0	2	1	1	0	0	2	0	0	0	1	1	2
	RTT 52 week waits (Non Admitted pathways)	2016/17	0	0	5	0	0	0	0	0	0	0	2	1	1	0	2	0
		2017/18	0	0	10	0	0	2	1	0	2	0	1	2	0	1	1	0
	First appointment from urgent cancer referral to be within 11 days (1 mth in arrears)	2016/17	93.0%	93.0%	85.3%	93.0%	86.6%	77.6%	80.0%	95.8%	82.7%	89.6%	94.0%	89.4%	92.3%	91.7%	85.3%	75.0%
		2017/18	93.0%	93.0%	80.8%	93.0%	68.1%	83.4%	69.1%	63.4%	75.3%	71.9%	76.0%	69.3%	92.1%	87.7%	80.8%	
	62 day standard % (1 mth in arrears)	2016/17	85.0%	85.0%	95.0%	85.0%	94.0%	97.0%	96.4%	93.4%	93.4%	93.6%	95.7%	97.8%	94.8%	96.6%	92.2%	94.6%
		2017/18	85.0%	85.0%	90.8%	85.0%	94.2%	93.0%	92.0%	92.7%	92.9%	91.1%	87.4%	87.6%	90.4%	90.8%	87.2%	
	62 day screening % (1 mth in arrears)	2016/17	90.0%	90.0%	94.4%	90.0%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%	94.4%
		2017/18	90.0%	90.0%	81.8%	90.0%	92.5%	96.4%	88.9%	85.7%	83.3%	77.3%	61.0%	81.1%	90.2%	87.5%	55.6%	
	31 days to first treatment % (1 mth in arrears)	2016/17	96.0%	96.0%	97.0%	96.0%	96.8%	98.9%	97.3%	99.0%	93.8%	92.7%	93.4%	95.7%	100.0%	100.0%	98.9%	100.0%
		2017/18	96.0%	96.0%	99.5%	96.0%	100.0%	100.0%	99.0%	97.8%	100.0%	98.2%	100.0%	100.0%	100.0%	99.0%	100.0%	
	31 days subsequent treatment (surgery) % (1 mth in arrears)	2016/17	94.0%	94.0%	95.7%	94.0%	94.4%	100.0%	100.0%	100.0%	78.6%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		2017/18	94.0%	94.0%	97.9%	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	92.9%	100.0%	100.0%	93.3%	100.0%	
	31 days subsequent treatment (anti cancer drugs) % (1 mth in arrears)	2016/17	98.0%	98.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		2017/18	98.0%	98.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Patients 2 week wait (all cancers) % (1 mth in arrears)	2016/17	93.0%	93.0%	98.8%	93.0%	99.1%	99.1%	98.0%	99.0%	98.5%	99.0%	98.9%	99.0%	98.5%	98.4%	99.1%	98.4%
		2017/18	93.0%	93.0%	97.4%	93.0%	93.9%	98.6%	98.6%	97.2%	97.2%	98.0%	98.3%	97.0%	97.8%	96.7%	97.9%	
	Patients 2 week wait (breast symptomatic) % (1 mth in arrears)	2016/17	93.0%	93.0%	95.2%	93.0%	97.0%	97.5%	96.0%	97.2%	95.8%	94.7%	95.5%	95.3%	90.2%	94.6%	94.0%	89.5%
		2017/18	93.0%	93.0%	65.9%	93.0%	89.1%	87.7%	45.1%	62.9%	21.8%	34.9%	38.1%	86.9%	89.9%	79.8%	88.9%	
	A&E 4 hour target	2016/17	95.0%	95.0%	82.5%	95.0%	80.3%	81.4%	85.3%	81.9%	86.1%	87.1%	81.5%	79.5%	79.2%	79.2%	85.3%	83.6%
		2017/18	95.0%	95.0%	81.9%	95.0%	82.5%	86.3%	84.6%	84.8%	78.3%	84.5%	88.0%	80.4%	76.9%	77.8%	79.6%	78.9%
Diagnostics and continued care of the services at BFT	Diagnostic Waits >6 weeks %	2016/17	1.0%	1.0%	0.8%	1.0%	1.5%	0.9%	1.0%	0.5%	1.2%	1.0%	0.7%	0.7%	0.6%	1.0%	0.3%	0.4%
		2017/18	1.0%	1.0%	2.3%	1.0%	0.3%	0.7%	0.3%	0.5%	0.8%	0.8%	1.5%	1.7%	5.3%	9.5%	4.8%	0.6%
Teams are appropriately staffed and flexible	Sickness absence levels are appropriately managed	2016/17	4.2%	4.2%	4.2%	4.2%	4.8%	4.4%	4.3%	4.8%	4.3%	4.3%	5.2%	5.3%	5.3%	5.3%	4.7%	4.2%
		2017/18	4.2%	4.2%	5.2%	4.2%	4.4%	4.1%	4.2%	4.5%	4.5%	4.6%	4.8%	5.2%	5.6%	6.2%	5.1%	5.2%
	iFM sickness	2017/18			8.97%		5.3%	6.2%	6.4%	7.8%	8.1%	7.7%	8.0%	7.3%	7.4%	9.6%	9.6%	9.0%
	Ward sickness	2017/18			7.72%		5.9%	5.5%	5.2%	6.0%	6.5%	6.6%	6.3%	6.8%	7.8%	8.4%	7.0%	7.7%

Bolton NHS Foundation Trust

Agenda Item No	

Meeting	Trust Board

Date	26/4/18

Title	2017/18 Data Security and Protection Requirements

Executive Summary	The Trust is required to respond to the requirements and confirm we are meeting the 10 key actions The Trust has reviewed its processes and can confirm compliance

Next steps/future actions	• To note the report and approve			
	Discuss		Receive	
	Approve	x	Note	X
	For Information		Confidential y/n	

This Report Covers (please tick relevant boxes)

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

Prepared by	P Winter	Presented by	A Ennis

Department of Health & Social Care

NHS England

2017/18 Data Security and Protection Requirements

NHS Bolton NHS Foundation Trust

Compliance Response

January 2018

Title: 2017/18 Data Security and Protection Requirements
Author: DDP 13920
Document Purpose: Guidance
Publication date: January/2018/NHS England Gateway Reference - 07571
Target audience: NHS Providers, Local Authorities, Social Care Providers, General Practices, Clinical Commissioning Groups
Contact details: Digital, Data and Primary Care, Department of Health, Quarry House, Leeds / 39 Victoria Street, London

Published to gov.uk, in PDF format only.
www.gov.uk/dh

2017/18 Data Security and Protection Requirements

Prepared by

Department of Health

NHS England

NHS Improvement

Summary

This document sets out the steps health and care organisations are expected to take in 2017/18 to demonstrate that they are implementing the ten data security standards[1], recommended by Dame Fiona Caldicott, the National Data Guardian for Health and Care and confirmed by Government in July 2017. This document also includes further details regarding the assurance framework for April 2018 onwards.

NHS
Bolton
NHS Foundation Trust

IT Services Compliance Response

To make the reading of this document easier and to maintain the DOH links and additional material we have placed our response in LIGHT BLUE after each of the data security and compliance requirements and then the statement of compliance.

[1] Review of Data Security, Consent and Opt-Outs - Parliament UK

Background

From April 2018 the new Data Security and Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit (IG Toolkit). It will form part of a new framework for assuring that organisations are implementing the ten data security standards and meeting their statutory obligations on data protection and data security. Further information on the new assurance framework, which will build on these requirements, is provided in this document.

The ten data security standards apply to all health and care organisations. When considering data security as part of the well-led element of their inspections, the Care Quality Commission (CQC) will look at how organisations are assuring themselves that the steps set out in this document are being taken. More information on the CQC inspection frameworks can be found here: http://www.cqc.org.uk/guidance-providers

NHS Providers

Organisations contracted to provide services under the NHS Standard Contract (NHS providers) must comply with the requirements set out in this document, as part of the data security and protection requirements set out in that contract. At the end of the 2017/18 financial year NHS Improvement will ask NHS providers to confirm that they have implemented the requirements set out in this document. In the longer term NHS Improvement will ensure that data security is included in their oversight arrangements.

