# AGENDA OF THE BOARD OF DIRECTORS

## PUBLIC BOARD

To be held at 09.00 am - 12.00 pm on Wednesday 4th October 2017

Seminar Room, Clinical Education Centre, Southport District General Hospital

---

<table>
<thead>
<tr>
<th>Ref No-</th>
<th>Agenda Item</th>
<th>Page No</th>
<th>Lead</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V = Verbal   D = Document   P = Presentation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PRELIMINARY BUSINESS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| TB191/17 (V)  | Chair’s welcome & noting of apologies  
To note the apologies for absence |         | Chair |        |
| TB192/17 (D)  | Declaration of Directors’ Interests  
To review and update declarations of interest relating to items on the agenda and/or any changes to the register of directors’ declared interests |         | Chair | 09.00 |
| TB193/17 (D)  | Minutes of the Meeting held on 6th September 2017  
To approve the minutes of the Board of Directors |         | Chair |        |
| TB194/17 (D)  | Matters arising action Log  
To review the Action Log and receive relevant updates |         | Chair |        |
| **STRATEGIC CONTEXT** |
| TB195/17 (D)  | Interim Chief Executive’s Report  
To note key issues and update from the CEO |         | COO | 09.10 |
| **QUALITY & SAFETY** |
| TB196/17 (V)  | Patient Story  
To discuss and note the learning from a patient or staff member’s experience of care |         | DoN | 09.20 |
| TB197/17 (D)  | CQC Improvement Plan  
To receive the monthly update report |         | DoN | 09.30 |
| TB198/17 (V)  | Priorities for the Winter  
To discuss plans to cope with winter pressures |         | COO | 09.35 |
| TB199/17 (V)  | Care For You  
To receive the monthly update report |         | DoN | 09.45 |
| TB200/17 (D)  | Safe Staffing Monthly Report  
To receive assurance of actions taken to maintain safe nurse staffing |         | DoN | 09.50 |
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Agenda Item</th>
<th>Page No</th>
<th>Lead</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB201/17 (D)</td>
<td>Chief Pharmacist Annual Report, including Medicines Safety.</td>
<td></td>
<td>MD</td>
<td>09.55</td>
</tr>
<tr>
<td></td>
<td>To receive the annual report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB202/17</td>
<td>Quality &amp; Safety Committee – AAA Highlight Report</td>
<td></td>
<td>Q&amp;S Chair</td>
<td>10.05</td>
</tr>
<tr>
<td></td>
<td>To receive the highlight report by way of assurance from the Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PERFORMANCE**

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Agenda Item</th>
<th>Page No</th>
<th>Lead</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB203/17 (D)</td>
<td>Audit Committee - AAA Highlight Report.</td>
<td></td>
<td>DoF</td>
<td>10.10</td>
</tr>
<tr>
<td></td>
<td>To receive the highlight report by way of assurance from the Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB204/17 (D)</td>
<td>Integrated Performance Report (IPR)</td>
<td></td>
<td>All Execs</td>
<td>10.15</td>
</tr>
<tr>
<td></td>
<td>To receive assurance from the current position in relation to national performance targets. Report includes the following updates from Matters Arising from meeting held 6 September 2017.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB205/17 (D)</td>
<td>Finance Performance &amp; Investment Committee: Alert Advise &amp; Assure (AAA) Report and Minutes of Meeting</td>
<td></td>
<td>DoF</td>
<td>10.35</td>
</tr>
<tr>
<td></td>
<td>To receive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB206/17 (D)</td>
<td>Director of Finance Report including Cost Improvement Programme and Internal Sustainability</td>
<td></td>
<td>DoF</td>
<td>10.40</td>
</tr>
<tr>
<td></td>
<td>To receive the current financial position at Month 3 and plans in place to deliver savings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB207/17 (V)</td>
<td>Capital Bid for Reconfiguration of the Stroke Ward</td>
<td></td>
<td>DoF</td>
<td>11.00</td>
</tr>
<tr>
<td></td>
<td>To receive an update</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB208/17 (D)</td>
<td>Charitable Fund Requests</td>
<td></td>
<td>DoF</td>
<td>11.05</td>
</tr>
<tr>
<td></td>
<td>To approve a request for use of Charitable Funds</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GOVERNANCE/WELL LED**

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Agenda Item</th>
<th>Page No</th>
<th>Lead</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB209/17 (D)</td>
<td>Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2017</td>
<td></td>
<td>COO</td>
<td>11.10</td>
</tr>
<tr>
<td></td>
<td>To approve the revised final review of the statutory Annual Report and Major Incident Plan V7 and Business Continuity Plan V7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB210/17 (D)</td>
<td>Statement of Compliance of the EPRR</td>
<td></td>
<td>COO</td>
<td>11.15</td>
</tr>
<tr>
<td></td>
<td>To approve the compliance statement to be submitted to NHS England</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB211/17 (D)</td>
<td>Board Assurance Framework (BAF)</td>
<td></td>
<td>ICoSec</td>
<td>11.20</td>
</tr>
<tr>
<td></td>
<td>To approve the strategic objectives and principal risks for 2017/18 and the BAF for 2017/18 and receive the BAF report for Month 8.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB212/17 (D)</td>
<td>Extreme Risk Register</td>
<td></td>
<td>DoN</td>
<td>11.30</td>
</tr>
<tr>
<td></td>
<td>To review all extreme risks and progress of mitigating actions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB213/17 (D)</td>
<td>Annual Business Cycle of Board and Committees &amp; Governance Structure</td>
<td></td>
<td>ICoSec</td>
<td>11.40</td>
</tr>
<tr>
<td>Ref No.</td>
<td>Agenda Item</td>
<td>Page No</td>
<td>Lead</td>
<td>Timing</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>To approve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB214/17(D)</td>
<td>Items for Approval / Ratification</td>
<td></td>
<td>DoN</td>
<td>11.50</td>
</tr>
<tr>
<td></td>
<td>• Risk Management Strategy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB215/17</td>
<td>Questions from Members of the Public</td>
<td></td>
<td>Public</td>
<td>11.55</td>
</tr>
</tbody>
</table>

**CONCLUDING BUSINESS**

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Agenda Item</th>
<th>Page No</th>
<th>Lead</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB216/17(V)</td>
<td>Any Other Business</td>
<td>Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To consider any other matters of business</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB217/17(V)</td>
<td>Items for the Risk Register/changes to the BAF</td>
<td>Chair</td>
<td></td>
<td>12.00</td>
</tr>
<tr>
<td></td>
<td>To identify any additional items for the Risk Register or changes to the BAF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>arising from discussions at this meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB218/17(V)</td>
<td>Message from the Board</td>
<td>Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To agree the key messages to be cascaded from the Board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>throughout the organisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB219/17(V)</td>
<td>Date and time of next meeting</td>
<td>Chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wednesday 1st November 2017, 9.00am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seminar Room, Clinical Education Centre, Southport District General Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACTIONS REQUIRED:**

- **Approve:** To formally agree the receipt of a report and its recommendations OR a particular course of action
- **Receive:** To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve
- **Note:** For the intelligence of the Board without the in-depth discussion as above
- **Assure:** To apprise the Board that controls and assurances are in place
- **For Information:** Literally, to inform the Board

Chair: Richard Fraser
<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION/ROLE</th>
<th>Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS</th>
<th>Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS</th>
<th>A position of authority in a charity or voluntary body in the field of health and social care</th>
<th>Any connection with a voluntary or other body contracting for NHS services</th>
<th>Related to anybody that works in the Trust</th>
<th>Other</th>
<th>Date of entry on register or amendment</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAXTER, Mrs Carol</td>
<td>Non-Executive Director</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Trustee Employers Network for Equality &amp; Inclusion</td>
<td>Trustee – Centre for Aging Better</td>
<td>4 February 2016</td>
</tr>
<tr>
<td>BIRRELL, Mr Jim</td>
<td>Non-Executive Director</td>
<td>Nil</td>
<td>Senior Adviser to Newton providing consultancy services to Private &amp; Public Sector</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>4 July 2017</td>
<td>Updated 25 September 2017</td>
</tr>
<tr>
<td>CLARKE, Mr Ged</td>
<td>Non-Executive Director</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Kinsella Clarke Chartered Accountants. A number of Trust’s Medical Consultants are clients.</td>
<td>1 May 2016</td>
<td></td>
</tr>
<tr>
<td>FRASER, Mr Richard</td>
<td>Chairman</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>1 December 2016</td>
<td></td>
</tr>
<tr>
<td>GIBSON, Mrs Pauline</td>
<td>Non-Executive Director</td>
<td>Director, Excel Coaching &amp; Consultancy Provision of coaching services to</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>25 July 2017</td>
<td></td>
</tr>
<tr>
<td>NAME</td>
<td>POSITION/ROLE</td>
<td>Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)</td>
<td>Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS</td>
<td>Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS</td>
<td>A position of authority in a charity or voluntary body in the field of health and social care</td>
<td>Any connection with a voluntary or other body contracting for NHS services</td>
<td>Related to anybody that works in the Trust</td>
<td>Other</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>GILLIES, Mr Rob</td>
<td>Executive Medical Director</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>GORRY, Mrs Julie</td>
<td>Non-Executive Director</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>JACKSON, Mrs Karen</td>
<td>Interim Chief Executive</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>LLOYD, Mrs Sheila</td>
<td>Executive Director of Nursing</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>PATTEN, Mrs Therese</td>
<td>Chief Operating Officer</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Trustee - Blackburn House Group</td>
<td>Nil</td>
</tr>
<tr>
<td>PENNELL, Mrs Ann</td>
<td>Non-Executive Director</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Governor – Burscough Primary Science College</td>
<td>Nil</td>
</tr>
<tr>
<td>ROYDS, Mrs Jane</td>
<td>Associate HR Director</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Vice Chair of Governors, Farnborough Road Junior School, Southport</td>
<td>Nil</td>
</tr>
<tr>
<td>SHANAHAN, Mr Steve</td>
<td>Director of Finance</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
</tbody>
</table>
Minutes of the Public Section of the Board of Directors’ Meeting
Wednesday, 6th September 2017 at 9.00 am
Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 4th October 2017)

PRESENT
Richard Fraser, Chair
Jim Birrell, Non-Executive Director
Ged Clarke, Non-Executive Director
Pauline Gibson, Associate Non-Executive Director*
Julie Gorry, Non-Executive Director
Sheila Lloyd, Director of Nursing, Midwifery & Therapies
Therese Patten, Chief Operating Office
Ann Pennell, Non-Executive Director (Vice Chair)
Dr Paul Mansour, Acting Executive Medical Director

IN ATTENDANCE
Audley Charles, Interim Company Secretary
Audrey Cushion, Assistant Director of Human Resources, Governance
Tony Ellis, Head of Marketing and Communications
Rachel Flood-Jones, Interim PA to the Company Secretary
Laura Hilton (Observer), Assistant Head of Human Resources
Michelle Kitson, Matron for Patient Experience (For Agenda Item TB170/17)
Gill Murphy, Deputy Director of Nursing
Chris Pilkington, Emergency Planning Liaison Support Officer (For Agenda Item TB181/17)
Kevin Walsh, Deputy Director of Finance

APOLOGIES
Carol Baxter, Non-Executive Director
Karen Jackson, Interim Chief Executive
Jane Royds,* Associate Director of Human Resources
Steve Shanahan, Director of Finance

*Indicates Non-Voting Members

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>MINUTE</th>
<th>ACTION LEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB165/17</td>
<td>CHAIRMAN’S WELCOME AND NOTE OF APOLOGIES</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Chairman, Mr Fraser, opened the meeting by welcoming board members and members of the public. He extended a welcome to new Non-Executive Director Mrs Gibson on joining the Board and to Mrs Gorry who was attending the board as a Non-Executive Director for the first time. Mr Fraser also introduced to the Board, the new Interim Company Secretary, Mr Audley Charles.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Chairman also welcomed Dr Mansour as Acting Executive Medical Director; Mrs Cushion attending in place of Mrs Royds as Assistant Director of Human Resources; Governance, Mrs Hilton observing as Assistant Head of Human Resources; Mr Kevin Walsh representing Mr Shanahan as Deputy Director of Finance and Mrs Gill Murphy, presenting papers on behalf of Mrs Lloyd. Mr Fraser thanked Mrs Lloyd representing Mrs Jackson in her capacity</td>
<td></td>
</tr>
</tbody>
</table>
as Acting Chief Executive Officer.

The Chairman noted apologies from:
Carol Baxter, Non-Executive Director
Karen Jackson, Interim Chief Executive
Jane Royds,* Associate Director of Human Resources
Steve Shanahan, Director of Finance

<table>
<thead>
<tr>
<th>TB166/17</th>
<th>DECLARATION OF DIRECTORS’ INTERESTS CONCERNING AGENDA ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Chair asked that any changes or additions to the Register of Interests declared by the Board of Directors should be submitted to the Company Secretary. The Register would be updated as required and brought back each month to the Board.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TB167/17</th>
<th>MINUTES OF THE MEETING HELD ON 27 JULY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Chair thanked the Interim Company Secretary and the Interim Assistant to the Company Secretary for the timely issue of the Board Pack.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>The Chair asked the Board to approve the Minutes of Meeting of 27th July 2017 subject to the following changes which were noted for amendment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Page 13: Self-assessment for Surgical should read “Requires Improvement”</td>
</tr>
<tr>
<td></td>
<td>Page 14: The action should be allocated to Mr Shanahan</td>
</tr>
<tr>
<td></td>
<td>Page 15: The Guardian of Safe Working has resigned from this role but that she continued to work as a Consultant within the Trust.</td>
</tr>
<tr>
<td></td>
<td>Page 15: The Children and Adolescent Mental Services’ (CAHMS) Risk should read “was appropriately classed as.”</td>
</tr>
</tbody>
</table>

|          | RESOLVED: The Board approved the minutes as an accurate record subject to the noted amendments. |

<table>
<thead>
<tr>
<th>TB168/17</th>
<th>MATTERS ARISING ACTION LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Board considered the following matters arising in turn:</td>
</tr>
</tbody>
</table>

**TB081/16 Chairs Report – Membership of Audit Committee**

- Mr Birrell confirmed his appointment as a member of the Audit Committee and as Chair of the Finance Performance and Investment Committee (FP&I). Mrs Gorry confirmed that she would take up the position of Chair of the Mortality Assurance & Clinical Improvement Committee (MACIC), an appointment which was supported by Mrs Pennell, who said that the role ideally required a Non-Executive Director with a clinical background.

Mrs Gibson requested a copy of the Membership of Committees.

**TB076/17 Integrated Performance Report - Capital Bid**

An update would be provided at the October Board on Capital Bid for the reconfiguration of the Stroke Ward.


An update on the Workforce Race Equality Standard (WRES) Action Plan is to be presented as part of Agenda Item TB174/17.

**TB134/17 Fire Safety Update**

Mrs Murphy confirmed that the Trust would be sharing a statement with Healthwatch Sefton and Healthwatch Lancashire confirming Fire Safety at the Trust, which they in turn would share with the public. (Item to be...
TB137/17 Integrated Performance Report – Mortality Data
Mr Clarke confirmed that he had received the requested data. To be presented as Agenda Item TB172/17 at the current board.