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs), as discrete NHS organisations responsible for their corporate IT services, must comply with the requirements set out in this document. As commissioners of GP IT services, CCGs must ensure commissioned GP IT providers are contractually required to comply with these requirements.

General Practice

General Practices, contracted to provide primary care essential services to a registered list under the NHS standard General Medical Services (GMS) contract (or Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contracts, must comply with the requirements set out in this document, as part of the data security and protection requirements set out in CCG-Practice Agreement (terms governing the provision and receipt of GPSoC services and GP IT services). Some requirements will be implemented by the commissioner of the GP IT & GP Information Governance Support Service (Clinical Commissioning Group (CCG) or NHS England Regional) on their behalf.

Local Authorities and Social Care Providers

A proportionate response is needed for local authorities and social care providers given the context they work within.

Local Authorities

Local authorities should comply with the requirements in this document where they provide adult social care or public health and other services that are receiving services and data from NHS Digital and / or are involved in data sharing across health and care where they process the personal confidential data of citizens who access health and adult social care services.

Social Care Providers

Social care providers who provide care through the NHS Standard contract need to comply with the new DSP Toolkit from April 2018.

For social care providers who do not provide care through the NHS Standard Contract, there is no action to take during 2017/18. However, it is recommended that all social care providers consider compliance with the new DSP Toolkit from April 2018. This will help to demonstrate compliance with the ten data security standards and prepare for the General Data Protection Regulation (GDPR) which comes into force from May 2018.

Further Queries

If you have any queries and / or would like to be signposted to more resources about the DSP Toolkit or CareCERT, please contact NHS Digital's Data Security Centre which provides services, guidance and support to health and care organisations at: cybersecurity@nhs.net

Part A: 2017/18 Data Security and Protection Requirements - NHS organisations

This section sets out the steps that NHS organisations are required to take in 2017/18 to implement the data security standards. These requirements are across the three leadership obligations under which the data security standards are grouped: people, process and technology. (Part B sets out how these requirements apply to General Practices and Part C sets out how these requirements apply to local authorities and social care providers).

Leadership Obligation One – People:

1. **Senior Level Responsibility:** There must be a named senior executive to be responsible for data and cyber security in your organisation. Ideally this person will also be your Senior Information Risk Owner (SIRO), and where applicable a member of your organisation's board.

The named person is Andy Ennis COO and SIRO

Status: **Fully Implemented**

2. **Completing the Information Governance Toolkit v14.1:** In 2017/18, organisations are still required to achieve at least level two on the current IG Toolkit before it is replaced with a new approach (the new DSP Toolkit), from 2018/19 onwards, to measuring progress against the ten data security standards.

The Trust published its 2017-18 toolkit return in March 2018. The Trust achieved at least level 2 standards in all of the 45 criteria and achieved a benchmark figure of 83% compliance. This is comparable with all other Trusts in Greater Manchester and across the NW of England

Status: **Fully Implemented**

3. **Prepare for the introduction of the General Data Protection Regulation (GDPR) in May 2018:** The Beta version of the Data Security and Protection Toolkit, to go live in February 2018, will help organisations understand what actions they will need to take to implement GDPR, which comes into effect in May 2018.

The Trust has a comprehensive work programme in place to meet the requirements of GDPR. The Board are aware of the work and have approved the implementation. The risks associated with GDPR have been documented. All divisions are represented on the working group. Staff awareness is ongoing and formal training has been arranged for Board members and senior managers.

Status: **Fully implemented**

4. **Training Staff:** All staff must complete appropriate annual data security and protection training. This training replaces the previous IG training whilst retaining key elements of it: https://www.e-lfh.org.uk/programmes/data-security-awareness/

All staff must undertake IG training annually. IG training reports are monitored monthly and reported to the IG Committee.

The levels are consistently around 90% of all staff.

Status: **Partially Implemented**

Leadership Obligation Two - Processes:

5. **Acting on CareCERT advisories:** Organisations must:

- Act on CareCERT advisories where relevant to your organisation;
- Confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect; and
- Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect.

Note: Action might include understanding that an advisory is not relevant to your organisation's systems and confirming that this is the case.

More information on CareCERT (including CareCERT Collect) can be found here: https://nww.carecertisp.digital.nhs.uk/

Organisations wishing to sign up or log in to CareCERT Collect should go to:

https://nww.carecertcollect.digital.nhs.uk

We take each CareCERT advisory and place the individual security items on our service desk system for tracking, delegation, auditing and remediation.

2017/18 Data Security and Protection Requirements
Live Example for Service Desk System:

Number ▲	Caller ID	Short description	Priority	State	Location	Assignment group	Configuration item	3rd Party	Close notes
INC239554	Brett Walmsley	KaiXin Exploit Kit	3 - Moderate	Closed	IT Services	Security			The Trust complies with all the recommen…
INC239557	Brett Walmsley	Microsoft Word DDE Has Been Disabled	3 - Moderate	Closed	IT Services	Security			We are currently using Office 2010. IT S…
INC239558	Brett Walmsley	ROBOT Attack	3 - Moderate	Active	IT Services	Security			
INC239560	Brett Walmsley	New Variant of CryptoMix	3 - Moderate	Closed	IT Services	Security			File Extension .WORK added to FRSM on al…
INC239561	Alex Fildes	Keylogger on HP Devices	3 - Moderate	Closed	IT Services	Security			have disabled the application on these d…
INC239563	Brett Walmsley	Loapi Mobile Trojan	3 - Moderate	Closed	IT Services	Security			Only Portatrac devices are Android and t…
INC239564	Brett Walmsley	GnatSpy Mobile Malware	3 - Moderate	Closed	IT Services	Security			Only Portatrac devices are Android and t…
INC239565	Brett Walmsley	Vendor Security Updates	3 - Moderate	Closed	IT Services	Security			Chrome V63 has been pushed out to PCs an…
INC240269	Brett Walmsley	Malware Trio Attacking SQL Servers	3 - Moderate	Closed	IT Services	Security			The Trust currently complies with all of…
INC240271	Brett Walmsley	WPAD Exploits	3 - Moderate	Closed	IT Services	Security			The C_GPO_Security_Services has the sett…
INC240272	Brett Walmsley	Vendor Security Updates	3 - Moderate	Closed	IT Services	Security			Only IT Services use Firefox. Dean Ecker…

All high severity CareCERT advisories are acted upon in the same way as above but within the 48 hour remediation/mitigation deadline. They are evidenced through CareCERT Collect. Note (This web portal is not always available)

All points of contact have been provided through CareCERT Collect. The key contacts are

Phillipa Winter – CIO
Brett Walmsley – CTO
Phil Howe – Infrastructure Manager

Status: **Fully implemented**

6. **Continuity planning:** A comprehensive business continuity plan must be in place to respond to data and cyber security incidents.

We confirm we have a business continuity plan put in place under our ISO 27001 accreditation.

Please see embedded “Business Continuity Plan v2.docx”

Business Continuity Plan v2.docx

IT Services ISO 27001 Certificate:

APPROACHABLE
certification

Certificate of Registration

This is to certify that the Information Security Management System of:

Bolton NHS Trust
IT Services, The Royal Bolton Hospital
Minerva Road
Farnworth
Bolton
Greater Manchester
BL4 0JR

has been approved by Approachable Certification to the following standard(s)

ISO 27001:2013

APPROACHABLE REGISTERED
UKAS MANAGEMENT SYSTEMS
8320

Certificate Number:	**10834-ISMS-001**
Scope of Activities:	**Provision and management of Bolton NHS Foundation Trust's e-mail service in accordance with statement of Applicability Version 2.3 Dated 20/2/18**
Signed: (on behalf of AC)	Rachel Maxwell
Issue Date:	**19 April 2018**
Expiry Date:	**18 April 2021**

This certificate has been issued by Approachable Certification Ltd, 18, The Forum, 2 Tameside Business Park, Windmill Lane, Denton, Manchester, M34 3QS and will remain current subject to the company maintaining its system to the required standard(s). This will be monitored regularly by Approachable Certification.

www.approachable.uk.com

Status: **Fully implemented**

7. **Reporting incidents:** Staff across the organisation report data security incidents and near misses, and incidents are reported to CareCERT in line with reporting guidelines.

IT services have the processes in place to respond and report within CareCERT Guidelines.

Status: **Fully implemented**

Leadership Obligation Three - Technology:

8. **Unsupported systems:** Your organisation must:

- Identify unsupported systems (including software, hardware and applications); and
- Have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.

NHS Digital good practice guide on the management of unsupported systems can be found at: https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care (and associated documents on the main CareCERT web site)

There will be an asset register with ownership and mitigation in place by the end April 2018. However there is clinical equipment that still requires departmental business cases to replace or update outside of IT Services. Where possible these will be mitigated with the significant security systems:

- Firewall with IPS/IDS/DDOS/Threat Emulation/Application control
- Proxy servers with IPS, Sandstorm technology, Website categorisation
- Local Area Network (LAN) Network access controls and policy based port control
- Internal LAN Artificial Intelligence (AI) monitoring for lateral and usual behaviour detection

Status: **Partially Implemented**

9. **On-Site Assessments:** Your organisation must:

- Undertake an on-site cyber and data security assessment if you are invited to do so by NHS Digital; and
- Act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.

There is a site security assessment scheduled on August 2018. In addition, we use security scanning tools on a regular basis to scan and report on key systems

Status: **Partially Implemented**

10. **Checking Supplier Certification:** Your organisation should ensure that any supplier of IT systems (including other heath and care organisations) and the system(s) provided have the appropriate certification. A list of certification frameworks is provided below.

Supplier Certification Frameworks

Depending on the nature and criticality of the service provided, certification might include:

- ISO/IEC 27001:2013 certification - Supplier holds a current ISO/IEC27001:2013 certificate issued by a UKAS accredited certifying body and scoped to include all core activities required to support delivery of services to the organisation.
- Cyber Essentials (CE) certification - The supplier holds a current CE certificate from an accredited CE Certification Body.
- Cyber Essentials Plus (CE+) certification - The supplier holds a current CE+ certificate from an accredited CE+ Certification Body.
- Digital Marketplace - Supplier services are available through the UK Government Digital Marketplace under a current framework agreement.
- Other types of certification may also be applicable. Please refer to Cyber Security Services 2 Framework via Crown Commercial:

https://ccs-agreements.cabinetoffice.gov.uk/contracts/rm3764ii

It should be noted that where a provider holds certification it is not always the case that the services they provide are certified to the same level. Further, placement on a procurement framework does not guarantee the level of certification of a supplier or service. In general, Cyber Essentials should be considered a minimum requirement.

We have written to our critical IT systems suppliers (list agreed by the IG group) regarding GDPR compliance – copy attached. Under section 2 I have asked about their security accreditation. Deadline for return is 30th April 2018

Status: **Partially Implemented**

NOTE: we will be sending a round robin email to ALL our suppliers stating that we expect them to be GDPR compliant or working towards same.

Part B: 2017/18 Data Security and Protection Requirements – General Practice

This section sets out the steps that General Practitioners, CCGs and their commissioned GP IT Delivery Partner(s) are required to take in 2017/18 to implement the ten data security standards within General Practice. These requirements are across the three leadership obligations under which the ten data security standards are grouped: people, process and technology.

Leadership Obligation One – People:

1. **Senior Level Responsibility:** Each practice must have a named partner, board member or equivalent senior employee to be responsible for data and cyber security in the practice. This requirement further defines existing practice obligations to identify the person with lead responsibility for IT matters in the Practice (CCG-Practice Agreement - 5.3). The CCG as commissioner of GP IT services will be responsible for providing specialist support to this role but each practice remains accountable. CCGs must ensure their commissioned GP IT Delivery Partner has allocated equivalent senior level responsibility for data and cyber security within their organisation.

2. **Completing the Information Governance Toolkit v14.1:** Each practice remains accountable and responsible for completing the current GP IG Toolkit with a recommendation that practices attain level two as a minimum. From 2018/19 onwards it will be replaced with a new approach to measure progress against the ten data security standards. The commissioned GP IG services are available to support practices in this. The locally commissioned GP IT Delivery partner will also be contractually required to complete the current IG toolkit to at least level two for their organisation and the services delivered under the GP IT contract.

3. **Prepare for the introduction of the General Data Protection Regulation (GDPR) in May 2018:** The Beta version of the Data Security and Protection Toolkit, to go live in February 2018, will help organisations understand what actions they will need to take to implement GDPR, which comes into effect in May 2018.

4. **Training Staff:** Each General Practice is accountable for ensuring all staff complete appropriate annual data security and protection training. Online training is available. This training replaces the previous IG training whilst retaining key elements of it: https://www.e-lfh.org.uk/programmes/data-security-awareness/

Leadership Obligation Two - Processes:

5. **Acting on CareCERT advisories:** CCGs will ensure the locally commissioned GP IT delivery partner(s) will be responsible for meeting the following requirements with the CCG holding accountability actioned through exception reporting. Organisations must:

- Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect.

Note: Action might include understanding that an advisory is not relevant to your organisation's systems and confirming that this is the case.

More information on CareCERT (including CareCERT Collect) can be found at: https://nww.carecertisp.digital.nhs.uk/

Organisations wishing to sign up or log in to CareCert Collect should go to:

https://nww.carecertcollect.digital.nhs.uk

6. **Continuity planning:** Each General Practice must continue to maintain a business continuity plan (CCG-Practice Agreement) which will include the response to data and cyber security incidents. CCGs are required to ensure commissioned GP IT delivery partner(s) maintain business continuity and disaster recovery plans for services provided to General Practices, which will include responses to data and cyber security incidents.

7. **Reporting incidents:** Each General Practice is accountable for ensuring data security incidents and near misses are reported to CareCERT in accordance with national reporting guidance and legal requirements (NHS GP IG Toolkit ref 14.1-320). Specialist support for GP Cyber Security incident reporting and management will be part of the commissioned IT security and IG service.

Leadership Obligation Three - Technology:

8. **Unsupported systems:** CCGs must ensure for all supported General Practices the following:

- Identify unsupported systems (including software, hardware and applications); and
- Have a plan in place by April 2018 to remove, replace or actively mitigate and actively manage the risks associated with unsupported systems.

NHS Digital good practice guide on the management of unsupported systems can be found at: https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care (and associated documents on the main CareCERT web site)

9. **On-Site Assessments:** CCGs must ensure the commissioned GP IT delivery partner carries out the following for all supported General Practices and GP IT infrastructure. General Practices must fully support such assessments, and:

- Undertake an on-site cyber and data security assessment if you are invited to do so by NHS Digital; and
- Act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.

All practices must comply with agreed action plans to meet their responsibilities described in the CCG – Practice Agreement.

Where systems and IT infrastructure process person identifiable data outside the scope of the CCG's commissioned GP IT delivery service or GPSoC, then individual General Practices are accountable for assuring all of the above requirements are met.

10. **Checking Supplier Certification:** All parties who commission or procure IT Systems

i.e. individual General Practices, CCG, GP IT Delivery Partners and NHS Digital (GPSOC) will ensure that any supplier of IT Services, infrastructure or systems used in General Practice have the appropriate certification. CCGs will ensure commissioned GP IT services include access to specialist technical advice for IT procurement.