TB115/16 Board Assurance Escalation Framework
An update given within the Governance Report, as part of Agenda Item TB183/17 (Item to be removed from Matters Arising Log).

TB022/16 Matters Arising Action List – TB153/16 Integrated Performance Report (IPR) – Workforce
The Terms of Reference for the Workforce Committee are to be presented as part of Agenda Item TB174/17. The Terms of Reference for the Organisational Development Committee and the new Governance Structure will come to the October Board.

TB023/17 Interim Chief Executive's Report
The six month review paper on the Leadership Executive Group (LEG) would be brought to the October Board as part of the Governance Review.

TB076/17 Integrated Performance Report – Integrated Community Re-enablement and Assessment Service (ICRAS) Model
Mrs Patten confirmed that an update on the implementation of the ICRAS Model will be presented as part of Agenda Item TB179/17. (Item to be removed from Matters Arising Log).

TB076/17 Integrated Performance Report – Stroke Target
To be brought to the October Board.

TB076/17 Integrated Performance Report – Mandatory Training
To be brought to the October Board.

TB085/17 Quality and Safety Committee, Chair’s Assurance Report – Learning from Deaths
An update to be presented as part of Agenda Item TB172/17. (Item to be removed from Matters Arising Log).

TB026/17 Matters Arising – Integrated Performance Report – Medicines Safety Update
To be brought to the October Board.

TB026/17 Matters Arising – Engagement Plan / Cultural Review
The Cultural Review Report would be brought to the Board once the related live investigation had been completed.

TB022/17- 153/16 Workforce Committee
A Non-Executive Director to be confirmed for the Workforce Committee at the October Board. Completed-to be removed from Matters Arising Log.

TB076/17 Integrated Performance Report – Discharge Planning
An update will be given as part of Agenda Item TB179. (Item to be removed from Matters Arising Log).

TB153/17 Chief Executive’s Report – National Guardian Review
An update will be given as part of the Interim Chief Executive’s Report, Agenda Item TB169/17

TB154/17 Care For You Programme
An update would be included as part of the Interim Chief Executive’s Report, Agenda Item TB169/17. (Item to be removed from Matters Arising Log).

TB159/17 Quality and Safety Assurance Report – Mortality Position
An update to be given as part of Agenda Item TB172/17. (Item to be removed from Matters Arising Log).

TB159/17 Quality and Safety Assurance Report – Medical Staffing
Item completed; to be removed from Matters Arising Log.

TB158/17 Finance Performance and Investment Committee – Assurance Report – Capital Programme
Item to be presented at September’s Private Board, Agenda Item TB078/17. (Item to be removed from Matters Arising Log).

TB158/17 Finance Performance and Investment Committee – Assurance Report – Cost Improvement Programme
Item to be presented at September’s Private Board, Agenda Item TB180/17. (Item to be removed from Matters Arising Log).

TB158/17 Extreme Risk Register – CAMHS Service
An update would be given as part of the Agenda Item TB182. (Item to be removed from Matters Arising Log).

TB163/17 Message From The Board – CQC Routine Provider Information Submission
All actions listed on the Matters Arising Log were on track. (Item to be removed from Matters Arising Log).

TB69/17 CHIEF EXECUTIVE’S REPORT
Mrs Lloyd presented the Chief Executive’s Report on behalf of Mrs Jackson, highlighting:

- **The Visit of the Secretary of State:** Jeremy Hunt, Secretary of State for Health and the Chief Nurse of England, Professor Jane Cunningham had visited the Trust as part of a nationwide tour. The Trust, via Mrs Lloyd gave a presentation focused on advancements in safety, detailing activities around the deteriorating patient and maternity risks.

- **The Cultural Review:** during the month of September the Executive Medical Director was excluded from work; more would be known over the next four to five weeks. Dr Paul Mansour was acting up in the interim.

- **Development of Strategic Direction:** The Care for You Board Meeting was held on 24th August, chaired by Kieran Murray, Medical Director of NHS England (NHSE), attended by the Trust’s two CCG partners. The programme was endorsed by NHSI and NHSE. Clear targets for a Frailty Pathway, A&E Flow and Women’s and Children’s Services were to be agreed by the end of September.

- **National Guardian Review:** Feedback from the National Guardian visit would be given in September and would be shared with the Board, once available.

- **Financial Review:** an increased figure for the Financial Deficit Plan was reported to NHSI on 31st August, the Trust was currently awaiting feedback ahead of a meeting with the regulatory body on 26th September.

- **Meetings with MPs:** Mr Fraser reported that regular meetings were being held with Damien Moore (Conservative MP for Southport) and Rosie Cooper (Labour MP for West Lancashire) to ensure that they
were kept informed on all Board issues.

- **Average Length of Stay / Discharge Planning**: Mrs Patten reported on the implementation of the ICRAS) model into the Trust which had been adopted from the North Mersey Footprint. Fiona Taylor, CEO of Southport and Formby CCG was taking the lead to look at the real pressures impacting Urgent Care patient flow; improvements were required to be delivered before the winter.

There was a discussion regarding suggestions for improvements; Mrs Patten explained that contracts with care homes had been revised but that the implementation of changes was taking time.

- **Chief Executive Visits**: very positive staff feedback had been received in response to the continued Chief Executive Ward visits made by Mrs Jackson. All feedback was being given through the routes outlined in the organisation plan.

- **The Leadership Executive Group (LEG)**: the format of the group was currently under consideration with a view to becoming the Trust Management Board.

It was agreed that all Board minutes and papers were to give the full name or wording of item before the associate acronyms could be used.

**RESOLVED:**
The Board received the Chief Executive’s Report.

### TB170/17 PATIENT STORY – HOSPITAL INSIGHT

Mrs Kitson, Matron for Patient Experience, presented in the place of Mr John Grundy, Health Care Assistant on the case for changes to Trust uniforms.

Mr Grundy had collapsed on the Ward in the summer of 2016 from the effects of the heat and was backing the case for changes to the current uniforms which many staff find uncomfortable and restrictive (particularly for manual handling).

Mrs Kitson stated that the proposal had been discussed in the associated Task and Finish Group and had been presented to the Patient Experience Group. Over 240 staff had responded to a questionnaire with feedback that patients and families found the great variation in uniform colours confusing. The current proposal was for scrubs in fewer colour schemes, with differentiation through the clear embroidery of roles and names.

Mrs Gorry asked to be sent the details of the scrubs proposal.

Mr Clarke proposed that the requirement would be a suitable initiative for Charitable Funds.

Mr Fraser asked Mrs Kitson to give feedback that the proposal was being taken very seriously by the Board as it was recognised that the comfort and morale of the staff was of the utmost importance. This was backed up by Mrs Pennell who recognised the amount of engagement, enthusiasm and initiative that had been put into the project.

**RESOLVED:**
The Board noted the proposal.

### TB171/17 INFECTION PREVENTION AND CONTROL ANNUAL REPORT

Mrs Murphy presented the Annual Report to the Board as assurance of the work that had been done by the Infection Prevention and Control Team. The
report was presented to the Quality and Safety Committee on 26th July 2017.

Mrs Murphy reported that the targets for Clostridium difficile (C Difficile) had been on trajectory and that there had been only one case of Methicillin-resistant Staphylococcus aureus (MRSA) over the reported twelve month period which had been subject to a full Root Cause Analysis process.

Mrs Pennell asked for clarity on the Blood Culture Contamination Rate (Page 43 of 434 of the Board pack). Dr Mansour explained that there was an expectation that some blood cultures would become contaminated, but that the new technique would reduce the probability of that happening. Mr Fraser asked for further clarification to be taken to the Quality and Safety Committee and in turn to be brought back to the Board.

Mr Birrell stated that the recommendations made in the report were not clear and that details of contingency plans and arrangements for escalation in the event of an outbreak (of a contagious disease) were missing.

Mrs Murphy and Mrs Patten confirmed that there was an official escalation process for both the organisation and the regional health economy which was available in a separate document. Mr Birrell suggested that this information should have been incorporated into the Annual Report.

Mrs Patten and Mrs Murphy confirmed that any reports of outbreaks would be escalated to the Health and Safety Committee.

Mrs Lloyd informed the Board that the report had been to the Health and Safety Committee and it confirmed that the Trust was compliant with the requirements of the Health and Social Care Act of 2008 for the purpose of infection prevention and control.

RESOLVED:
The Board approved the recommendations of the report.

TB172/17  MORTALITY REVIEW TASK AND FINISH GROUP REPORT

Dr Mansour updated the Board of the work of the Mortality Review Task and Finish Group which was created after the March 2017 "National Guidance on Learning from Deaths."

Dr Mansour advised the Board that:

- A revised Mortality Policy would be available by the end of October.
- A process mapping exercise would be undertaken on 29th September.
- There would be an interim period before full integration of the revised policy (which has been delayed due to amended training dates for the Structured Judgement Review Method).
- It was recommended that the current review system remained in place until the agreed implementation date.
- The national training module for which would be undertaken by two AMD’s in November which would then be cascaded to other reviewers within the Trust.
- The Trust would be one of the first to trial an upgrade of the Datix Cloud (the Trust’s on-line incident management system). This would present an opportunity for the teams to mould the functionality to the Trust’s specific reporting requirements.

Dr Mansour confirmed that the Mortality Dashboard was taken to the Quality and Safety Committee, the Clinical Effectiveness Committee and would be
shared with the Patient and Carer Experience Group.

Mr Clarke questioned the time lag in the statistical reporting of deaths and whether there was a way that this could be hastened. Dr Mansour explained that raw data was reported to NHS Digital before the SHIMI measure was made available, the process for which could not be changed. Dr Mansour assured Mr Clarke that all deaths which occurred in the hospital were picked up within the month in hand by the Mortality Review Group and any concerns were tackled immediately.

Mr Birrell challenged the media reports of high Summary Hospital-level Mortality Indicator (SHMI) levels at the Trust in comparison to other Trusts. Dr Mansour explained that the measures could be subjective and that it was not useful to compare like for like with other Trusts, particularly in view of the complexity, frailty and age of a high proportion of the Trust’s patients. He explained that current coding did not take into consideration the palliative status of some patients unless they were treated specifically by palliative staff.

Dr Mansour said that mortality levels were expected to come down in 2016/17 and that regular audits were undertaken.

Mrs Lloyd explained that the revised governance structure provided an increasingly robust escalation of patient deterioration or a requirement to investigate.

**RESOLVED:**

a) The Board received the interim report.

b) The Board recommended that the reporting mechanism to the Public Board be set up from Quarter three.

c) The Board agreed the timescale for full implementation.

<table>
<thead>
<tr>
<th>TB173/17</th>
<th>LORD CARTER REVIEW AND PROPOSED ACTION PLAN FOR SOUTHPORT AND ORMSKIRK NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Cushion presented an update to the Board on the Action Plan for the Trust based on the Lord Carter Review. The Board was requested to note and agree the progress against the proposed action plan developed to achieve the recommendations and to provide assurance that the Carter report recommendations would be delivered to plan.</td>
<td></td>
</tr>
</tbody>
</table>

Mrs Cushion alerted the Board to the only amber status on the Action Plan which was that the original date for E-forms to be reviewed had passed. Mrs Cushion acknowledged high levels of attribution and a lack of information collated from exit interviews.

Mr Birrell asked how cost savings would be made in line with the recommendations. Mrs Cushion explained that E-rostering would ensure the mainstay of savings as it would increase efficiencies and reduce bank and agency spend.

Mrs Patten elaborated by stating that savings would be made through:

- The bringing forward of Cost Improvement Programme (CIP) targets for job planning to the end of December.
- The rationalisation of Personal Assistant staffing to bring a saving of £400k.
- A requirement for staff to make up hours owed from bank shifts.

Mr Charles informed the Board that the first revised Workforce Committee’s
Terms of Reference would be placed in October and that each month assurance would be brought back to the Board.

**RESOLVED:**
The Board **received** the progress against the proposed action plan.

<table>
<thead>
<tr>
<th>TB174/17</th>
<th>WORKFORCE RACE AND EQUALITY STANDARD (WRES) ACTION PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Cushion reported to the Board on the status of the Workforce Race and Equality Standard (WRES) Action Plan.</td>
<td></td>
</tr>
</tbody>
</table>

The Board was requested to note the progress of the WRES 2016/17 Action Plan, which had not been delivered; to confirm its closure, to acknowledge that the WRES was part of an ongoing process and to accept a move to the 2018/19 Action Plan.

Mrs Lloyd pointed out that the new governance structure and the transferral of the management of Human Resources to St Helens and Knowsley NHS Hospital Trust were improvements which would support the imperative delivery of the WRES in 2018/19.

Mrs Patten stated that Non-Executive Director membership was required on the Workforce Committee and that that needed to be added into the Terms of Reference of the same.

Mrs Lloyd emphasised the requirement for the Trust to scrutinise the contractual requirements for the management of the Human Resources function were met and that if any additional activity was required that that was addressed.

**RESOLVED:**
The Board **approved** the closure of the incomplete 2016/17 Workforce Race and Equality Standard Action Plan and endorsed the move to the 2018/19 Plan.

<table>
<thead>
<tr>
<th>TB175/17</th>
<th>HEALTH AND SAFETY ANNUAL REPORT 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Murphy presented to the Board the Annual Health and Safety Report 2016/17 (1st April 2016 to 31st March 2017) which was taken to the July Quality and Safety Committee giving assurance that the the Trust had met the requirements of the Health and Social Care Act and the Health at Work Act and that the Trust was compliant with the Security Management and Fire Safety requirements of the Health and Safety Executive. The report also gave additional assurance over recent national fire concerns.</td>
<td></td>
</tr>
</tbody>
</table>

Mrs Murphy clarified that the Health and Safety Committee met bi-monthly and that any concerns were to be escalated to the Quality and Safety Committee via the Assure, Alert and Aspire (AAA) Report”.

Mr Birrell stated that the report was not well written and was confusing. He noted that the report made reference to activity in the future and argued that an annual report should only make reference to activity that had taken place in the reportable period.

The Board agreed that all annual reports should cover only the time period in hand and that that would be communicated via all committees, in particular the Quality and Safety Committee.

**RESOLVED:**
The Board received the Annual Health and Safety Report with recommendations for the content of future reports.

**TB176/17 CLINICAL AUDIT ANNUAL REPORT 2016/17**

Mrs Murphy presented the Clinical Audit Annual Report 2016/17 (1st April 2016 to 31st March 2017) reporting that while there had been an improvement year on year, only 81% of project listed on the clinical audit forward plan had been completed. There had been a move of ownership from corporate to the clinical teams.

**RESOLVED:**

The Board received the Clinical Audit Annual Report 2016/17.

**TB177/17 SAFE STAFFING MONTHLY REPORT**

Mrs Murphy presented the Safe Staffing Monthly report to the Board for the month of July confirming 90% of the fill rate alongside ongoing recruitment and retention activity.

Mrs Lloyd reported that Trust staffing levels had not been sufficiently low to trigger support from the NHSI but that they had become involved after she had approached them. The national team was connecting the Trust with contacts who could provide support and discussions were ongoing.