Supplier Certification Frameworks

Depending on the nature and criticality of the service provided, certification might include:

- ISO/IEC 27001:2013 certification - Supplier holds a current ISO/IEC27001:2013 certificate issued by a UKAS accredited certifying body and scoped to include all core activities required to support delivery of services to the organisation.
- Cyber Essentials (CE) certification - The supplier holds a current CE certificate from an accredited CE Certification Body.
- Cyber Essentials Plus (CE+) certification - The supplier holds a current CE+ certificate from an accredited CE+ Certification Body.
- Digital Marketplace - Supplier services are available through the UK Government Digital Marketplace under a current framework agreement.
- Other types of certification may also be applicable. Please refer to Cyber Security Services 2 Framework via Crown Commercial:

https://ccs-agreements.cabinetoffice.gov.uk/contracts/rm3764ii

It should be noted that where a provider holds certification it is not always the case that the services they provide are certified to the same level. Further, placement on a procurement framework does not guarantee the level of certification of a supplier or service. In general, Cyber Essentials should be considered a minimum requirement.

Part C: 2017/18 Data Security and Protection Requirements – Local Government and Social Care Providers

This section sets out the steps that local authorities and social care providers need to take in 2017/18 to implement the ten data security standards. A proportionate response is needed for local authorities and social care providers, given the context they work within.

Local authorities

Local authorities have responsibility for the safe and secure handling of personal and confidential information across a range of services including public health and adult social care. Local authorities may also have access to relevant health information, either to support their care delivery role or to support their commissioning responsibilities.

The ten data security standards will be integrated within the new DSP Toolkit from April 2018. A number of the requirements in the Toolkit will be mandatory for completion (to ensure application of the standards), whilst others will be optional.

As with existing arrangements for the IG Toolkit, non-NHS organisations (including local authorities) will need to complete the new DSP Toolkit where they are accessing systems, services and data provided by NHS Digital or where they provide adult social care or public health.

In addition, the new DSP Toolkit can be used to support the local sharing of health and adult social care information by providing evidence about the effective handling of information across organisations. It may be used by local authorities where they are commissioning or co-commissioning services.

Many local authorities already complete the existing IG Toolkit so this is not a new requirement. The new DSP Toolkit will be relevant for adult social care, public health or other services that may be accessing NHS Digital services or processing health and care information. Many local authorities have used the IG Toolkit across the whole organisation and others may wish to consider this as part of the new Toolkit.

Local authorities already have quality assurance arrangements in place either through the Public Service Network (PSN), ISO or other quality standards. To ensure there is no duplication between these frameworks, the DSP Toolkit will be tailored accordingly where local authorities have completed aspects of the new DSP Toolkit through other quality assurance arrangements. For example, the current PSN IA Certification provides the equivalence to the IG Training Standard in the IG Toolkit and this is planned to continue. Local authorities will therefore only be required to complete the relevant sections. NHS Digital is working closely with the Cabinet Office to ensure these frameworks are aligned to help to reduce any additional requirements from local authorities.

In summary:

- During 2017/18, local authorities should complete the 2017/18 IG Toolkit Version 14.1 where they provide adult social care or public health or are accessing services and data from NHS Digital and / or are involved in data sharing across health and care.

- From April 2018 onwards, local authorities should complete the new DSP Toolkit for adult social care, public health and other services that are receiving services and data from NHS Digital and / or are involved in data sharing across health and care where they process the personal confidential data of citizens who access health and adult social care services.

Social care providers

Social care providers who provide care through the NHS Standard Contract

For social care providers who provide care through the NHS Standard contract, there is a mandatory requirement to comply with the new DSP Toolkit from April 2018.

Social care providers who do not provide care through the NHS Standard Contract

For social care providers who do not provide care through the NHS Standard Contract, there is no action to take during 2017/18.

However, it is recommended that all social care providers consider compliance with the new DSP Toolkit from April 2018 because:

- All social care providers are expected to be compliant with the ten data security standards.
- In preparation for the GDPR which comes into force from May 2018. The GDPR will replace the 1995 data protection directive by bringing together privacy laws across Europe and aims to give greater protection and rights to individuals.

It is acknowledged that few social care providers have completed the existing IG Toolkit. This guidance therefore recognises that many social care providers will need time to enhance their level of digital maturity and develop systems and processes to achieve compliance.

Whilst it will not be mandatory for all social care providers to complete the new DSP Toolkit from 2018/19 and there has been no deadline established for compliance for those who do not operate under the NHS standard contract, the new DSP Toolkit has been designed and tested with social care providers to be both relevant and proportionate to the sector (with accompanying guidance for the sector).

Opportunities for Social Care Providers

The new DSP Toolkit will help social care providers audit their own systems and practices against the ten data security standards, as well as help social care organisations understand how the GDPR will impact on them.

Completing the new DSP Toolkit will also open up opportunities for social care providers to be involved in local information sharing initiatives and gain access to a range of national resources which will support data and cyber security and greater information sharing between health and social care including:

- Access to NHSmail, enabling the sharing of information across organisational and geographical boundaries. This includes the use of collaborative tools such as the NHSmail directory, Skype for Business options and secure email with other NHSmail users and those

who also use secure email systems e.g. local authorities using Microsoft Office 365. NHSmail can be accessed from all common smartphones, tablets and desktop computers.

- Access to Summary Care Records (SCRs) for approved organisations which meet all the necessary IG and data protection requirements. Work has now started to investigate the best secure way for care providers to access SCRs, which traditionally contain key information from General Practitioners including medication, allergies and adverse reactions. Additional information such as details of long-term conditions, significant medical history, personal preferences including specific communications needs can be added with the person's consent. Over 97% of people registered with a General Practice in England (55.2 million people) now have an SCR.

Both options have already been rolled out to Community Pharmacies after completion of the IG Toolkit and much can be learnt from the way they were implemented.

CQC Key Lines of Enquiry (KLOE) include a focus on the use of technology and sharing information for the benefit of the care to the individual. In addition, from 1 November 2017, CQC introduced a new KLOE under the Governance and Management section of the well-led inspection area covering data security. Whilst the KLOE does not specifically reference the DSP Toolkit, it will be looking for providers to operate within a framework that demonstrates robust arrangements around the security, availability, sharing and integrity of confidential data, records and data management standards.

The CQC are piloting using NHS Digital intelligence from the DSP Toolkit, on-site assessments and network monitoring to support them in inspections. Staff learning and training regarding IG in general is key to supporting fulfilment of the KLOE and data security standards.

In summary:

- For social care providers who provide care through the NHS Standard Contract, it will be mandatory to comply with the new DSP Toolkit from April 2018.
- Whilst it will not be mandatory for social care providers who do not provide care through the NHS Standard Contract to complete the new DSP Toolkit from April 2018, it is recommended that providers consider completing it to help demonstrate compliance against the ten data security standards, prepare for the forthcoming GDPR and support information sharing.

Understanding the approach to measuring progress from 2018/19 onwards

The approach to measuring progress in implementing the ten data security standards and compliance with data protection legislation, through the DSP Toolkit which will replace the IG Toolkit from April 2018, is being tested with over 500 health and care organisations.

In preparing for 2018/19, you may consider that you need to increase your organisation's understanding of data and cyber security:

- Read 'An Introduction to Cyber Security': http://www.careprovideralliance.org.uk/guidance.html which, although published for social care providers, has information that will be of use to anyone wishing to learn more about cyber security.
- Consider the Ten Steps to Cyber Security: https://www.ncsc.gov.uk/guidance/10-steps-cyber-security and how these steps might apply to your organisation to support the implementation of the ten data security standards.
- Refer to NHS Digital's Data Security Good Practice Guides for health and care - specific guidance on how to achieve aspects of the Ten Steps to Cyber Security: https://www.digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care

Key dates:

November 2017: The replacement for the IG Toolkit, the new DSP Toolkit started to be piloted with users.

February 2018: All organisations will have access to the new DSP Toolkit to familiarise themselves with the approach to measuring implementation and compliance and consider how they might apply to their organisation from April 2018.

April 2018: Further guidance will be published to support organisations to use the new DSP Toolkit.

April 2018: All organisations will now be required to complete the new DSP Toolkit.

May 2018: The EU GDPR, and Security of Network and Information Systems Directive, come into force. This will increase the legislative data security and protection requirements on health and care organisations.

Agenda Item No: 15

Meeting	Board of Directors

Date	Thursday 26th April 2018

Title	Readiness Assurance re: The General Data Protection Regulations May 2018

Executive Summary	The report outlines actions being taken by the Trust to ensure compliance with GDPR. Whilst final detail has not been published nationally, the Trust is updating its processes/training and policies in line with information received so far. The GDPR will apply in the UK from 25th May 2018. The government has confirmed that the UK's decision to leave the EU will not affect the commencement of the GDPR. The Trust must demonstrate compliance with the GDPR and have processes and systems in place that meet the requirements. This paper sets out a summary of the work that has been undertaken to meet the changes. • The Trust has proven IT security procedures in place as evidenced following the cyber-attack in 2017. • Given the above and controls in place for managing records and access controls to systems , the risks of a serious breach of Data Protection and enforcement action from the Information Commissioner's Office are felt to be limited. • The legal basis for processing data has been established and conforms with NHS guidance • To note that access to personal records will be free of charge from 25th May 2018. The current numbers are likely to increase. Compliance will need to be monitored. The full implementation of GDPR within the UK is still not clear. The Data Protection Bill which is still going through parliament may change certain aspects of the law. We will await further guidance from NHS England as to how GDPR may be interpreted within the NHS.

Previously considered by	

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

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

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

Prepared by	Graham Fullarton – Information Governance Manager	Presented by	Andy Ennis – Chief Operating Officer

Board Paper April 2018

European General Data Protection Regulations (GDPR)

1. BACKGROUND

On 4th May 2016 the European General Data Protection Regulations (GDPR) – Regulation (EU) 2016/679 was passed.

With the General Data Protection Regulations, the European Commission intends to strengthen and unify data protection within the European Union (EU). As this is a European Regulation, it will have a direct effect and will not require domestic legislation to be passed. All EU member states must comply with the GDPR by the 25th May 2018. The UK is currently passing the Data protection Bill which will enact the legislation in UK law

It is therefore of vital importance that the Trust demonstrates that is taking all reasonable endeavours.

2. CURRENT POSITION

In the financial year ending March 2018 the Trust reported 144 data protection incidents. All of those were of a minor nature and caused no harm or distress and none were reportable to the Information Commissioner's Office.

The Trust has robust IT security procedures in place as evidenced by its ability to cope with the cyber-attack in October 2017 without disruption. Controls are in place to continually updated security software and controls and new threats emerge.

The Trust's IT department has recently achieved ISO 27001 (information security standards). This is a national standard and demonstrates to robustness of our systems and working practices. In addition the Trust has achieved full compliance with all the standards in the Information Governance toolkit and can provide evidence in support. Our toolkit assessments compare favourable with other Trusts in Greater Manchester and the North West.

It should be acknowledged that incidents will still occur but given the IT systems controls which already been proven , externally audited supported by ongoing staff awareness and training we would judge that the likelihood of a very serious data breach happening is small and therefore the possibility of statutory enforcement limited.

GDPR training has been arranged for Board Members and Senior Managers for 15th May 2018.

3. SUMMARY OF THE MAIN LEGISLATIVE CHANGES, ASSURANCE and GAP ANALYSIS STATEMENTS

Description	GAP Analysis	Timescales	Assurance Statement	Risk Score (Likelihood vs impact)
3.1 Enforcement • The maximum fine for a breach has increased from £500,000 - £17 million (at today's exchange rate) • It will become easier for data subjects to make a claim in relation to a data breach. • Data Subjects will have the right to compensation from the data controller or data processor if a data breach or inaccurate data demonstrably causes harm/distress and where the Trust is shown to be negligent or proven not to have taken all reasonable steps.	• Review training, guidance, develop the IG Champions etc. • Review format and content of reports submitted to the IG Committee to ensure ongoing compliance with the GDPR and other data protection legislation. • Update record keeping standards	September 2018 June 2018 Complete – now on Moodle e-learning	The Trust coped with the NHS Wannacry cyber-attack in October 2017 effectively. Robust IT controls meant that there were no disruptions to patient care/services. The Trust has been audited against ISO information security standards and achieved accreditation – February 2018. No serious externally reportable during 2017-18. Incidents that did occur caused no harm/distress nevertheless we acknowledge that incidents will still happen but we will have all our procedures under review and report/escalate issues as they arise. The Trust achieves at least 90% compliance with its mandatory Information Governance training. This is monitored regularly within each division. We have a Data Quality team and supporting procedures in place to maintain the accuracy of our data as well as newly developed e-learning materials for records keeping on Moodle. Clinical effectiveness audit record keeping standards and these are reported via the relevant quality for ums. Records standards are also reviewed as part of the BoSCA accreditations.	2x 5

			Incidents as they occur are reported and acted upon. The Information Governance group reviews incidents to identify trends.	
3.2 Accountability • New principle of accountability means there is a need to demonstrate compliance. In this way, the Trust can be fined even if no 'harm' has occurred. • The Trust must keep a record of processing through data flow mapping exercises. • All new systems and processes should be designed in accordance with privacy by design and privacy by default.	• Maintain the Information Asset Registers and Systems registers to inform ongoing contractual requirements. • Strengthen the current Spot Check arrangements to ensure that they audit compliance with the GDPR.	Complete – IT systems and corporate records updated to March 2018 September 2018	The Trust is undertaking a review of its bulk transfers of data (20 records +). There are documented reasons for the legal basis for processing data available for inspection. All new projects/service changes must be accompanied by Privacy Impact assessments before approval. This will be monitored at CRIG and IT services. The Trust has inventories of IT systems and servers and all shared network drives as at March 2018. Ownership and responsibilities have been assigned. All data registers are compliant with ICOs classification and have been risk assessed for loss and business impact.	2x4
Description	**GAP Analysis**		**Assurance Statement**	**Risk Score (Likelihood vs impact)**
3.3 New Data Subject Rights • Consent (for processing personal and personal sensitive data) must be freely given, specific, informed and unambiguous, provided by clear affirmative statement or action and which is able to be easily withdrawn.	• Further explore the implications of the GDPR right to data portability – • Review existing erasure and inaccuracies procedures			4X3 Likely increases in numbers of requests and resources needed to comply

• Parents will be required to provide their consent to the processing of children's personal data where those children are under a particular age (varying between 13 to 16 years old).
• The rules for dealing with subject access requests will change significantly under the GDPR:
▪ The timeframe for the provision of the requested information is being reduced from 40 days to 30 days.
▪ There will be no more fees – with the removal of a fee there is an anticipated increase in request activity. In 2016, the Medical Legal Department received 2,159 requests.
• Individual Rights are strengthened in relation to:
  • having inaccuracies corrected;
  • having information erased, (not applicable to health records);
  • preventing direct marketing;
  • preventing solely automated decision making and profiling.
  • data portability;
  • having a wider right to be 'forgotten'.
	• Review information provided to patients and staff to ensure they fully reflect individual's rights under GDPR
	
	• Review policies and procedures to reflect GDPR requirements
	
	• Undertake a resource assessment of Medical/Legal team and wider organisational impact (expectation is that SAR requests will increase given no fee involved and clinicians/managers will have less time to process requests)
	
	• Ensure all staff are aware of the changes to requirements to comply with SAR under GDPR
		June 2018
		
		September 2018
		
		Complete – updated leaflets, posters/website
		
		September 2018
		
		Review in September 2018 – monitor activity/compliance
			Health Records have updated their standard operating procedures to reflect the new requirements.
			
			It is recognised that loss of income and reduced timescales for compliance presents risks. These have been documented on the risk register.
			
			Corrections to records are much easier now that many systems are linked and thus information can be updated very readily.
			
			The Trust is linked to national and local databases and has electronic links to GPS for example. The Trust has an established and experienced data quality team in post.	