**RESOLVED:**

The Board received from the report in the maintenance of safe staffing levels across the Trust.

**TB178/17 FINANCE, PERFORMANCE AND INVESTMENT COMMITTEE – AAA HIGHLIGHT REPORT**

As Chair of the Finance, Performance and Investment Committee, Mr Birrell presented the ‘AAA Highlight Report’ to the Board.

**RESOLVED:**

The Board received the report.

**TB179/17 INTEGRATED PERFORMANCE REPORT**

**Accident and Emergency**

Mrs Patten advised the Board that July and August had seen the highest ever numbers in A&E, with the high complexity of patients increasing. The numbers of patients attending on Sunday and Monday was on the increase and there was also an increase in the number of high volume days across the week, putting continuous pressure on the teams. The average length of stay of patients, however, was on the decrease.

Mrs Patten reported that the 95% target for A&E was not being hit and that this was a major concern going into winter. The adoption of the new ICRAS model into the Trust would drive improvement in this area.

Mrs Patten informed the Board that the first System Meeting had been attended by the Trust but had not been attended by the CCGs. Winter Planning would have been addressed at the meeting but activity was impacted by this delay.

Mr Fraser informed the Board that Dame Gill Morgan, Chair of NHS Providers would be visiting the Trust the following day and that the subject of A&E would be discussed with her.

Mrs Patten reported that the Trust had been successful in the Talk Bid for
capital monies, which had been approved by the Department of Health and the Treasury. The monies, however, were not released because the Trust had failed to sign its control total and was subsequently been withdrawn. The Trust was therefore required to undertake GP Streaming without funds. Mr Fraser said that this would be brought to the attention of Dame Gill Morgan.

Mrs Patten explained that GP Streaming could be very subjective and that only 9% to 11% of patients were turned away from A&E.

Mr Clarke questioned the value of the GP On Call unit at the front of the Southport site. Mrs Patten confirmed that if the GP was not on site the centre would then be unmanned. Ideally the unit would become more of a geriatrician and therapies service supporting the front end of the frailty pathway.

Mrs Birrell questioned whether improvements to the Frailty Pathway would have the greatest impact on admissions. Mrs Patten confirmed that a strategy would be agreed in principle at the Advancing Quality Alliance (AQuA) workshop with the CCG’s on 13th September.

Ambulance Handovers
Mrs Patten emphasised the importance of ambulance turnaround, stating that the optimum handover time was 15 months but that currently only 40% were hitting that target.

Stroke
Dr Mansour confirmed that the reconfiguration of the Stoke Ward was going ahead and that that would help with mixed sex breeches.

Harm Free
Mrs Murphy explained that the ‘Percentage of Patients with Harm Free Care’ had dipped below the 98% threshold to 96.5% in July. Data had been affected since the transfer of Community Services and a review was being undertaken to ascertain whether there is incorrect reporting and a requirement for further training.

Friends and Family
Mrs Murphy reported that the response rates for ‘Friends and Family Feedback’ were very low and that that would be addressed as part of the new Patient, Carers and Family Strategy and the Eight Pledges project.

Delivering Same Sex Accommodation (DSSA) Breaches
Mrs Patten reported that there continued mixed sex breech in the Intensive Care Unit as documented in previous Public Board Meetings. The long term patient had been due to be discharged in September; however that date had been moved back to November.

62 Day GP Referral to Treatment
Dr Mansour reported that the Trust had fallen below the 85% target and that this could be remedied if the pathway was improved for a small number of patients. Weekly calls were currently being held with NHSI.

Dr Mansour explained that endoscopy capacity was also an issue, a review of which was being taken taken to the Quality and Safety Committee in September.

Average Length of Stay
Mrs Patten confirmed that the average length of stay had increased by half a
day in July which was attributable to the increase in the number of patients.

**Sickness**
Mrs Cushion told the Board that the Trust was still an outlier as far as sickness data were concerned, however, a review of the sickness policy and additional administrative support since the merge with St Helens and Knowsley Hospital Trust was expected to improve the management of the issue. Savings could be made if this were dealt with. A progress report would be presented at the next Audit Committee.

**Mandatory Training**
Mrs Cushion reported that figures were now believed to be as accurate as possible and that issues of non-compliance were being picked up locally.

Mrs Murphy explained that there was a Nursing Task and Finish group looking at the use of E-learning for mandatory training.

Mr Birrell proposed that the prioritisation of mandatory training should be discussed at the Finance Performance and Investment Committee.

Mrs Pennell proposed that the Workforce Committee should look at organisational health indicators whilst comparison of sickness rates and mandatory training rates against those of St Helens and Knowsley should be done at the Finance Performance and Investment Committee.

**RESOLVED:**
The Board received the report and updates.

---

**TB180/17**
**DIRECTOR OF FINANCE REPORT INCLUDING COST IMPROVEMENT PROGRAMME**

Mr Walsh presented the report for the Trust's financial position at the end of Month 4, which had been presented to the Finance Performance and Investment Committee on 29th August 2017 where it had been agreed that the Trust Plan deficit of £18.1m would not be reached.

Mr Walsh explained that the key reason for the adverse performance to date was activity underperformance and the consequent impact on income. The majority of the shortfall for which related to commissioning income; the Trust being £2.3m below the CCG contract plan. (Referrals down 13.8% Year to Date (YTD) and GP referrals being 31.2% below the YTD plan). Elective activity was reported as being £797k below plan at Month 4.

Mr Walsh confirmed that NHSI had already been notified that the target of £18.1m deficit would not be achieved by the end of the financial year.

Mrs Hillyard explained that the Trust plan for CIP had been £5.6m for the full year but despite workshop planning and ongoing activity across the organisation, this remained closer to £4.6m. In order to mitigate risks a programme of ongoing work was being undertaken with support of the Programme Management Office (PMO). Mrs Hillyard advised that the Trust should put itself into internal turnaround and that this should be communicated to staff to encourage and increase CIP and saving activity.

Mrs Patten confirmed that a budget cleanse exercise would be undertaken to bring any unused funds back from the Clinical Business Units into the Corporate Budget.

Mr Fraser and Mrs Lloyd emphasised the importance of providing healthcare
for the needs of the local population, which they added could only be effectively done if there was a robust, unified strategy to sustainable funding across the healthcare economy. They highlighted the issue of contracts based on activity, with punitive penalties, which were leaving the Trust with a financial gap which was preventing the effective provision of healthcare to the local population.

Mrs Lloyd affirmed that in order to support the local healthcare economy the Trust should be paid to plan and that the CCG’s should cease to take Commissioning for Quality and Innovation (CQUIN) monies and financial penalties. Mrs Patten stated that CQUIN should be within the Trust’s gift to achieve.

Mr Birrell confirmed that Mrs Jackson was in talks with the CCGs and that proposals had been submitted the previous week ahead of the next meeting with NHSI on 26th September.

Mr Clarke asked the board whether the focus of the Cost Improvement Plan should be moved to an Income Improvement Plan. Mrs Lloyd confirmed that some of the issue was attributable to a significant drop in GP referrals. Mrs Patten affirmed that marketing activity was being undertaken to drive improvement in this area but that it would take time to see the results.

Mr Fraser proposed that there should be representation from both CCGs on the Board and that Southport and Ormskirk Hospital Trust should have representation on the CCG Boards. This proposal was to be taken to the Care For You Board.

RESOLVED
The Board received the report and updates.

TB181/17 BUSINESS CONTINUITY PLAN (BCP) EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT 2017

Mrs Patten presented the report to the Board and thanked Mrs Pilkington, author of the document for her work.

Mrs Patten explained that she had delayed the finalisation of the annual report on two occasions to incorporate the learnings of the two major events; the Cyber Attack in May 2017 and the Decontamination Major Incident in xxx 2017.

Mr Birrell affirmed that from a governance perspective, an annual report should only cover an ascribed twelve month period, which in this case should have been April 2016 to March 2017. Mrs Patten confirmed that a summary report covering the annual period in question would be brought to the October Board.

It was agreed that the next annual report would cover only the period from April 2017 to March 2018.

The Chair thanked Mrs Pilkington for her work and Mrs Pennell thanked Mrs Pilkington and Mrs Patten for the assurance provided.

RESOLUTION:
   a) The Board requested that the Emergency Preparedness, Resilience and Response (EPRR) Annual Report and Major Incident Plan Version 7 and Business Continuity Plan Version 6 be revised and
brought back to the Board for approval.

<table>
<thead>
<tr>
<th>TB182/17</th>
<th>EXTREME RISK REGISTER</th>
</tr>
</thead>
</table>
| Mrs Murphy explained to the Board that the extreme risks presented had been pulled from the Trust’s risk management system at the beginning of August.  
Mrs Murphy confirmed to the Board that the Paediatric team had been challenged over the categorisation of ‘catastrophic’ for CAMHS risk and that they had maintained that that was the appropriate status; there were no staff trained in paediatric mental health and there was no safe room yet in place. Mrs Patten confirmed that she would be meeting with the CEO of West Lancashire Community Services later in the week and that an update would be taken to the September Quality and Safety Committee and reported back to the October Board.  
Mrs Patten updated the Board on Adult Mental Health support for A&E and confirmed that the 24/7 liaison service would commence on 27th September.  
Mrs Lloyd reported that the Trust was mitigating risks appertaining to the CQC report. It was agreed that the wording of the description for register item 1362 would be changed to reflect the commitment to improvement.  
Mrs Lloyd proposed that one to one meetings with NEDs to discuss Extreme Level Risks would be beneficial.  
RESOLVED:  
a) The Board received the report and noted the changes to the High Level Risk Register.  

<table>
<thead>
<tr>
<th>TB183/17</th>
<th>BOARD ASSURANCE FRAMEWORK (BAF) REVIEW</th>
</tr>
</thead>
</table>
| Mr Charles explained that the Board Assurance Framework (BAF) had been brought to the September Board in draft form as it had not yet been presented to the Board since the beginning of the financial year. Mr Charles explained that the BAF should be the basis of the board agenda. He also suggested that normally there should be a six monthly review to assess the key risks to strategic objectives. A quarterly update should also be brought to the board.  
Mr Charles confirmed that the BAF was based upon the work that the board had undertaken at the July Board Away Day to review and refresh the Trust’s strategic objectives.  
Mrs Pennell asked to see the objectives for the preceding year for the purposes of comparison and requested the addition of Safeguarding and Safe Sustainable Services in the stating of risks that may be impede the objectives.  
Mrs Lloyd stated that there was a Board Escalation Framework which would help to bring synergy between the BAF and the Extreme Risk Register.  
RESOLVED:  
The Board received the BAF and noted its final draft to come to the October Board.  

<table>
<thead>
<tr>
<th>TB184/17</th>
<th>RESPONSIBLE OFFICER’S REVALIDATION ANNUAL REPORT AND STATEMENT OF COMPLIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Mansour informed the Board that as the Trust’s Responsible Officer he</td>
<td></td>
</tr>
</tbody>
</table>

| COO | Oct Board |
| DoN | Sept 2017 |
| Co Sec | Dec Board |
| Co Sec | Sept 2017 |
was required to make recommendations every five years to the General Medical Council for doctors who wished to continue to practice or to make deferrals where required.

Dr Mansour reported that there had not been any incidents of non-engagement and that the extensive review by NHSE had raised no major concerns despite some recommendations being made to the Trust.

Dr Mansour explained that there was currently only one part-time administrative resource supporting the programme and that he had submitted a case for a small amount of additional resource.

Mr Birrell requested monthly updates to the Board on doctors who are under investigation.

RESOLVED:

a) The Board approved the report and signed off the ‘Statement of Compliance’ for submission to NHSE.

TB185/17 ITEMS FOR APPROVAL

Standard Operating Procedure (SOP) for the Administration of Meetings

Mrs Murphy informed the Board that the procedure had been presented to the LEG in August and had been supported in principle with three additional flow charts to be added for the Finance Performance and Investment Committee, the Mortality Assurance and Clinical Improvement Committee and the new Workforce Committee.

Mr Birrell proposed that the document could also be used to advise on:

- The production of sensible sized quality reports
- The definition and purpose of an Executive Summary

Mrs Pennell highlighted the importance of appropriate instructions for the ‘AAA Reports’ and emphasised that the Board Business Cycle required finalisation. Mr Charles stated that Cycles for the Board and all committees were being finalised and would be incorporated into a master cycle which should be published on the Trust intranet.

Mr Fraser confirmed that the NED Chair and Executive for each committee should meet in advance to plan each meeting agenda. Asked by Mr Walsh about the submission timetable for committee papers, Mr Charles responded that in Foundation Trusts, the standard was for papers to be sent out 7 days in advance for boards and 5 days for committees. The board agreed with the implementation of those standards into the organisation.

Standard Operating Procedure for Trust Quality Visits

Mrs Murphy presented the procedure and confirmed that it would be updated to incorporate amendments as required.

Mrs Gorry requested a tour of both sites prior to the Quality Visits.

The Board discussed the pro-forma for the visits and the value of a checklist approach for the purpose of guidance; it was agreed that the existing document could be used as a supporting tool. Mr Birrell requested further supporting information from previous ward visits or assessments to further support the Non-Executive Directors.

Mrs Murphy advised that any issues should be escalated immediately to the
There being no other business, the meeting was adjourned.

matron on the relevant ward and to herself. Those would then be addressed at the following weekly Executive Meeting.

It was agreed that Ms Flood-Jones would coordinate the dates for the Quality Visits.

**RESOLVED:**
- The Board approved the Standard Operating Procedures subject to the proposed changes.

**TB186/17 QUESTIONS FROM MEMBERS OF THE PUBLIC**
There were no questions posed by members of the public.

**TB187/17 ANY OTHER BUSINESS**

**Use of Emergency Powers for the Utilisation Loan**
The Company Secretary asked the Board to ratify a resolution which was approved by the Chair and CEO under emergency powers as set out in Section 5.3 of the Trust’s Standing Orders. The action was supported by two Non-Executive Directors.

**RESOLVED:**
- The Board ratified the action.

**TB188/17 ITEMS FOR THE EXTREME RISK REGISTER / CHANGES TO THE BAF**
There were two changes to be made to the Extreme Risk Register:
- The rewording of Item 1362 to reflect the continuous improvement work in response to CQC recommendations

**TB189/17 MESSAGE FROM THE BOARD**
The Chair confirmed that the action of the Board would also be agreed in the Private Section of the Board.