Description	GAP Analysis		Assurance Statement	Risk Score (Likelihood vs impact)
3.4 Data Protection Officers (DPO's) All NHS bodies whose core business is the delivery of health and social care must appoint a DPO. DPO's must be independent and must not be instructed on how to carry out their role within the organisation. DPO is a cornerstone of accountability and appointing a DPO can facilitate compliance. In addition to facilitating compliance through the implementation of accountability tools (such as facilitating or carrying out data protection impact assessments and audits), DPOs act as intermediaries between relevant stakeholders (e.g. supervisory authorities, data subjects, and business units within an organisation). DPOs are not personally responsible in case of non-compliance with the GDPR. Data protection compliance is a responsibility of the controller or the processor. The DPO must report directly to the highest level of management (it has been	• Undertake a full assessment of the DPO role in line with that of the IG Manager. • Formally allocate the IG Manager role and title as the organisation's DPO. • Ensure the Information Governance team is properly resourced to deliver against the requirements of the GDPR. • Put in place a reporting infrastructure that protects the role of the DPO and enables unfettered reporting through to Board.	June 2018 May 2018 September 2018 May 2018	It is recommended that in the interim the Information Governance Manager still reports to the Chief Informatics Officer but with a subsidiary reporting to the SIRO (Chief Operations Officer) for the purposes of acting as Trust Data Protection Officer. The IG Manager already works across the entire Trust, is not responsible for any procurements of information systems and would not determine the nature of the processing. The IG Manager is already the registered contact for the Information Commissioner's Office as part of the current registration. There are identified risks in the staffing levels within the IG team to support our statutory obligations under a range of legislation such as GDPR, Data Protection, Freedom of Information etc.	3X4 Currently the IG department has 2 staff

suggested that they should report directly to the CEO).				
3.5 Conditions for Processing Stricter rules will apply to processing of sensitive personal data such as medical information. What constitutes sensitive personal data has been widened and will now include genetic and biometric data (i.e. any information which can identify who someone is). Public Authorities can no longer rely upon the legitimate interests' condition BUT can rely upon carrying out a public function instead. The Schedule 3 medical purposes condition is expanded to expressly include social care and there is an entirely new Schedule 3 condition for public health, quality and safety of health care and quality and safety of drugs and medical devices.	• Ensure any legal bases we rely upon for processing is identified within the Information Asset Register and ISPs and is reviewed to reflect compliance with the GDPR • Place legal bases for processing in our Privacy Notices	Complete Complete	The Trust has established its legal basis for processing data under GDPR**.** The reasons for processing data are: • Patient Data • Staff Data • Suppliers • Complaints and Enquiries • Survey responders • Professional experts and consultants • CCTV The legal framework for processing data under GDPR is under Article 6(e) – performance of a public task and article 9 (g) or 9(b) for sensitive data. Sensitive data is defined as the processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation Information sharing protocols (ISP) are documented on the Greater Manchester Sharing Gateway. This is supported by the guidance from NHS Digital.	Compliant

Description	GAP Analysis		Assurance Statement	Risk Score (Likelihood vs impact)
3.6 Breach Notifications There is a new duty to inform data subjects of high risk breaches; • There is a duty to notify Information Commissioner's Office (ICO) within 72 hours of breaches unless they are unlikely to result in a risk to the rights and freedoms of natural persons; and • There is a duty to report to the ICO even if only small numbers of service users are affected.	• Review policies and procedures • Review Safeguard reporting categories in respect of GDPR	September 2018 Complete – risks recorded on Safeguard	The Trust already has an obligation to report breaches under the existing NHS standards. This is via the Information Governance toolkit where incidents of a most serious nature are automatically sent to the Information Commissioner's Office. The Trust already has a reporting of serious untoward incident policy in place that takes account of data breaches**.** Where any breaches have occurred the Trust has adopted the duty of candour to inform patients.	Compliant
Description	**GAP Analysis**		**Assurance Statement**	**Risk Score (Likelihood vs impact)**
3.7 New Duties for Data processors • Duty under GDPR to for a data processor to act in accordance with controller instructions; • Data processors become data controllers if they act beyond instruction; • There are extra requirements for data processing requirements; and • There will be restrictions on sub-contracting by data processors	• Ensure all contracts with data processors have the relevant IG clauses and contracts are monitored routinely.	New contracts – complete. Existing contracts for critical systems – May 2018	All new contracts placed after March 2018 have the relevant contractual clauses included as part of the Crown Commercial Services standards. A review of business critical IT suppliers is being undertaken to seek assurance – April 2018**.** Processes are being reviewed where we are acting as joint data controllers e.g. Bolton Care Record, Integrated Neighbourhood Teams.	3X3

Description	GAP Analysis		Assurance Statement	Risk Score (Likelihood vs impact)
3.8 Fair Processing Notices There is a requirement for extra information to be included in privacy notices, including data retention periods, source of data and an outline of the processing conditions relied upon. Further, privacy notices need to be understood by children whose data is being processed by the organisation.	• Fair processing/Privacy notices includes the right to complain but we need to ensure our notices are compliant with the requirements set out in the GDPR / ICO Code of Practice	Complete	The Trust has completed its privacy notices for patients and staff in accordance with ICO guidance. The website is being updated and posters will be on display in public areas of the hospital and community.	Compliant
Description	**GAP Analysis**		**Assurance Statement**	**Risk Score (Likelihood vs impact)**
3.9 Privacy by Design Privacy Impact Assessments (PIA) must be carried out as appropriate for all projects involving the processing of sensitive personal data on large scale. A privacy impact screening questionnaire will assess whether a PIA in necessary given the circumstances.	• Carry out awareness raising of the requirement to conduct DPIAs to reflect GDPR changes. • Undertake DPIA on newer systems and determine the risk of older systems	On-going Complete	All new projects/service changes that process identifiable data and are submitted to CRIG or IT services must have a privacy impact assessment before approval. This is effective April 2018 Processing health data is considered as "high" risk data in the eyes of the ICO	3X4

4. CONCLUSION AND RECOMMENDATIONS

The risks associated with GDPR compliance are documented on the risk register.

We believe that the main risks to the Trust are:

1. Increased demand for access to records, the loss of associated income and reduced timescales for compliance. Steps are being taken to address these potential issues within the affected departments but numbers of requests will need to be monitored and reviewed on a regular basis and senior management advised of trends.

2. The financial impact for the Trust of a serious breach of Data protection is punitive. In mitigation we believe we have robust standards for IT security as evidenced by our recent ISO security accreditation. In mitigation out IT services have recently achieved ISO security standard accreditation. Whilst it would be acknowledged that incidents will still occur we can show that over 90% of our staff have current information governance accreditation which we will support with audits and spot checks during 2018/19.

3. The Information governance department have limited resources to cope with the increasing legislative and NHS policy demands regarding information rights. Staff awareness, professional advice and timely support is an essential component for the Trust to maintain compliance. Availability of staff for any long term reason poses a risk hence consideration should be made to enhancing the capability.

The full implementation of GDPR within the UK is still not clear. The Data Protection Bill which is still going through parliament may change certain aspects of the law. We will await further guidance from NHS England as to how GDPR may be interpreted within the NHS.

The Trust already complies with NHS Digital's Information Governance toolkit. Most of the standards within GDPR can already be evidenced by our IG toolkit returns. The Trust can demonstrate assurance for IT security by its response to last years's cyber attacks and that it has recently achieved ISO 27001 accreditation

It should be noted that the Information Commissioner's view is that they are not necessarily expecting full compliance with GDPR by 25th May but that organisations must be taking reasonable endeavours to achieve this goal and have action plans in place.

We would therefore seek to assure the Board that the Trust has recognised the significance of the changes to Data Protection within the UK and is taking all reasonable endeavours to meet its statutory obligations.

Graham Fullarton
Information Governance Manager
17th April 2018

Agenda Item No: 16

Meeting	Board of Directors

Date	26 April 2018

Title	Operational Plan refresh 2018/19

In December 2016, the Board approved a two year Operational Plan for 2017/18 and 2018/19. In accordance with guidance provided by NHSI and shared with the Board in February 2018 the Board are asked to approve a refresh of this plan for submission to NHSI.