**TB190/17 DATE, TIME AND VENUE OF THE NEXT MEETING**
Wednesday 4th October 2017
9.00am Seminar Room, Clinical Education Centre, Southport Hospital
# Public Board Matters Arising Action List – as at 4 October 2017

## FOR REVIEW AND UPDATE

### BRAG Status Key

<table>
<thead>
<tr>
<th>Color</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Significantly delayed and/or of high risk</td>
</tr>
<tr>
<td>Amber</td>
<td>Slightly delayed and/or of low risk</td>
</tr>
<tr>
<td>Green</td>
<td>Progressing on schedule</td>
</tr>
<tr>
<td>Blue</td>
<td>Completed</td>
</tr>
</tbody>
</table>

### Action List

<table>
<thead>
<tr>
<th>DATE</th>
<th>AGENDA ITEM</th>
<th>LEAD AND TARGET DATE</th>
<th>COMMENTS/UPDATE</th>
<th>ACTION</th>
<th>BRAG STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEC 2016</td>
<td>TB153/16 IPR Workforce</td>
<td>ADHR Apr 2017</td>
<td>The terms of reference for the HR Operational Group would be submitted to the Q&amp;S Committee and Board for discussion.</td>
<td>April 2017: Sub-structure paper to Q&amp;S in March for agreement. Awaiting a decision regarding establishment of a Workforce Committee. &lt;br&gt;July 2017: Workforce Committee to be established as part of the revised governance arrangements due in September. &lt;br&gt;October 2017: The Terms of Reference for the Workforce and OD Committee to come to October Board as the new Governance Structure has been drafted. On the agenda.</td>
<td>AMBER</td>
</tr>
<tr>
<td>MAR 2017</td>
<td>TB023/17 Chief Executive's Report</td>
<td>CEO July 2017</td>
<td>The Board would receive a six months review paper on the Leadership Executive Group (LEG) to provide assurance that the Group was delivering the expected outcomes.</td>
<td>July 2017: Item would be reviewed as part of the revised governance arrangements due to be presented in September. &lt;br&gt;October 2017: As part of the Governance Review, this will come to the October Board as part of CEO's Report. On Agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>DATE</td>
<td>AGENDA ITEM</td>
<td>LEAD AND TARGET DATE</td>
<td>COMMENTS/UPDATE</td>
<td>ACTION</td>
<td>BRAG STATUS</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>MAR 2017</td>
<td>TB026/17 Medicines Safety Update</td>
<td>MD</td>
<td>The Medicines Safety Update will be incorporated into the Chief Pharmacist's Annual Report which would be presented at the October Board.</td>
<td>Medicines Safety Update will be incorporated into the Chief Pharmacist’s Annual Report which would be presented at the October Board. October 2017: Update to be brought to the October Board via the Chief Pharmacist’s Annual Report. On Agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>MAY 2017</td>
<td>TB076/17 Integrated Performance Report (IPR) – Stroke Ward Reconfiguration</td>
<td>DOF June 2017</td>
<td>June 2017 Capital Bid presented to the Capital Investment Group in June. July 2017 Bid considered by the Capital Investment Group. Further priorities required due to oversubscription of bids, in the interim the tendering process has commenced.</td>
<td>June 2017: To provide an update in relation to the capital bid to reconfiguration of the stroke ward. September 2017: Details to be provided at the October Board. October 2017: An update on the Capital Bid for the reconfiguration of the Stroke Ward to be given at the October Board as standalone item. On Agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>MAY 2017</td>
<td>TB076/17 Integrated Performance Report – Stroke Target</td>
<td>MD June 2017</td>
<td>To provide an update regarding maintaining a safe service provision prior to the establishment of a hyper-acute service across North Mersey.</td>
<td>June 2017: Verbal update to be provided. July 2017: Current service is safe. SSNAP rating maintained ‘C’. No complaints or SUIs from Stroke Unit. Stroke Ward Dashboard in development. Decision not expected until September 2017. Further updates in October. October 2017: Update to be brought to the October Board as part of IPR - On Agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>DATE</td>
<td>AGENDA ITEM</td>
<td>LEAD AND TARGET DATE</td>
<td>COMMENTS/UPDATE</td>
<td>ACTION</td>
<td>BRAG STATUS</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>MAY 2017</td>
<td><strong>TB076/17 Integrated Performance Report – Average Length of Stay / Discharge Planning</strong></td>
<td>COO June 2017</td>
<td>To provide an update regarding the change in the discharge planning process following transfer of community services.</td>
<td><strong>June 2017</strong>: Verbal update to be provided.</td>
<td>GREEN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>July 2017</strong>: Due to high activity Virgin Care &amp; LCFT are not able to process discharges in a timely manner which is impacting on delayed discharges. ICRAS meetings are in place to consider this matter. This will also be raised in the Contract meeting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>September 2017</strong>: Ms Patten agreed to produce a proposal around the ICRAS model for September’s Board meeting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>September 2017</strong>: An update is incorporated in the CEO’s Report.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>October 2017</strong>: An update on the implementation of the Integrated Community Re-enablement and Assessment Service (ICRAS) Model is an item on the Agenda.</td>
<td></td>
</tr>
<tr>
<td>JUNE 2017</td>
<td><strong>TB116/17 Engagement Plan</strong></td>
<td>CEO July 2017</td>
<td>Engagement Plan to be brought to the Board on the back of the final version of the cultural review.</td>
<td>To ensure that the findings of the cultural review are fed into the WRES action plan.</td>
<td>AMBER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Final Version of Review received in late August. CEO to bring details of action to October Board.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Deferred to November 2017</strong>: Cultural Review to be brought to the Board after the related investigation has been completed. Investigation on-going.</td>
<td></td>
</tr>
<tr>
<td>DATE</td>
<td>AGENDA ITEM</td>
<td>LEAD AND TARGET DATE</td>
<td>COMMENTS/UPDATE</td>
<td>ACTION</td>
<td>BRAG STATUS</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>5 JULY 2017</td>
<td><strong>TB137/17 Integrated Performance Report – Mortality Data</strong></td>
<td>MD August 2017</td>
<td>Provision of mortality data.</td>
<td>Mr Clarke requested data relating to actual numbers of deaths in the last 3 years with in the Trust and the data set available and used at Grimsby.</td>
<td>GREEN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>September 2017</strong>: Details to October Board.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>October 2017</strong>: Mortality data to be brought to the October Board as part of the IPR. On Agenda.</td>
<td></td>
</tr>
<tr>
<td>27 JULY 2017</td>
<td><strong>TB076/17 Integrated Performance Report - Mandatory Training</strong></td>
<td>DOF</td>
<td>Mrs Jackson reported improvement in the delivery of training to the theatre team which was being delivered within the department.</td>
<td>Mr Shanahan to report the Mandatory Training figures to the September Board. Deferred to October Board. October 2017: To be brought to the October Board via the IPR.</td>
<td>GREEN</td>
</tr>
<tr>
<td>27 JULY 2017</td>
<td><strong>TB153/17 CEO’s Report - National Guardian Review</strong></td>
<td>CEO</td>
<td>Southport and Ormskirk Hospital Trust is the first Trust to be supported by NHSI to review the National Speak Out Guardian requirements starting from the week commencing 31st July. The NHSI will provide the Terms of Reference, timeframes and details of what’s required.</td>
<td>All processes relating to whistle blowing will be reviewed. Mrs Jackson will update the September Board. October 2017: Update to be included in the CEO Report: Speak Up Guardian, Speak Up Champion and role of DoN and CoSec to be clarified. On the Agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>27 July 2017</td>
<td><strong>TB154/17 Care For You Programme</strong></td>
<td>CO.SEC</td>
<td>The Chair confirmed that this would become a monthly agenda item for the foreseeable future.</td>
<td>This will be built in as a stand-alone item from October Board. October 2017: To be brought to the October Board.</td>
<td>GREEN</td>
</tr>
<tr>
<td>DATE</td>
<td>AGENDA ITEM</td>
<td>LEAD AND TARGET DATE</td>
<td>COMMENTS/UPDATE</td>
<td>ACTION</td>
<td>BRAG STATUS</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB170/17 Patient Story – Hospital Insight</strong></td>
<td>DON Sept 17</td>
<td>Patient Experience Matron, Mrs Kitson send the details of the scrubs uniform proposal to Mrs Gorry</td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB171/17 Infection Prevention and Control Annual Report</strong></td>
<td>MD Oct 2017</td>
<td>Clarification to be taken to the Quality and Safety Committee and then to the Board on the new method for taking blood which will reduce the chance of blood culture contamination.</td>
<td><strong>September 2017:</strong> To be taken to the Q&amp;S Committee</td>
<td>AMBER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>October 2017:</strong> To be brought to the Board</td>
<td></td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB174/17 Workforce Race and Equality Standard (WRES) Action Plan.</strong></td>
<td>CO SEC/AD HR Sept 2017</td>
<td>Non-Executive Director membership was required on the Workforce Committee and that this needed to be added into the Terms of Reference of the same.</td>
<td><strong>October 2017:</strong> To be confirmed ahead of the first meeting in October. <strong>Completed</strong></td>
<td>GREEN</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB174/17 Workforce Race and Equality Standard (WRES) Action Plan.</strong></td>
<td>ADHR</td>
<td>Mrs Lloyd emphasised the requirement for the Trust to scrutinise the contractual requirements for the management of the Human Resources function were met and that if any additional activity was required that this was addressed.</td>
<td>Formal Arrangements for scrutiny and reporting mechanism to the Board and its relevant committee to be put in place.</td>
<td>AMBER</td>
</tr>
<tr>
<td>DATE</td>
<td>AGENDA ITEM</td>
<td>LEAD AND TARGET DATE</td>
<td>COMMENTS/UPDATE</td>
<td>ACTION</td>
<td>BRAG STATUS</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB179/17 Integrated Performance Report - A&amp;E</strong></td>
<td>CHAIR Sept 2017</td>
<td>Mrs Patten reported that the Trust had been successful in the Talk Bid for capital monies, which had been approved by the Department of Health and the Treasury. The monies however were not released because the Trust had failed to sign the control total and had subsequently been withdrawn. The Trust was therefore required to undertake GP Streaming without funds. Mr Fraser said that this would be brought to the attention of Dame Gill Morgan.</td>
<td>An update to be brought to the October Board via the IPR. <strong>On the Agenda</strong></td>
<td>GREEN</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB179/17 Integrated Performance Report - Mandatory Training</strong></td>
<td>ADHR/DOF Oct 2017</td>
<td>The Workforce Committee should look at organisational health indicators. Comparison of sickness rates and mandatory training rates against those of St Helens and Knowsley should be undertaken at the Finance Performance and Investment Committee.</td>
<td>To be discussed at the October Workforce Committee and brought to the November Board. To be discussed in the September FP&amp;I Committee and brought back to the October Board via the IPR. <strong>On the Agenda</strong>.</td>
<td>GREEN</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB180/17 Director of Finance Report (Including Cost Improvement Programme)</strong></td>
<td>CEO Oct 2017</td>
<td>Southport and Formby and South Sefton CCG both to be invited to send representation to the Southport and Ormskirk Public Board. The Trust to request mutual representation on both CCG Boards. To be taken to the Care For You Board.</td>
<td>An update to be brought to the November Board.</td>
<td>AMBER</td>
</tr>
<tr>
<td>DATE</td>
<td>AGENDA ITEM</td>
<td>LEAD AND TARGET DATE</td>
<td>COMMENTS/UPDATE</td>
<td>ACTION</td>
<td>BRAG STATUS</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td>TB181/17 Business Continuity Plan (BCP) Emergency Preparedness, Resilience and Response (EPRR) Annual Report</td>
<td>COO Oct Board</td>
<td>Mrs Patten confirmed that a summary report covering the annual period April 2016 to March 2017 would be brought to the October Board.</td>
<td>On the Agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td>TB182/17 Extreme Risk Register</td>
<td>COO Oct Board</td>
<td>Mrs Patten to update the Board on the meeting with COO of Lancashire Care Foundation Trust regarding CAMHS provision.</td>
<td>Update to be brought to the October Board as part of Extreme Risk Register Agenda Item. On the Agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td>TB182/17 Extreme Risk Register</td>
<td>DoN Sept / Oct 2017</td>
<td>Meetings to be arranged for the NEDs to meet with Mrs Lloyd to discuss the Extreme Risk Register.</td>
<td>Meetings have begun and will continue until all NEDs have been seen.</td>
<td>AMBER</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td>TB183/17 Board Assurance Framework</td>
<td>CO SEC Oct. 2017</td>
<td>Mrs Pennell asked to see the Strategic Objectives for 2016/17 to compare with the new ones for the purposes of comparison and requested the addition of Safeguarding and Safe Sustainable Services to the impact section.</td>
<td>The BAF has been updated to reflect this. On the agenda.</td>
<td>GREEN</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td>TB184/17 Responsible Officer’s Revalidation Report and Statement of Compliance</td>
<td>MD Oct 2017</td>
<td>Monthly updates to be brought to the Board regarding doctors who are under investigation.</td>
<td>Update to be brought to the Board when there is something to report.</td>
<td>GREEN</td>
</tr>
</tbody>
</table>
• The definition and purpose of an Executive Summary  
• Papers to be issued 7 days in advance for boards and 5 days for committees. | Amendments to be made to the Standard Operating Procedure for the Administration of Meetings. Amendments have been made to reflect suggestions by Board members. Completed and Pas to be trained by Interim Company Secretary. | GREEN        |
<table>
<thead>
<tr>
<th>DATE</th>
<th>AGENDA ITEM</th>
<th>LEAD AND TARGET DATE</th>
<th>COMMENTS/UPDATE</th>
<th>ACTION</th>
<th>BRAG STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEPT 2017</td>
<td><strong>TB185/17</strong> Items for Approval - Standard Operating Procedure for the Administration of Meetings</td>
<td>CO SEC OCT 2017</td>
<td>The Board and Committees’ Annual Business Cycles to be brought to the October Board. Cycles for all committees are to incorporated into a master cycle which should be published on the Trust internet site.</td>
<td><strong>On the Agenda.</strong></td>
<td>GREEN</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB185/17</strong> Items for Approval - Standard Operating Procedure for Trust Quality Visits</td>
<td>DDON Sept 2017</td>
<td>Mr Birrell requested further supporting information from previous ward visits or assessments to further support the Non-Executive Directors.</td>
<td>To be organised ahead of the Quality Visits. Completed and circulated to NEDs and Executive Directors.</td>
<td>AMBER</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>TB185/17</strong> Items for Approval - Standard Operating Procedure for Trust Quality Visits</td>
<td>Temp PA to the ICOSEC Sept 2017</td>
<td>Ms Flood-Jones to coordinate the dates for the Quality Visits.</td>
<td>To be organised ahead of the October Board. <strong>Completed.</strong></td>
<td>AMBER</td>
</tr>
<tr>
<td>SEPT 2017</td>
<td><strong>Items for the Extreme Risk Register / Changes to the BAF</strong></td>
<td>DON Sept 2017</td>
<td>Two changes to be made to the Extreme Risk Register: • The rewording of Item 1362 to reflect the continuous improvement work in response to CQC recommendations.</td>
<td>To be amended with immediate effect. <strong>Completed.</strong></td>
<td>GREEN</td>
</tr>
</tbody>
</table>
### Agenda Item TB195/17 Report Title: Interim Chief Executive Report

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>Karen Jackson, Interim Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Officer</td>
<td>Karen Jackson, Interim Chief Executive</td>
</tr>
</tbody>
</table>

**Action Required**
- [ ] Note
- [ ] Approve
- [ ] Assure

### Key Messages of this Report & Recommendations (2/3 headlines only)

This report seeks to provide the Trust Board with contextual information about the current challenges facing the NHS, and their impact locally,

### Strategic Objective(s) (The content provides evidence for the following strategic objectives)

- Lifelong integrated care
- Excellence in Treatment and Care
- Best Performance within Resources
- Develop Staff
- Organisational Sustainability

### Governance (the report supports a.....)

- Statutory requirement
- Annual Business Plan Priority
- Linked to a Key Risk on BAF/HLRR – Ref ……..
- Service Change
- Best Practice
- Other List (Rationale)

### Impact (is there an impact arising from the report on the following?)

- Quality
- Finance
- Workforce
- Equality
- Risk
- Compliance
- Legal

### Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)

- Strategy
- Policy
- Service Change

### Next Steps (List the required actions following agreement by Board/Committee/Group)

- Note the contents of the report which are for information
Southport & Ormskirk Hospital NHS Trust Board Meeting  
4th October 2017 (Public Section)  

Chief Executive Report  
Karen Jackson, Interim Chief Executive

1 **National Priorities**

1.1 The CEOs of organisations in category 3 and 4 for A&E four hour wait delivery were required to attend a meeting with the Secretary of State, Simon Stephens and Jim MacKay on Monday 18th September.