The attached narrative will be submitted to NHSI alongside three workbooks setting out the financial, operational and workforce submission. The workbooks are available on request.

As Board members are aware we have reviewed and revised our performance report to align with national priorities and our own performance priorities, the new performance report for month one will be presented to the Board in May 2018.

NHSI require all Boards to self-certify:

1. that they are satisfied that adequate governance measures are in place to ensure the accuracy of data entered in the planning templates.
2. that the Board has accepted its control total and has an operational plan for 2018/19 that meets or exceeds the required financial control total for 2018/19 and the Board agrees to the conditions associated with the Sustainability and Transformation fund.
3. that the Board agrees to the delegated limit for capital expenditure and business case approvals in line with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts.
4. That to the best of its knowledge, using its own processes, the financial projections and other supporting material included in the completed templates represent a true and fair view, are internally consistent with the operational and, where relevant, strategic commentaries, and are based on assumptions which the board believes to be credible.

Next steps/future actions	Board members are asked to approve the refreshed operational plan and to approve the self certification statements			
	Discuss		Receive	
	Approve	✓	Note	
	For Information		Confidential y/n	

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

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

Prepared by	Executive Team	Presented by	Mrs Armstrong-Child Director of Nursing/Deputy Chief Executive

NHS
Bolton
NHS Foundation Trust

Refreshed operational plan 2018/19

Version 0.5

April 2018

VISION OPENNESS INTEGRITY COMPASSION EXCELLENCE

Contents

Acronyms

A&E	Accident and emergency
CCG	Clinical Commissioning Group
AQuA	Advancing Quality Alliance
CQUIN	Commissioning for quality and innovation
CVS	Community and voluntary services
DTOC	Delayed transfer of care
HES	Hospital episode statistics
ICIP	Income and cost improvement
ICO	Integrated care organisation
IPM	Integrated performance meeting
PSF	Provider Sustainability Fund
RTT	Referral to treatment

1. Introduction

The Borough of Bolton is part of Greater Manchester and has a resident population of approximately 280,000.

Bolton NHS Foundation Trust provides care and support in health centres and clinics as well as domiciliary care and ill-health prevention services. We also provide intermediate care in the community and a wide range of services at the Royal Bolton Hospital.

On 1st April 2016 the Greater Manchester Health and Social Care Partnership took charge of the £6bn health and social care budget from central government. The shared vision across Greater Manchester is to see the greatest and fastest improvement to the health and wellbeing of the 2.8 million people who live in Greater Manchester. *Taking Charge* is a five-year strategic plan for Greater Manchester built up from individual locality plans developed by the ten local authorities and NHS organisations across the city region.

The health and social care system comprises a number of statutory organisations along with a GP Federation and vibrant community and voluntary sector:

- Bolton Foundation Trust
- Bolton Council
- Bolton Clinical Commissioning Group
- Greater Manchester West Mental Health Foundation Trust
- Bolton GP Federation
- Bolton Community and Voluntary Services (CVS)
- Healthwatch Bolton

These organisations and wider stakeholders have worked jointly to develop *Bolton's Five-year Plan for Reform* (our locality plan) to deliver real improvements in health and wellbeing for the people of Bolton and make services more sustainable for the future. In 2018/19 Bolton NHS Foundation Trust will continue to support the implementation of the locality plan, including the development of integrated care organisation (ICO) spanning health and social care.

2. A refreshed operational plan

- Bolton NHS Foundation Trust developed its operational plan for 2017/18 and 2018/19 in response to the *NHS Operational Planning and Contracting Guidance 2017-2019* released in September 2016.

- The joint NHS England and NHS Improvement planning guidance has subsequently been updated and is set out in the document *Refreshing NHS Plans for 2018/19*.

- The updated planning guidance sets out how the November 2017 budget announcement of additional NHS revenue funding for 2018/19 will be distributed.

- It also sets out the expectation that providers should prepare short updates to their operational plans for 2018/19 in the light of the new guidance.

- Bolton NHS Foundation Trust has submitted a full suite of operating plan submissions in response to the updated guidance and in line with its requirements.

- This document provides an overview and explanation of the key changes to the operational plan in the following areas:
    - Activity
    - Quality
    - Workforce
    - Finance

3. Activity

Together the trust and Bolton CCG will be continuing with the aligned incentives contract for 2017/19 which will mitigate the financial risk for both parties. The contract has four key components: activity reduction, cost reduction, risk share and fixed income.

The joint NHS England and NHS Improvement planning guidance – *Refreshing NHS Plans for 2018/19* – set out increased funding to CCGs for a number of key areas, including levels of emergency activity in plans, the additional elective activity necessary to tackle waiting lists and transformation commitments for cancer services.

3.1. Urgent and emergency activity

We have agreed with NHS Bolton Clinical Commissioning Group planning assumptions of 3% growth in non-elective admissions and 3% growth in A&E attendances in 2018/19. This has been included at a high level in the trust's plans and discussions are ongoing with commissioners with regard to how best to deliver this growth and how this will enable improved A&E performance in 2018/19.

In common with many, the trust has struggled to achieve the A&E four-hour standard. Working with NHS Improvement's Emergency Care Improvement Programme (ECIP) and partners in the CCG and local authority, the trust aims to achieve the 90% threshold set out in the revised planning guidance by September 2018. This will be changed through a combination of support from ECIP on pathway transformation, focus on support from community services and estate capital work.

3.2. Elective activity

We have agreed with NHS Bolton Clinical Commissioning Group planning assumptions of 0.5% growth in total outpatient attendances and 0.5% growth in elective admissions in 2018/19. The planning assumption for England as a whole is that GP referrals will increase by 0.8%. This again has been included at a high level in the trust's plans and discussions are ongoing with commissioners with regard to how best to deliver this growth and how this will improve waiting times for patients in 2018/19.

Since September 2017 the trust has not achieved the referral to treatment standard due to a combination of underlying capacity issues and urgent care pressures. The trust is working with the CCG on a Capacity Management Programme which will include some backlog clearance work, demand management and investment in capacity. The plan has not been finalised at the time of writing, but it is anticipated that the trust will be on track to deliver compliance with the standard by the year end.

The trust's plan is that there will be no patients waiting over 52 weeks at March 2019. In addition, the trust is planning that the referral to treatment (RTT) waiting list, measured as the number of patients on an incomplete pathway, will be reduced from current levels by March 2019.

3.3. Delayed transfers of care

We aim to continue to reduce delayed transfers of care (DTOCs), both through reducing NHS-driven DTOCs and through continuing to work with the local authority to reduce social

care DTOCs. We aim to reduce the proportion of beds occupied by DTOC patients to 3.5% in 2018/19.

3.4. Length of stay

The trust continues to focus on length of stay reduction, with the aim of reducing this overall by at least half a day. There are many initiatives that we will continue to embed to achieve this, including driving discharges by 12 noon and 4 pm, NHS Improvement's SAFER patient flow bundle and Red2Green approach, and the reduction of medical outliers.

3.5. Cancer activity

Bolton NHS Foundation Trust has historically delivered on cancer waiting time standards and is committed to maintaining this in 2018/19. It is anticipated that with the involvement in the GM Cancer Plan, which includes initiatives such as faster diagnosis, that the trust will maintain this performance. We will ensure that all eight waiting time standards for cancer are met, including the 62 day referral to treatment cancer standard. As part of this we will ensure that the '10 high impact actions' for meeting the 62 day standard are fully implemented.

The main risk to the continued delivery is the Greater Manchester adoption of the national cancer breach allocation policies. Initial analysis suggests that the trust will be allocated more breaches and fewer treatments as a result of the change, with a potentially detrimental impact on performance.

3.6. Winter planning

There will be no additional winter funding in 2018/19. We will produce a separate winter demand and capacity plan, triangulating the finance and activity implications along with the actions and proposed outcomes, following the release of new guidance (expected March 2018).

4. Quality

The trust is focused on improving the quality of care for patients and maintaining financial balance, whilst working in partnership to strengthen the sustainability of services for the future.