1.2 Three priorities were identified for focus from Trust Boards for the remainder of 2017/18 and these were:
   - A&E four hour wait delivery
   - 62 day Cancer wait delivery
   - Delivery of the financial outturn position

1.3 The Trust is under pressure for all of these performance requirements and the Board must be focused on delivery for the remainder of 2017/18 and beyond. Plans are being developed to secure improvement in performance and will be shared with the Board on a regular basis through its sub committees and at Board meetings.

1.4 Involvement of the local system in these priorities has also been sought as delivery is part of a wider pathway solution. Delivery and escalation will be managed via the operational groups that already work across the system and detailed reporting to the Board is under development.

2 **Care for You – Strategic Direction**

2.1 The work on Care for You continues with there being a requirement from the Regulators to produce detailed business case documentation. The resources for this are currently being identified.

2.2 Positive progress continues to be made in development of a clinical strategy.

2.3 Outline deadlines are on target to be met and these will help the Trust drive the agenda.

3 **Financial Review**

3.1 The financial situation of the Trust has deteriorated over the past month and remedial action is urgently needed. There is a risk that should this action not deliver the Trust will end the year with a deficit being significantly beyond the control total agreed with NHSI and therefore it is a priority for the Trust to grip this issue tightly and deliver a changed position. This was discussed in detail at the Trust Finance, Performance and Information Committee and is reported on in full under that heading of the Board meeting.
3.2 The Trust has launched an initiative driven by quality and safety to engage all staff in this issue and to ensure there is ownership throughout the organisation. The initiative is being promoted by a pink pig mascot and will be a continual campaign to ensure engagement is achieved and progress is made.

4 Chief Executive Visits

4.1 The CEO has continued with visits to departments around the Trust aimed at raising profile and ensuring that issues are escalated throughout the organisation.

4.2 Trust wide staff meetings have continued lead by the CEO and it is planned that this are maintained for the foreseeable future to address the issue of communication and to ensure that during this time of considerable change staff are engaged.

4.3 The CEO attended the Spinal Injuries Unit charity Annual General Meeting and was able to update trustees on progress with the Trust direction and current issues of interest. The CEO also thanked the group for the support given to the Trust and its patients.

Karen Jackson
Interim Chief Executive
25th September 2017
The report describes the current position and progress monitoring of the CQC improvement plan following the CQC inspection 12th – 15th April 2016. The report was received on 15th November 2016 and following review a detailed action plan has been developed. There are currently 2 schemes, with 4 actions off track which have been escalated to executive team and all appropriate actions in place.

- The MUST do actions have been completed as planned by 30/06/17, except for the 4 actions described in this report.
- The agreed self-assessment and supporting data was submitted as planned on 31/7/17. Following submission the CQC asked for a small amount of additional information which was duly provided.
- This assessment will now be completed annually.

The Trust’s CQC Relationship Officer and new Inspection Manager visited the Southport site on Tuesday 26th September 2017 as part of the CQCs new provider engagement programme, a similar visit will be planned for the Ormskirk site in October 2017.

**Board is requested to:**
Receive this report as assurance that the CQC improvement plan is in place with appropriate systems and processes to implement identified actions and escalate any additional concerns as required

**Strategic Objective(s) (The content provides evidence for the following strategic objectives)**

<table>
<thead>
<tr>
<th>X Lifelong integrated care</th>
<th>X Develop Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Excellence in Treatment and Care</td>
<td>X Organisational Sustainability</td>
</tr>
<tr>
<td>X Best Performance within Resources</td>
<td></td>
</tr>
</tbody>
</table>

**Governance (the report supports a…..)**

<table>
<thead>
<tr>
<th>X Statutory requirement</th>
<th>☐ Annual Business Plan Priority</th>
<th>☐ Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Other List (Rationale)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Agenda Item (Ref): TB197/17  | Report Title: CQC Improvement Plan Update**

<table>
<thead>
<tr>
<th>Executive Lead</th>
<th>Sheila Lloyd, Director of Nursing Midwifery Therapies and Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Officer</td>
<td>Gill Murphy, Deputy Director of Nursing Midwifery Therapies and Governance</td>
</tr>
<tr>
<td>Action Required</td>
<td>Assure</td>
</tr>
</tbody>
</table>
The work will continue to ensure all overdue MUST actions are completed, and all SHOULD actions are completed by the end of December 2017.
1 Executive Summary
The CQC conducted a focused follow up inspection of the organisation between the 12th and 15th April 2016. This was to review the progress of the Trust following a previous inspection in November 2014 when concerns were raised.

The CQC reviewed all the services across the Trust including all the areas of concern which were raised at the previous inspection in order to assess any changes.

Overall, the Trust was rated as requires improvement.

With specific Inadequate ratings in:
- A&E - Rated inadequate for Safe.
- Surgery – rated inadequate for Safe, Well Led and overall.

Detailed action plans for A&E and Surgery are in place to address inadequate ratings.

2 Current Position
The organisation action plan to deliver the CQC recommendations is in place and led by the appropriate CBU Associate Medical Director, Head of Nursing / Midwifery and Associate Director of Operations.

Additional support from an external consultant has now completed with Planned Care CBU. In addition weekly support meetings with Executive colleagues are in place.

A commitment to complete all MUST do actions by end Q1 and all SHOULD do actions by end Q3 has been given to the Executive Improvement Board.

A central drive is in place to collate all the supporting evidence of completion. The DDON has been working with the Business Intelligence team and develop a matrix to monitor compliance. This matrix has indicators from three routes:
- The current data warehouse
- ‘Go and See’ visits
- Audit of compliance

A Good Governance – assurance plan from board to floor has been approved and in progress.

All action plans are being actively monitored through weekly meetings / teleconference call, led by Gill Murphy, Deputy Director of Nursing Midwifery and Jo Simpson, Assistant Director for Quality. These meetings will continue until completion and lessons learned embedded.
All Action plans are accessible on a shared drive to all action leads to continually update, with a standard operating procedure to follow.

**Table 1 – Current status of MUST and SHOULD do actions.**

<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Speciality</th>
<th>Must Do</th>
<th>On track</th>
<th>Off track</th>
<th>Completed</th>
<th>Should Do</th>
<th>On track</th>
<th>Off Track</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Board</td>
<td>Board</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>All CBUs</td>
<td>Outpatients and Imaging</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Accident and Emergency</td>
<td>13</td>
<td>-</td>
<td>1</td>
<td>12</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Medicine</td>
<td>8</td>
<td>-</td>
<td>1</td>
<td>7</td>
<td>10</td>
<td>9</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Critical Care</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>Surgery</td>
<td>16</td>
<td>-</td>
<td>1</td>
<td>15</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Spinal Injuries</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>5</td>
<td>-</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paediatric A&amp;E</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s Services</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Maternity and Gynaecology</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>13</td>
<td>13</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Sexual Health</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
</tbody>
</table>

The above table identifies the actions completed either MUST or SHOULD.

Although these actions have been completed, many are new developments and will require embedding across the organisation. This work is ongoing and executive oversight and support will continue until evidence of sustainability is available.

**Table 2: Actions currently off track (for completion by 31st August), which have been escalated through executive team:**

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Area</th>
<th>Action off track</th>
<th>Progress to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>A&amp;E</td>
<td>Not all vacant posts will be filled</td>
<td>Active recruitment is in place – Safe Staffing is in place, supported by additional bank / agency staff. Recruitment continues, successfully engaging with 36 people who visited our stand at the Southport Flower show. A recruitment event is planned for mid-September to invite these potential</td>
</tr>
</tbody>
</table>
recruits in to take forward. Other initiatives are described in the monthly Safer Staffing report.

| Estates | All Ward areas | De-clutter and store equipment and resources appropriately | ‘Operation Sparkle’ took place 14th 15th 16th August 2017 on the Southport site with positive results. A similar event will take place at Ormskirk. A focused session with Estates and facilities took place on 30th August, with a CEO support and challenge session 31st August, with the directive to have a clear work programme in place. This will work alongside the ‘safe at all times’ project and support the dementia strategy. Decorating work commenced on Ward 14a w/c 18th September 2017. |
| Estates | Surgery | Refurbishment of wards to support dementia care | Plans being considered to use main theatres for elective work and Labour ward theatre for emergency cases. A meeting took place 15th August, between CBU, CEO, MD and DN with agreement to have robust plan in place end August 2017. (usage is rare, with 3 recent occasions of use for surgical procedures on 01/2/17, 10/6/17 and 01/08/17) |
| Estates | Maternity | Cease the use of room 8 as a second theatre in Labour ward | |

3 Progress Monitoring

Progress is monitored through the Monthly CBU Quality and Safety reports via Quality and Safety Committee (QSC, sub group to the Board) with escalation to the board when required as described in the Board Assurance Escalation Framework.

Bi- Monthly Executive Improvement Board meetings continue to monitor progress and compliance, with regular meetings with CQC in place. EIB have asked the CCG, NHSI and CQC to come and review evidence of completing of MUST do actions and report back to EIB in October, the evidence review event will take place on 29th September.

The CEO has held a ‘Challenge and Support’ meeting with all CBUs and Estates and facilities.

The Assistant Director of Quality has commenced her post on 1st August and has started to review the evidence of compliance for all MUST do actions. This process is being supported by the nursing quality standards leads and other staff who have offered their time across the organisation.

To ensure frontline staff are fully aware of progress made in all areas, ‘you said, we listened, we did’ posters are displayed within clinical and public areas.
(Appendix 1). The team are also attending clinical areas to give ‘face to face’ sessions and feedback on progress.

The Trust’s CQC Relationship Officer and new Inspection Manager visited the Southport site on Tuesday 26th September 2017 as part of the CQC’s new provider engagement programme, a similar visit is planned for the Ormskirk site in October 2017.

Feedback from the visit was positive, CQC colleagues reported that the Matrons and staff were fully engaged, demonstrated ownership and autonomy, they also commented that it was refreshing to see people ‘looking at the bigger picture and joined up thinking’ and it felt there was a shift in the overall culture.

However, it was noted that there were potential IG (Information Governance) issues on all wards regarding patient names being displayed on ‘white boards’ and IT screens. In addition areas requiring improvement were identified on the Stroke Ward, this is being addressed through the Heads of Nursing.

4 **CQC Annual Submission of Data and Self-Assessment of Position Against Five Fundamental Standards.**

This submission was completed as required by 31/7/17. The CQC then asked for further clarification on a few data items, which was duly provided within timescales. Going forward this will be an annual data submission.

The DDON is working on a booklet for staff to support the changes and what is expected going forward.
You said | We listened | We did
--- | --- | ---
- Although there was a culture of reporting and learning from incidents, staff did not have a focused approach to reviewing patient deaths (mortality). | | - All patients who die in the department who are not pre-hospital cardiac arrests are discussed at a local ‘harm meeting’ to make sure that all appropriate care was delivered. Findings are recorded and shared.
- Mandatory and statutory training compliance was not meeting the Trust target of 90% | - A Clinical educator has established mandatory training study days for A&E and observation ward nursing staff. Staff are allocated to attend on a monthly basis. This has now resulted in month on month improvement in mandatory and statutory training which is actively monitored to ensure consistency.
- There was no obvious signage to inform people that CCTV was in use within the areas | - Permanent signage is now in place within the A&E department.
- There was poor care whereby a patient experienced delays being monitored and receiving treatment for sepsis. Staff were not consistently using tools to help identify patients at risk of deterioration or identifying these risks themselves. National and local guidelines and care pathways were in place to support staff providing care, but the use of the pathways for managing sepsis was limited and some elements of sepsis care were worse than the regional average. | - A ‘sepsis lead doctor’ has been introduced on each shift with key responsibility for managing any patient with a diagnosis of sepsis. Sepsis trolleys with necessary equipment rolled out within wards and A&E. We have introduced a ‘Deteriorating patient Clinical lead’ and a ‘Deteriorating patient hub’ to support improvements in practice. Monthly sepsis audits in place. Cascaded to team and shared in A&E harm meetings. Improvement plans in place to address areas required.
- Local systems were not in place to audit records of patients to ensure that they received appropriate care and that all relevant risk assessments had been consistently completed and recorded. Only a small number of patients were included in routine Trust wide monthly audits of clinical observations and early warning scores and these were showing omissions | - Additional funding agreed by Trust board to allow A&E to have appropriate and safe staffing levels at all times. These posts are actively being recruited into.
- The department was not meeting the Department of Health target to admit, treat or discharge 95% patients within 4 hours. Re-attendance rates for patients were also worse than the national average. | - A Head of Patient flow has been recruited. Daily Huddle introduced to raise awareness across the site of daily pressures and performance.
Trust awarded ‘most improved performing Trust’ by NHS Improvement (NHSI). Actions from The Emergency Care Improvement Programme (ECIP) report to be monitored monthly at A&E delivery subgroup meetings.
PUBLIC TRUST BOARD
4th October 2017

<table>
<thead>
<tr>
<th>Agenda Item (Ref):</th>
<th>TB200/17</th>
<th>Report Title:</th>
<th>Safe Staffing Monthly Report</th>
</tr>
</thead>
</table>

**Executive Lead**
Sheila Lloyd, Director of Nursing Midwifery Therapies and Governance

**Lead Officer**
Carol Fowler, Assistant Director of Nursing Midwifery and Workforce lead

**Action Required**
Note

Key Messages of this Report & Recommendations

- The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices presented the following overall % fill rates of planned inpatient staffing levels against actual staffing levels for the month of August 2017 as:
  - RNs on days 90.08%
  - RNs on nights 89.98%
  - Care staff on days 112.45%
  - Care staff on nights 103.92%

- **Trust vacancy:**
  - 11.36% Registered Nurse vacancies at band 5 and above
  - 8.35% Healthcare assistant vacancies band 2 and above.