4.1. Quality improvement

The trust's quality improvement (QI) strategy covers 2017 to 2020 and is therefore in its second year. The strategy puts the needs of patients, their families and carers first, and as well as supporting the trust priorities and the requirements of national and local plans.

The quality improvement strategy outlines four key quality improvement aims:

1. Reducing Mortality
2. Preventing Harm
3. Enhancing Patient and Carer Experience
4. Creating a Continuous Learning Culture

Each aim of the quality improvement strategy has measurable ambitions for the duration of the strategy. A quality improvement dashboard is in development to allow the tracking of progress against these measures.

As a trust we have a fluid approach to quality improvement and constantly seek to find new ways to deliver on our main aims. In 2018 in relation to reducing mortality (aim 1) we will galvanise our arrangements for 'learning from deaths' to ensure that they are compliant with the guidance from NHS Improvement.

In respect of enhancing patient and carer experience (aim 3) the Trust has signed up to the national *Always Events* campaign. Always Events are defined as "aspects of the patient experience that are so important to patients and family members that health care providers must aim to perform them consistently for every individual, every time." Over the course of 2018 we will map out a programme of research and measurement that will be implemented in 2019.

Our commitment to preventing harm (aim 2) and creating a continuous learning culture (aim 4) remains in place. We will continue to prevent harm through understanding and learning via Harm Free Care Panels to improve practice and we seek at all times to share learning from incidents as well as successes.

For 2018/19 we have renewed our membership of the Advancing Quality Alliance (AQuA) and continue to obtain hospital episode statistics (HES) benchmarked clinical outcome intelligence through our information partner (CHKS Limited) to help us identify quality improvement opportunities.

4.2. CQUIN scheme

We will achieve the targets of the 2017/19 CQUIN scheme, including the following:

- Improving staff health and wellbeing
- Reducing the impact of serious infections (antimicrobial resistance and sepsis)
- Improving services for people with mental health needs who present to A&E
- Offering advice and guidance services for non-urgent GP referrals
- Preventing ill health by risk behaviours – alcohol and tobacco
- Improving the assessment of wounds
- Personalised care and support planning

An update to the 2017/19 CQUIN guidance was published by NHS England in March 2018. This update provided indicator thresholds for some indicators for year 2 of the scheme.

5. Workforce

The trust invests time and resources developing robust workforce plans to anticipate our future skill mix needs to meet the anticipated future clinical demands. Robust, service focussed workforce planning is a key component of the trust's people strategy. Our key drivers are to develop sustainable skills within the workforce, identify and create new roles and ways of working, and developing divisional people plans led by clinical management teams working closely with workforce and finance colleagues to map future clinical service requirements with skill resource requirements.

As part of our workforce planning process we have introduced new roles within the workforce actively embracing advanced practitioners, nursing associates and physician associates as part of the future proofing of our workforce. We have excellent partnership working with Bolton University with us now entering into our third year of running our recently established adult nurse training, which is positively contributing to filling our workforce gaps within qualified nurses. The trust is an active part of the Greater Manchester collaboration for the training nursing associate programme and we are entering into our second pilot phase which will now be part of the apprenticeship programme.

Our workforce plans consider the significant workforce supply and retention challenges in the NHS. For 2018/19, our workforce plans reflect latest projections of supply and retention, taking into account the supply of staff from Europe and beyond, changes to NHS nursing and allied health professional bursaries, improvements expected in agency and locum use.

Our plans consider the workforce that will be required to deliver the growth in non-elective and elective activity working closely in collaboration within the North West Sector and across the Greater Manchester footprint. In doing this we have a strategic workforce plan to reduce our agency usage which we are committed to managing within our agency ceiling. Our plans also take account of the strengthening of bank arrangements and opportunities identified for improved productivity and workforce transformation through new roles and new ways of working.

We are focussed on the retention of our workforce and have a strategic plan to reduce labour turnover, support the health and well-being of the workforce aiming to ensure that Bolton NHS Foundation Trust is an employer of choice with Greater Manchester.

6. Finance

The updated NHS England and NHS Improvement planning guidance sets out that providers will are expected to plan on the basis of their 2018/19 control totals. The Board of Bolton NHS Foundation Trust confirms its acceptance of its control total.

6.1. Control total and Provider Sustainability Fund

The control total for 2018/19 was updated in the February 2018 guidance and is set at £2.1m with additional flexibility to reduce to £1.6m if the 2017/18 control total is delivered. The Provider Sustainability Fund (PSF) allocation is £11.1m and the agency ceiling is £5.8m. This can be seen in the table below:

	Revised control total for 2018/19 £,000	**Flexibility if 2017/18 Control total delivered £,000**
2018/19 Control Target	**2,090**	**1,623**
2018/19 PSF	11,094	11,094
2018/19 Surplus	**13,184**	**12,717**
Agency Ceiling	**5,814**	**5,814**

6.2. Income and cost improvements

The income and cost improvements (ICIPs) that are required to deliver the control target in 2018/19 amount to £20.2m. This represents 6.6% of turnover.

There is a robust Quality Impact Assessment (QIA) process which means all cost savings schemes are subject to QIA. This process is supported by the Medical Director and Director of Nursing who sign off savings schemes to provide assurance that savings are not being made at the detriment to quality/workforce/patient or staff experience/performance. QIA continue to be measured 6 months post implementation of scheme to ensure no residual impact on quality. Examples can be provided on request and are tracked on a QIA dashboard overseen by an Integrated Performance Management Meeting.

6.3. Capital

The trust capital plan for 2018/19 is set at £20.7m. This supports the ongoing replacement programme, conclusion of the £30m estates and IT investments secured following the trust coming out of breach of its license and the delivery of an electronic patient record (EPR). The EPR is funded via loan finance. This level of spending on capital is only affordable if the income and expenditure plans along with ICIP targets are delivered.

The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template. We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.	*i*	Confirmed
2. 2018/19 Control Total and Sustainability & Transformation Fund Allocation The Board has accepted its control total and has submitted this operational plan for 2018/19 that meets or exceeds the required financial control total for 2018/19 and the Board agrees to the conditions associated with the Sustainability and Transformation fund	*i*	Confirmed - control total accepted: S&T fund allocation incorporated in the plan
3. 2018/19 Capital Delegated Limit		
All NHS Trusts have a capital delegated limit of £15m. Foundation Trusts that fulfil any of the distressed financing criteria in rows 22-24 will have a capital delegated limit of £15m. As set out in the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, providers with delegated capital limits require business case approval from NHS Improvement. Foundation Trusts that do not fulfil any of the distressed financing criteria are subject to existing reporting and review thresholds as per the Supporting NHS Providers: guidance on transactions for NHS foundation trusts (March 2015) Appendix 1 and the Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts.		
Please complete below.		FT
Are you in Financial Special Measures?	*i*	Not in Financial Special Measures
If you are an FT, are you in breach of your licence? Or are you an NHS Trust?	*i*	Not in breach of Foundation Trust license
Have you received distressed financing or are you anticipating receiving this in either of the planning years?	*i*	Not in Receipt of Distressed Financing
Delegated capital limit (£000)		Existing reporting and review thresholds apply
Adjusted delegated capital limit (£000)	*i*	N/A
The Board agrees to the delegated limit for capital expenditure and business case approvals in line with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts.	*i*	Confirmed

In signing to the right, the board is confirming that:
To the best of its knowledge, using its own processes, the financial projections and other supporting material included in the completed Provider Financial Monitoring System (PFMS) Template represent a true and fair view, are internally consistent with the operational and, where relevant, strategic commentaries, and are based on assumptions which the board believes to be credible. This operating plan submission will be used to measure financial performance in 2018/19 and will be included in the calculation of the finance and use of resources metrics assessed under the Single Oversight Framework in 2018/19.

Signed on behalf of the board of directors; and having regard to the views of the governors (for FTs):

Signature	*i*	x
Name		Annette Walker
Capacity		Director of Finance
Date		27th April 2018