<table>
<thead>
<tr>
<th></th>
<th>Wte funded establishment</th>
<th>Contracted</th>
<th>Vacancy total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust WTE establishment</td>
<td>Registered</td>
<td>865.76</td>
<td>767.38</td>
</tr>
<tr>
<td></td>
<td>Non registered</td>
<td>375.44</td>
<td>344.1</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Registered</td>
<td>291.02</td>
<td>235.91</td>
</tr>
<tr>
<td></td>
<td>Non registered</td>
<td>154.21</td>
<td>142.12</td>
</tr>
<tr>
<td>Planned Care</td>
<td>Registered</td>
<td>327.4</td>
<td>294.54</td>
</tr>
<tr>
<td></td>
<td>Non registered</td>
<td>167.95</td>
<td>147.83</td>
</tr>
<tr>
<td>Womens and Childrens</td>
<td>Registered</td>
<td>217.88</td>
<td>212.86</td>
</tr>
<tr>
<td></td>
<td>Non registered</td>
<td>52.28</td>
<td>53.8</td>
</tr>
</tbody>
</table>

- Care Staff monthly fill rates is higher than the funded ward establishment in some inpatient areas because of extra staff employed to either provide 1 to 1
care to vulnerable patients or to compensate for a shortfall in RN headcount levels when efforts to backfill RN gaps have proven unsuccessful.

- Nursing agency reports at 1.31% against the trust overall 5.25% agency usage. Agency spend is focused in Spinal Injuries Unit, Theatre (reduced numbers in month) and AED floor.

- In August 2017, a total of 28 staffing related incidents were reported via DATIX (55 in June). 14 highlighted ‘insufficient nurses/midwives with 4 of these being focused in Observation ward. Shortages occurred following risk assessments to support safe staffing levels within AED. A further 3 incidents were reported on 14A, 2 reported from Spinal injuries unit due to sickness and vacancies. The short stay unit (SSU) reported 2 staffing incidents in relation to acuity of patients inclusive of patients requiring Deprivation of Liberties (DoLs) assessments and supportive interventions and patients clinical treatment needs.

### Strategic Objective(s) (The content provides evidence for the following strategic objectives)

- X Lifelong integrated care
- x Excellence in Treatment and Care
- x Best Performance within Resources
- x Develop Staff
- x Organisational Sustainability

### Governance (the report supports a.....)

- X Statutory requirement
  - □ Annual Business Plan Priority
  - □ Linked to a Key Risk on BAF/HLRR
  - □ Service Change
  - □ Best Practice
  - □ Other List (Rationale)

### Impact (is there an impact arising from the report on the following?)

- X Quality
  - □ Finance
- X Workforce
  - □ Equality
  - x Risk
  - x Compliance
  - □ Legal

#### Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)

- □ Strategy
- □ Policy
- □ Service Change

### Next Steps (List the required actions following agreement by Board/Committee/Group)

- Note the content of the paper
- Take assurance from progress to date in securing safe staffing
1. Aim of the Report

1.1 To inform the Board of the Trust’s inpatient areas’ nursing and midwifery workforce staffing levels during August 2017.

1.2 The paper reviews for information whether there is a correlation between the monthly staffing levels and areas of harm that patients are at risk of experiencing.

1.3 To update the Board on recruitment activity in order to minimise the number of vacancies in the Nursing and Midwifery workforce in order to optimise staffing levels.

2. Background

It is a national requirement of all Trusts to publish their monthly nursing and midwifery staffing levels to NHS Choices website (Unify). Safer staffing levels are the total planned number of hours worked by registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. A monthly ward fill rate of 90% and over is considered acceptable nationally.

Staffing levels are the head count on each shift and is only one indication of the Trust’s ability to provide safe, high quality care across all wards. Safer staffing does not analyse skill mix, the impact of temporary staff on a shift by shift basis or being short of a member of staff on a particular shift if it has been unsuccessfully backfilled, e.g. only two trained staff on a night shift instead of 3 which for that shift is a fill rate of 66%. This may not be reflected in the ward’s overall monthly average which may still be over 100%.

2.1 Overall Fill Rates

The August 2017 submission indicates a trust fill rate for registered nurses on days 90.08 %, non –registered nurses days 112.45%. Fill rate of registered nurses nights 89.98% and 103.92% for Non-registered nurses’ nights. Where the overall fill rates for care staff is higher than 100% the figures are raised by both the employment of additional ‘specials’ (i.e. 1 patient to 1 care staff member) to protect vulnerable patients and the wards compensating for a shortfall in the registered nurse headcount on a shift by employing a non –registered nurse when efforts to backfill with a bank and/or agency registered nurse or the permanent registered nurses being offered extra time or overtime have proved unsuccessful.

3. Recruitment and Retention

The recruitment and retention of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge. Trust workforce data shows there were 11.36% Registered nurse Vacancies (98.38 WTE) and 8.35% non-registered nurse vacancies (31.34 WTE) at the end of August 2017 across the Clinical Business Units.

Nurse staffing reports as a high risk on the Corporate Risk Register (CRR) and is reviewed monthly. Recruiting and retaining the nursing and midwifery workforce continues to be an area of increased focus:-
3.1 The Recruitment of Bank staff via NHSP

Recruitment of bank HCAs is on-going, advertising every 2 months to recruit to the nurse bank and is delivering continued improvements. The business units are reviewing the non-registered vacancy position against the current CSWD program to advise future recruitment numbers.

Monthly operational meetings with NHSP continue with key leads from clinical business units attending to assure business unit staffing requirements are actioned. Agreement to start a new rate of pay in Theatres commenced from 4th Sept for all registered staff to help in reducing agency costs and increase numbers to the bank. With this new rate in place we would expect agency staff to migrate to bank particularly those who are long term bookers and already committed to working at the Trust.

Continuation of the ‘Bank Exclusive’ scheme

All staff on block bookings or regular agency bookers is actively being encouraged to apply to the NHSP bank by October to continue on a block booking arrangement. NHSP has a quicker process in place which means staff can work as their application progresses. Nursing agency reports at 1.31% against the trust overall 5.25% agency usage. Agency spend is focused in Spinal Injuries Unit, Theatre (reduced numbers in month) and AED floor. Theatre is reflecting a reduction in agency usage since August.

Quarterly Strategic meetings agreed with NHSP leads to assure the Trust vision and recruitment needs are aligned to workforce needs.

The trust in collaboration with NHSP during Oct will commence a scheme known as ‘auto reg’. The Auto Registration process is designed to replace the standard Substantive Registration process, which previously required individual trust substantive members of staff to complete a paper based application. Rather than individual Substantive members of staff completing applications forms, trust Substantive staff opt into the Auto Registration process and the trust shares their personal data with NHS Professionals. This information is uploaded directly onto the NHS Professionals system (Staff Bank).

Once this data has been uploaded, the worker will be sent a welcome emails, one providing their login and another requesting that they provide their ID at the local NHS Professionals office. Once the documentation has been received the worker will be available to work. This process will commence at the point of recruitment to new starters.

Trust benefits:
- Improved shift fill, an increased number of available Flexible Workers will potentially lead to increased shift fill and less reliance on agency workers.

4. Student Nurse Recruitment Update

The Trust’s Student Nurse Practice Education Facilitators have confirmed optimum Recruitment Open Day dates for 2017 to link with the stage in students training (end of 2nd year) when they are job seeking. The Trust is planned to Speak at the Association of Graduate Careers Advisory Services national ‘Nursing Update’, on Sept 12th at Edge Hill University.
During the Trust recruitment event in Sept the trust welcomed conditional offers of employment to 3 candidates who had shown interest in employment opportunities with the Trust when visiting the trust stand at Southport Flower Show.

**On-going Recruitment of Registered Nursing Staff**

All areas including specialist areas have on-going local recruitment as required to attract registered nursing staff to the Trust with the support of HR.

In respect to recruitment activity, collaborative approaches in recruitment to the apprenticeship levy are actively being discussed with health and education providers going forward to assure robust and clear pathways of access are available to prospective and current staff. During August the business units providing expressions of interest from nursing and AHP staff groups in respect to the assistant/advanced practitioner programs available. These are now to be formalised with the HEI’s.

The Trust welcomed the opportunity to showcase at the Southport Flower show during August. Staff engaged positively to engaging with the public and promoting the trust and its services. The stand generated interest to over 30 members of the public interested in volunteer roles in the organisation in the future and a further 23 with interest in substantive posts in clinical roles.

During Sept the trust will commence a communication exercise following post code notification of NMC registrants in the northwest region. This will include opportunity for known registrants who currently do not work at Southport and Ormskirk trust to attend a recruitment afternoon in November to discuss opportunities available.

5. **Staffing Related Reported Incidents**

In August 2017, a total of 28 staffing related incidents were reported via DATIX (55 in June). 14 highlighted ‘insufficient nurses/midwives with 4 of these being focused in Observation ward. Shortages occurred following risk assessments to support safe staffing levels within AED. A further 3 incidents were reported on 14A, 2 reported from Spinal injuries unit due to sickness and vacancies. The short stay unit (SSU) reported 2 staffing incidents in relation to acuity of patients inclusive of patients requiring DoLs assessments and supportive interventions and patients clinical treatment needs.

7. **Inpatients experiencing moderate harm or above following a fall in July 2017**

60 Falls in month of which 40 no harm, 18 low harm and 2 moderate both resulting in fractures. Such incidents are STEIS reported and made subject to a robust Serious Incident Review Investigation which investigates all possible root causes including staffing levels as this harm may occur when staffing levels are correct.

8. **NHS Improvement Safer Staffing Guidance**

On the 15th June NHSI offered Southport and Ormskirk Trust to join one of 11 Trusts nationally identified to pilot the NHSI and Health Education England (HEE) Acute and Emergency Care Advanced Clinical Practice (ACP) FastTrack program.

The Trust has since secured from NHSI part funding towards the current identified 3 ACP posts. Collaborative working with the NHSI program lead Clare Sutherland (based
at Derby Hospitals), commenced on 8th Sept. The trust ‘buddy’ for the ACP program is Nottingham and a visit to Derby to support the next steps takes place in Sept.

In Sept the trust returned the proposed contract following further consultation with national and local NHSI leads. Confirmation against this contract has now been finalised against the supportive offer going forward inclusive of:

- Workforce Governance review
- Workforce ‘Star Chamber’ review
- Retention support
- Job Planning for AHPs & Clinical Nurse Specialists
- Rostering control
- Attendance Management
- Flexible Contracts
- Clinical Strategy Development
- One of 11 Trusts nationally pilot site for Acute and Emergency Care Advanced Clinical Practice Fast Track Programme

The NHSI Operational Programme Lead supporting the Forward Plan and timelines is Claire Morris.

Summary

The report has presented information on staffing headcount fill rates on inpatient wards for the month of August 2017 and provided an update regarding on-going nursing and midwifery workforce recruitment activities to address vacancies.

Carol Fowler
Assistant Director of Nursing and Midwifery (Workforce lead)
### Agenda Item (Ref): TB201/17

**Report Title:** Chief Pharmacist Annual Report including Medicines Safety (Originally The Drugs & Therapeutics Committee, Medicines Optimisation Annual Report 2016-2017)

<table>
<thead>
<tr>
<th>Report to</th>
<th>Trust Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Lead</td>
<td>Paul Mansour, Acting Medical Director</td>
</tr>
<tr>
<td>Lead Officer</td>
<td>John Williams Acting Chief Pharmacist</td>
</tr>
<tr>
<td>Action Required</td>
<td>□ Note □ Approve □ Assure</td>
</tr>
</tbody>
</table>

### Key Messages of this Report & Recommendations (2/3 headlines only)

Medicines optimisation refers to the safe and effective use of medicines. This annual report describes how the Drugs & Therapeutics Committee (DTC) provides assurance that medicines optimisation within the trust has continued to develop, with particular reference to medicines safety, cost improvement and governance.

The Trust complies with all legal and regulatory requirements including those relating to controlled drugs. Regular clinical audits around medicines safety and optimisation take place throughout the year. The Medical Gases Committee has now been brought under the remit of the DTC.

An MIAA review of medicines safety during the year provided “significant assurance” to the Board.

The aseptic suite was refurbished and additional staff employed, to comply with the requirements of Quality Control Northwest.

The Chief Pharmacist retired during the year and the post is currently covered on an interim basis by the Deputy Chief Pharmacist.

The pharmacy department not only trains its own staff in medicines optimisation but also makes a major contribution to the training of other staff, especially junior doctors and nursing staff.

**Strategic Objective(s)** *(The content provides evidence for the following strategic objectives)*

- Excellence in Treatment and Care ✓
- Best Performance within Resources ✓
- Lifelong integrated care
- Develop Staff ✓
- Organisational Sustainability

### Governance (the report supports a.....)
<table>
<thead>
<tr>
<th>Statutory requirement ✓</th>
<th>Best Practice ✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Business Plan Priority □</td>
<td>Other List (Rationale) □</td>
</tr>
<tr>
<td>Linked to a Key Risk on BAF/HLRR – Ref …</td>
<td></td>
</tr>
<tr>
<td>Service Change □</td>
<td></td>
</tr>
</tbody>
</table>

**Impact (is there an impact arising from the report on the following?)**

| Quality ✓ | Risk ✓ |
| Finance ✓ | Compliance ✓ |
| Workforce ✓ | Legal ✓ |
| Equality □ | |

**Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)**

| Strategy □ | Policy □ | Service Change □ |

**Next Steps (List the required actions following agreement by Board/Committee/Group)**
Sections

1. Introduction
2. The Pharmacy Service
3. Finance
4. Controlled Drugs and Accountable Officer Activity
5. Audit
6. Medicines Safety Committee
7. Antimicrobial Stewardship
8. Education and Training
9. Clinical Policies and Guidelines
10. Medical Gases Committee
11. Conclusions
12. Recommendations for 2017-2018
SECTION ONE: INTRODUCTION

Medicines optimisation is defined by NICE as “the safe and effective use of medicines to enable the best possible outcomes”. The Drugs and Therapeutic Committee (DTC) is the Trust body that provides governance assurance regarding medicines optimisation throughout the Trust.

The committee is a multi-disciplinary team consisting of consultants from each Clinical Business Unit (CBU), pharmacists from the Trust and the Clinical Commissioning Groups and nursing staff from training and consultant roles across the Trust. It is essential that this group takes account of all medicines optimisation roles within the Trust including the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care.

To achieve this relies on the Pharmacy department and its staff as an underpinning resource to the Committee and the Trust’s contribution to Medicines Optimisation. The Pharmacy department supports other clinical staff including Medical and Nursing staff to deliver the safe and effective use of medicines and it is essential that all these professional groups work together to optimise medicines for our patients.

The Committee held 10 monthly meetings during the year May 2016 to May 2017 with no meeting in May and August 2016.

The Committee managed the entry of new medicines into the Trust in liaison with the Pan Mersey Area Medicines Management Committee and according to NICE guidelines, re-launched the Medicines Safety Committee and reviewed medicines related policies.

The Drug and Therapeutic Committee escalate issues to the Trust’s Quality and Safety Committee. Examples of this include the delay in the introduction of electronic prescribing (which has a risk register entry) and enabling attendance to maintain a quorum.

The Clinical Audit team are represented on the Drug and Therapeutic Committee where all medicines related audits are reviewed. The Pharmacy and Clinical Audit team produce an annual forward plan for new and repeat audits. The Drug and Therapeutic Committee and the Pharmacy Department were praised for the quality and delivery of the audit forward plan.

SECTION TWO: THE PHARMACY SERVICE

As noted the Pharmacy Department is an essential tool for the Trust to deliver the Medicines Optimisation agenda. There have been some staff changes to the Department in the last twelve months and changes to the political landscape for the service to deliver.
The Pharmacy Department have suffered significant losses in staff, which has been destabilising for the team with the need to use a significant number of agency staff. Some of this is due to Technical staff moving to neighbouring Trusts for specific roles not routinely provided at Southport and Ormskirk. This is not helped by the lack of hospital trained staff available for recruitment and the need to take on community trained Pharmacists and Technicians with the inevitable increase in time to recruit and train staff to deliver the service. As noted under the training and development section of this report it is essential for the Department to continue to train and retain staff over the coming months and years to help overcome these issues.

The most significant loss was that caused by the retirement of Adrian Brown as Chief Pharmacist after over two decades of service. It is important for this post to be replaced from both a statutory requirement and from a strategic point of view. Before his departure Adrian completed the Trusts’ Hospital Pharmacy Transformational Plan (HPTP) as an NHSE requirement. This has since been approved by the Trust Board. The HPTP is heavily influenced by Carter metrics and delivery of this plan will be a vital part of the Trust’s Medicines Optimisation delivery in the future.

During the year, the aseptic suite support area was completely refurbished and additional staff employed, to comply with recommendations made by Quality Control Northwest over the last three years. As well as addressing risks within the Trust’s own service, this will also help the input the Department makes to the Local Delivery System (LDS) Alliance work stream for aseptic work and subsequently that of the Strategic Transformational Plan (STP) for Cheshire and Mersey. The aseptic unit provides both clinical and technical expertise for the delivery of injectable medicines to the wards and departments. Currently it provides high risk items such as Parenteral Nutrition and Chemotherapy for our patients. The need to expand this service to increase the ready-made products available to wards and departments is informed by the NPSA 20 audit on the safe use of injectable medicines completed this year. This will be explored further with the LDS and STP.

The Department is working with its LDS partners on three work streams including clinical pharmacy, aseptic services and outsourcing of services. All these work streams are related to Carter and standardising services across the Alliance.

In line with these work streams, the Emergency Care Improvement Program (ECIP) report and to improve the retention of staff, the Pharmacy Department continues to enhance ward based services. ECIP commended the Pharmacy Department for its ward based trolley service provided to EAU / SSU and suggested that this be rolled out further. There is currently a second trolley with the two trollies servicing EAU / SSU/ FESS and Stroke ward where staffing levels allow. The Pharmacy Department will continue to re-engineer work systems where possible and where staffing numbers allow.

The Pharmacy Department has a monthly governance meeting to review Pharmacy related incidents, review key performance Indictors and provide assurance for the service. This will be reviewed in 2017-18 in line with the Trust governance review and it is likely that this meeting will report to both the Drugs and Therapeutic Committee and the Specialist Services CBU in the future.
SECTION THREE: FINANCE

The Chief Pharmacist is required to produce a quarterly report to the Trust’s Finance Performance and Investment Committee relating to the trends in medicines usage across the Trust and note the financial impact. This is shared at the Drug and Therapeutic Committee.

The medicines spend has been consistently below the national average with any unusual costs being highlighted and accounted for (such as a large spend on fomepizole in quarter 4 for a single antifreeze overdose patient costing £14,000), or the increase in spend on antibiotics due to piperacillin / tazobactam shortages as mentioned under Antimicrobial Stewardship.

The overall performance and contribution to the Trust’s Cost Improvement Plans is also highlighted with the savings via gain share in biosimilar agents following best practice and NHSE / NHSI instructions. The introduction of biosimilar agents has presented a significant saving this financial year, contributing to a cost improvement saving of over £300,000. Achieving the same scale of CIP saving in 2018-2019 will present a significant challenge. However the horizon scanning of the Drug and Therapeutic and Pan Mersey Area Medicines Management Committees will be able to identify medicines coming off patent with potential costs savings in the future years. Contracting via the Central Medicines Unit for the North of England and direction from NHSE also contribute to Cost Improvement Plans on an annual basis.

It is not only the cost of medicines that impact on cost savings in Medicines Optimisation. It is important to consider Information technology and different ways of providing services that can contribute to the Trust’s financial position. Current examples of this include:

- The use of automation in Pharmacy has improved prescription accuracy and turnaround, reduced the storage footprint in Pharmacy, improved stock control and reduced staffing cost by a 2008 value of over £160,000 per year;
- Outsourcing outpatient prescriptions to Rowlands Pharmacy has saved £100,000 per year in staff costs since its introduction as well as 20% VAT savings on medicines supplied;
- The re-use of patients’ own medicines reduces dispensing costs for inpatients as well as improving quality and prescription turnaround.

SECTION FOUR: CONTROLLED DRUGS AND ACCOUNTABLE OFFICER ACTIVITY

The previous Chief Pharmacist continued as Accountable Officer for Controlled Drugs until his retirement in March 2017, when the Deputy Chief Pharmacist took over both roles on an interim basis. The Accountable Officer has continued to provide quarterly reports to the Local Intelligence Network for Controlled Drugs across Merseyside in line with national requirements. The Local Intelligence Network for Controlled Drugs meets four times a year
to review the latest legislation, share any local issues to prevent misuse of Controlled Drugs and look at common problems and share solutions. One issue most Trusts have in common is how patient’s own Controlled Drugs follow them during their journey through the hospital. This is reflected in reported Controlled Drug incidents which are also included in the bulletin mentioned in the Medicines Safety section.

The Trust is in the process of applying to the Home Office for a Controlled Drug licence to allow continued care for patients looked after by Queenscourt Hospice, Virgin Care and Lancashire Care. The Home Office has accepted that the Trust should continue to supply these services in the short term while the application is in process.

Destruction of unwanted or expired Controlled Drug returns from wards has been completed on a regular basis and the records are available to view in both Pharmacy Departments if required.

During the year, concern was raised about the prescribing of controlled drugs in a clinic setting by one consultant, and this is currently subject to formal investigation. There were no other patterns to the incidents reported attributable to a specific ward or person.

Ward Controlled Drug audits have been completed every three months by the ward Pharmacists and once a year via the Southport and Ormskirk Clinical Accreditation Scheme (SOCAS).

Apart from taking action from incidents reported within the Trust, the Pharmacy Department will use intelligence from standard reports produced from the Pharmacy computer system, central reports and CAS alerts, the Risk department and other external partners such as Rowlands Pharmacy and the Local Intelligence Network to prevent risk from the inappropriate use or misappropriation of Controlled Drugs.

SECTION FIVE: AUDIT

The Clinical Audit team are represented on the Drug and Therapeutic Committee where all medicines related audits are reviewed. Medicines related Clinical Audits other than the regular Antibiotic and Controlled Drug audits (see Antibiotic Stewardship and Controlled Drug sections) included;

- Re-audit of Pharmaceutical Contributions
- Patient choice between warfarin and novel oral anticoagulants (NOACs) at the point of prescribing
- Development of Pharmacy service to Observation Ward SDGH
- Omitted doses
- Regular medication omissions/incorrectly prescribed on admission

The Re-audit of Pharmaceutical Contributions noted that the highest numbers of contributions are made on the prescription chart and during the medicines reconciliation process. This concentration of effort continues to achieve high volumes of medicines
reconciliations within 24 hours of admission as required by Clin. Corp 74 ‘Inpatient Medicines Reconciliation Policy’. It also noted that the impact of regular antibiotic audits and feedback resulted in fewer contributions to care needed for drugs from chapter 5 (‘Infection’) of the British National Formulary (BNF).

The Patient choice between warfarin and NOACs at the point of prescribing was an important audit to demonstrate that prescribers were not merely substituting NOACs (New Oral Anticoagulants) for warfarin without offering each patient a choice as per NICE guidelines. This is an example of how important it is to involve a patient in their care and the Trust’s requirement to support this process.

The Southport and Ormskirk Clinical Accreditation Scheme (SOCAS) included a robust audit for monitoring the safe and secure handling of medicines according to the Duthie report 2005. The Pharmacy Technical team conducting this audit will continue to audit wards and departments using this tool, despite the cessation of the SOCAS programme. These audits are reported to the Medicines Safety Committee each month.

The Pharmacy Department is subject to external audits and benchmarking. Examples include ECIP and Quality Control Northwest audit on the aseptic service mentioned under “The Pharmacy Service”. The Pharmacy Department has taken the appropriate action from these reports and continues to improve services. The Pharmacy Department will continue to provide data for the NHS benchmarking tool.

SECTION SIX: MEDICINES SAFETY COMMITTEE

The Medicines Safety Committee was reformed as a subgroup of the Drug and Therapeutic Committee this year as a recommendation of the CQC and has provided assurance around medicines safety for the Trust.

Medicines and Health Related products Agency (MHRA) alerts, defect reports, Central Alerting System (CAS) alerts, Southport and Ormskirk Clinical Accreditation Scheme (SOCAS) reports and policies related to medicines safety are discussed and escalated as appropriate to the Drug and Therapeutic Committee.

During the year, the Mersey Internal Audit Agency (MIAA) produced a review of medicines safety and safe use of controlled drugs, which provided the Board with significant assurance. It found that the Trust has a well-established and defined process for implementing safety controls for the management of medicines and that the overall approach to the safety of medicines and reporting of any incidents is evident. It commended the recruitment of a replacement, dedicated Patient Safety Pharmacist to help to ensure that safety issues, Datix reports and incidents are more regularly reviewed and actioned. It concluded that the visibility of a Ward Pharmacist Team to support medicines management at ward level provides positive links to promote and sustain a safe medicines culture.

There has been a considerable amount of effort notably from the Pharmacy and Intensive Care teams looking at Human Factors relating to medicines related incidents, which has
provided a significant input to the Medicines Safety Committee. The first issue has been the review of how medicines related incidents are dealt with by the Trust, resulting in a major change to the Medicines Optimisation Policy replacing an outdated error matrix with the NHS Decision Tree for dealing with incidents on a fair blame basis. They have also supported the introduction of B Braun Smart infusion pumps and the design and testing of drug libraries to for use with these pumps. This has since been rolled out the other wards across the Trust.

The recruitment of a Medicines Safety Pharmacist has enhanced the processing of incident reports and identification of trends. In the future this will improve the information and training provided to clinical staff to reduce risk in the prescribing and administration of medicines. The ability to give feedback to prescribers and the relevant consultant is resulting in appropriate reflection by the staff involved in medicines related incidents.

Controlled drug incidents recorded on the Trust’s incident reporting system and reviewed by the Committee suggested some trends and a medicines safety bulletin was therefore produced and subsequently audited. The audit provided assurance that ward staff had the knowledge required to order, receive and account for Controlled Drugs in the ward environment.

SECTION SEVEN: ANTIMICROBIAL STEWARDSHIP

The Antimicrobial Stewardship Committee presents a monthly antibiotic usage report to the Drugs and Therapeutic Committee, on which the Antibiotic Pharmacist and the Consultant Microbiologist also sit.

Regular antibiotic point prevalence audits are completed, the results of which are presented to the Drug and Therapeutic Committee and highlighted to the consultant teams caring for the patients audited with feedback on prescribing, indication and review.

The Microbiology team has dealt with significant national shortages of antibiotics in a seamless way continuing to provide safe and effective treatment by adapting the Antimicrobial Guidelines at short notice with no detrimental effect to patient care. This shortage of antibiotics has had a significant impact on the Trust’s drug spend with escalating prices in the changing market place. This issue has been reported to the Finance Performance and Investment Committee (please refer to the Finance section).

The Antibiotic Pharmacist has improved prescribing of high risk antibiotics such as Gentamicin and Vancomycin, redesigning the inpatient medicine charts providing enhanced guidance at the point of prescribing and administration. The training for prescribers and Pharmacist in the use of this documentation was vital given the reduced presence of Microbiologists to provide on the spot guidance. This has reduced the number of pharmacist contributions to care needed for antibiotic prescriptions, as recorded by the Re-audit of Pharmaceutical Contributions (see Audit section).
SECTION EIGHT: EDUCATION AND TRAINING

Training and development for Medicines Optimisation has always been a high priority within the Pharmacy service delivery. The Pharmacy team continue to provide training for both Medical and Nursing staff. The new intake of junior medical staff receives induction training in August and February each year, concentrating on high risk areas such as insulin, anticoagulants and antibiotic as well as general principles of prescribing. In addition to this Pharmacist and Pharmacy Technicians provide training in specific clinical / disease states and technical issues such as the use of the electronic discharge system to help support good practice in patient care.

The Medicines Management for Nurses study day continues to be well received with excellent feedback from participants, who value the face to face style and the ‘admission to discharge’ flow of the sessions. The attendance has been low with some sessions cancelled due to low numbers of students available to attend. The sessions have been extended to student Nurses from Edge Hill and the University of Central Lancashire. Clinical Nurse Induction sessions are now provided monthly via the Assistant Matron Nurse Education and Training. Again these sessions are well received with positive feedback, such as “Excellent course, very relevant content throughout, well delivered”, “All of it very informative”.

The Pharmacy department are under increasing pressure to deliver training to 4th and 5th medical students from Liverpool University. Although this training is structured, the time to prepare and deliver these increasing sessions is starting to put pressure on the Clinical Pharmacy service. There is a need to mirror other Trusts who have a teaching post within the department structure.

Liverpool John Moores University (LJMU) also works closely with the Pharmacy Department and there are links to undergraduate training between the two organisations.

The absolute requirement for the Pharmacy Department to train their own staff and retain newly qualified personnel is high on the agenda for the coming years in line with the Trust’s view of retaining staff trained within the organisation. Currently the Pharmacy provides support to train two student Pharmacy Technicians and two Pre-registration Pharmacists each year to this end.

This year sees the completion of all of the 8A Pharmacists’ training as Non-Medical Prescribers and a commitment to train the band 7 Pharmacist next. This had led to some prescribing during the process of medicines reconciliation on admission, but to release staff to have a more substantive role in prescribing remains difficult despite a successful pilot in pre admission clinics for orthopaedic surgery.

The Pharmacy Department continues to support band 6 Pharmacists to complete their clinical diploma to enhance their clinical skills to support the safe and effective use of medicines.
SECTION NINE: CLINICAL POLICIES AND GUIDELINES

Medicines related Policies and Guidelines are discussed and ratified at the Drug and Therapeutic Committee. Any such documents are taken through the Clinical Business Unit governance structure for dissemination and comment. Those ratified during the year were:

- Guideline for the safe use of High Strength Insulin
- Policy for the Implementation of the National Demand Management Plan for Immunoglobulin CLIN CORP 98
- Policy Governing the Aseptic Preparation of Pharmaceuticals in Clinic and Ward Areas (including Injectable medicines) CLIN CORP 73
- Adult Antimicrobial Guidelines
- Management of Hypoglycaemia Guideline in Diabetes Mellitus
- Management of Diabetic Ketoacidosis (DKA) in Adults Emergency Care Pathway
- Acute Coronary Syndrome (ACS) Pathway Initial Management
- Policy for the Management of the Extravasation of Injectable Medicines CLIN CORP 86

SECTION TEN: MEDICAL GASES COMMITTEE

The Medical Gases Committee meets every two months and reports to the Drug and Therapeutic Committee. It has completed the first Trust medical gases policy for approval and has dealt with two medical gas alerts so far this year, one concerning the confusion between medical air and oxygen. The committee plans to introduce medical gas training for Trust clinical staff, with particular reference to oxygen prescribing which was noted as a deficiency the CQC.
SECTION ELEVEN: CONCLUSIONS

Medicines optimisation is a Trust-wide issue requiring multidisciplinary working and training.

This report demonstrates how the Drugs and Therapeutic Committee ensures that the medicines optimisation processes that it oversees have a significant influence on quality and safety, development of services, risk reduction and finance.

Collaboration between local Trusts to share resources and ideas is proving to be a useful process providing support to all involved.

However, there is still a great deal to accomplish both within the Trust and in the Trust’s external environment including within the LDS Alliance, the STP and the local clinical landscape, and these will be the focus of next year’s work.

SECTION TWELVE: RECOMMENDATIONS FOR 2017-2018

The committee’s terms of reference will be reviewed in light of the recent standardisation of Trust committees’ operating principles. In particular, the respective responsibilities of the DTC and the Specialist Services CBU for medicines optimisation will be clarified.

The HPTP report must map out the future needs for Medicines Optimisation within the Trust some of which can be achieved with changes in process and training, but many will need investment in the future.

Electronic prescribing and administration of medicines is part of the IM&T strategy for the next financial year and its lack of implementation up to now is on the risk register as a high risk. It important this strategy is adhered to.

The plan for the Pharmacy Governance Committee to report to the Drug and Therapeutic Committee can be implemented quickly. The importance for their continued effectiveness of the Drug and Therapeutic and Medicines Safety Committees being quorate must be addressed by the new Trust governance structure and standard terms of reference.

The Pharmacy should continue to develop the work streams with the LDS and STP with particular reference to Aseptic services and the safe use of injectable medicines. Using this forum to review automation both in the Pharmacy Departments and out in clinical areas, working with the Clinical Business Units to maintain the progress achieved so far is important.

The Pharmacy should continue to support NHS benchmarking to support best practice within the Trust and the wider NHS.

It is vital for the Pharmacy Department to be able to over recruit the staff they train each year in terms of maintaining the quality and development of the service and maintaining cost effectiveness rather than using agency staff. This must include a recruitment strategy that
provides staff with desirable roles such as ward based work for Technical staff and prescribing roles for Pharmacists. This strategy must be linked into the Clinical Business Units plans for the development of their services. Having Pharmacy staff in new areas such as Accident and Emergency, pre admission clinics and outreaching into the community should be considered.

Medicines Optimisation training needs to be reviewed and support for staff to provide and attend training should be given. A plan to deliver this need to be agreed Trust wide.

The Medicines Safety Committee will continue to provide briefings and bulletins to support the safe and effective use of medicines in both a proactive and reactive way using alerts and incidents to inform them.
HIGHLIGHT REPORT

Committee/Group: Quality & Safety Committee

Meeting date: 27th September 2017

Lead: Ann Pennell, Non-Executive Director

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

- A&E Target – Over the coming months A&E and patient flow will be a focus for Trust Board and an update position paper will be provided for the Board.
- Lockdown Policy – A policy is being produced which will identify which staff have access all areas and which areas across the Trust are restricted. The Chief Operating Officer will provide an update at the next Quality & Safety Committee Meeting.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

- The Committee received the Drugs & Therapeutic Committee (Medicines Optimisation) Annual Report 2016/17 and was assured that it is meeting legal and statutory requirements.
- 62-day cancer waiting time target action plan received. Progress is being made and an update will be provided at the Quality & Safety Committee in November 2017.

ASSURE

(Detail here any areas of assurance that the committee has received)

- Stroke performance is continuing to be monitored.
- CQC Action Plan - self-assessment and well-led reviews will be organised.
- The Quality & Safety Committee will link in with the work on Mortality and will receive exception reports from the Mortality Assurance & Clinical Improvement Committee (MACIC).

<table>
<thead>
<tr>
<th>New Risk identified at the meeting</th>
<th>Cyber attack may impact on diagnostic services affecting patient care delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for</td>
<td>A cyber attack may impact diagnostic imaging</td>
</tr>
</tbody>
</table>
new risk devices because they run embedded Microsoft operating systems. Many of the devices are running legacy versions due to the age of the devices and these cannot be patched easily (without supplier support). Furthermore remediation of infection or imminent risk of infection is dependent on the system supplier/ vendor and this may incur prolonged impact of downtime.

Review of the Risk Register

Extreme Risk
Catastrophic 5
Possible 3 =15
High level risk
Catastrophic 5
Unlikely 2 =10

(Detail the risks on the committee’s risk register that were reviewed in the meeting, including scores C&L and current actions)
Committee/Group: Audit Committee
Meeting date: 13 September 2017
Lead: Ged Clarke-Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

(Alert the Board to areas of non-compliance or matters that need addressing urgently)

Board Assurance Framework (BAF): The Committee was concerned to be reminded of the fact that the Board Assurance Framework had been outstanding since March 2017. It was pleased to learn that work was being undertaken to ensure that a final draft with recommendations for approval of refreshed objectives and associated risks would be brought to the October Board for approval. There was also discussion about the degree to which there was synergy between the BAF and the Trust’s corporate risk register. There was a desire that this be completed as quickly as possible so that the Board and its committees have clear sight of the risks.

Value for Money: KPMG’s, outgoing External Audit’s conclusion that, due to its underlying cumulative deficit of £33.2M at 31 March 2017; its failure to achieve the CIP target; agency expenditure in excess of plan which exceeded the ceiling set by NHS Improvement; lack of a comprehensive sustainability strategy/detailed operational plans; the planned £18.1M deficit in 2017/18 indicating a potential breach of the ‘break even’ duty; its reliance on significant cash support in 2016/17 and anticipated levels of cash support as included in its 2017/18 plan; and its overall CQC rating of ‘requires improvement’, the Trust had not put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, needs addressing.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

The BAF to be formalised and show synergy with the Trust’s Risk Register.

ASSURE

(Detail here any areas of assurance that the committee has received)

The Committee received assurance on the following:

- Anti-Fraud making progress against the outlined plan
- Risk Management Audit gave positive assurance with some recommendations that need addressing not later than 30 September 2017; these are on track for completion
- With regards to security management security awareness and crime prevention now incorporated into the corporate induction of the Trust

New Risk identified at the meeting

NONE

The Extreme Risk Register, containing 13 risks, was received and reviewed. Noting that no new risks had been added and none closed in month, the Committee:

a) approved the reduction in the risk rating in relation to risk number 1440 Cyber attack threat to ‘high’.

Review of the Risk Register

(Detail the risks on the committee’s risk register that were reviewed in the meeting, including scores C&L and current actions)
**PUBLIC TRUST BOARD**

4th October 2017

<table>
<thead>
<tr>
<th>Agenda Item (Ref):</th>
<th>TB204/17</th>
<th>Report Title:</th>
<th>Integrated Performance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Lead</strong></td>
<td>Steve Shanahan, Director of Finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lead Officer</strong></td>
<td>Kevin Walsh, Deputy Director of Finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action Required</strong></td>
<td>□ Note</td>
<td>□ Approve</td>
<td>X Assure</td>
</tr>
</tbody>
</table>

**Key Messages of this Report & Recommendations**

The report highlights the indicators that require discussion by Trust Board. Some of these indicators require corrective action to be taken. A brief narrative has been provided in order to provide assurance that corrective measures are in place.

A new front sheet has been included which highlights key areas for the Board to consider and discuss. This incorporates finance, quality, workforce and performance measures.

The strategic objectives within the report will be changed in forthcoming months to reflect the CQC and NHS I Single Oversight Framework areas of Caring, Effective, Responsive, Safe and Well-led. Included will also be operational and our money.

The Board is asked to discuss the report and highlight any further assurance necessary in relation to areas of poor performance.

**Strategic Objective(s)** *(The content provides evidence for the following strategic objectives)*

- □ Lifelong integrated care
- X Excellence in Treatment and Care
- X Best Performance within Resources
- X Develop Staff
- X Organisational Sustainability

**Governance (the report supports a…..)**

- X Statutory requirement
- □ Annual Business Plan Priority
- □ Linked to a Key Risk on BAF/HLRR
- □ Service Change
- X Best Practice
- □ Other List (Rationale)

**Impact (is there an impact arising from the report on the following?)**

- X Quality
- X Finance
- X Workforce
- □ Equality
- □ Risk
- X Compliance
- □ Legal

**Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)**

- □ Strategy
- □ Policy
- □ Service Change

**Next Steps** *(List the required actions following agreement by Board/Committee/Group)*
Items to note:

- Increase in A&E attendances but fewer admissions as patients streamed more appropriately in department. Four hour target missed in month impacted by poor flow evident in increased length of stay and volume of bed days for patients medically fit for discharge. Also impacted on 90% stay on stroke ward and mixed sex breaches, both of which remain non-compliant.
- Continued poor performance in diagnostics and 62 day cancer target, which are linked below-plan contracted activity performance remains a significant issue and is impacting negatively on Trust finances. Additional reports have been provided to the committee. These are being complimented with demand and capacity work and an operational plan developed.
- HSMR remains above the 100 ratio. Work in relation to coding co-morbidities and improving accuracy of casenote continues. A more robust process will be embedded from Q3.
- Trust performance in relation to infection control remains strong with our trajectory remaining well below plan.
- Harm-free care and friends and family test compliance remain challenging.

Quality:

- Mixed Sex breaches
- Pressure Sores
- A&E 4 hour Activity
- Diagnostic Wait times
- Nursing vacancies
- 62 day cancer
- CIP Plan delivery
- MRSA & C.Diff
- Sickness Absence

Performance:

Increase in A&E attendances but fewer admissions as patients streamed more appropriately in department. Four hour target missed in month impacted by poor flow evident in increased length of stay and volume of bed days for patients medically fit for discharge. Also impacted on 90% stay on stroke ward and mixed sex breaches, both of which remain non-compliant.

- Continued poor performance in diagnostics and 62 day cancer target, which are linked below-plan contracted activity performance remains a significant issue and is impacting negatively on Trust finances. Additional reports have been provided to the committee. These are being complimented with demand and capacity work and an operational plan developed.

Finance:

- Deficit in month of £2.8m adverse variance of £1.2m from plan. Shortfall largely driven by shortfall in income however in month expenditure up as a result of CIP and non-clinical agency spend.
- Majority of CIP schemes developed by Four Eyes Insight due to start during Q2. Plan is not predicted to deliver savings and non-recurrent run-rate reductions required.
- Cash loans will be exhausted before the end of the financial year due to the deficit exceeding plan.

Workforce:

- Sickness absence remains high across the Trust. A new sickness absence administration team have been established in September to support managers and HR.
- The number of nursing vacancies has reduced. This can also be seen in the lower agency spend in this area. Nursing agency spend is the lowest in two years.
- Compliance with mandatory training is below plan, though improvements have been made over the last quarter.
Integrated Board Report. Reporting on August data.

RAG Ratings by Section

- **Strategic Objective 1:** Embed An Integrated Care Model Across The Local Health Economy
  - Green: 20%
  - Yellow: 40%
  - Red: 40%
  - Grey: 10%

- **Strategic Objective 2:** Ensure Excellence In Treatment And Care
  - Green: 20%
  - Yellow: 40%
  - Red: 40%
  - Grey: 10%

- **Strategic Objective 3:** Deliver Performance, Within Resources, Comparable With The Best The NHS Can Offer
  - Green: 20%
  - Yellow: 40%
  - Red: 40%
  - Grey: 10%

- **Strategic Objective 4:** Empower And Develop Staff To Achieve Their Objectives
  - Green: 50%
  - Yellow: 20%
  - Red: 30%
  - Grey: 10%

- **Strategic Objective 5:** Maintain Organisational Sustainability
  - Green: 20%
  - Yellow: 80%
  - Grey: 0%
<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>No associated Indicators</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
## Strategic Objective 2: Ensure Excellence In Treatment And Care

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency - 4 Hour compliance</td>
<td>Percentage of patients spending less than 4 hours in a A&amp;E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.</td>
<td>Performance for August was 88.7% at Trust level. Disappointingly, performance for the Southport site alone against the 4-hour target was 75.3% compared to 84.8% last year. There was a 1.8% increase in overall ED attendances, a 6.4% increase within majors category compared to the same month last year. Despite the increase in activity at the front door, there was a 8.9% decrease in admissions compared to last year, and the overall conversion rate from attendance to admission was 33.16% compared to 36.94% last year. ED continues to consider alternative pathways for patients to avoid admission, which is evident from the reduction in admissions. ED has had</td>
<td>Quality &amp; Safety Committee</td>
<td><img src="image1.png" alt="Graph" /></td>
</tr>
<tr>
<td>Ambulance Handovers &lt;=15 Mins</td>
<td>All handovers between ambulance and A&amp;E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes.</td>
<td>August saw a marginal improvement compared to last month in the average notification to handover time (22:24 minutes), but this is still a drop in performance compared to April - June inclusive). The department continues to experience pressures during periods of escalation with over occupancy and severely limited space. At the end of August, the department started a pilot using radiology sub-wait overnight and at weekends to safely manage and care for 4 patients, improving privacy and dignity. Feedback from the clinical team has been positive, but there is still work to do to drive down some of the delays in ambulance handovers. A visit to Liverpool Royal is being planned to review</td>
<td>Quality &amp; Safety Committee</td>
<td><img src="image2.png" alt="Graph" /></td>
</tr>
<tr>
<td>TIA (Transient ischaemic attack)</td>
<td>Proportion of patients diagnosed with a TIA Treated within 24 hours. Threshold 60%. Good performance is higher.</td>
<td>During August 2017, there were 13 TIA’s referrals, 4 of these were reportable for which we were 25% compliant. The key themes for reasons for breaches were delay in referral being received following on from 1st seen and Clinic Capacity. To address the issue of clinic capacity an additional TIA clinic has now set-up every Monday, Tuesday &amp; Thursday within AEC, this will allow for flexible capacity for urgent TIA’s to be seen in a more timely manner. This went live on Monday 11th September.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image3.png" alt="Graph" /></td>
</tr>
<tr>
<td>Stroke 90% ward stay</td>
<td>Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Previously reported performance may change as a result of validation.</td>
<td>This indicator remains a challenge as reported monthly - currently 46.8%. Until commissioning is agreed to implement Early Support Discharge to improve patient flow achieving this standard will be challenging. The reconfiguration of stroke beds and the Rehab Ward move to Southport has been completed. It is anticipated that improvements will be seen over the next two-three months. An options appraisal is being considered and shared with North Mersey Board to support patient flow and dedicated placement on stroke ward. A meeting is booked for end September with commissioners to discuss Early Supported Discharge.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image4.png" alt="Graph" /></td>
</tr>
</tbody>
</table>
### Strategic Objective 2: Ensure Excellence In Treatment And Care (Page 2 of 5)

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SHMI (Summary Hospital-level Mortality Indicator)</strong></td>
<td>Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly and is 6 months behind due to when Dr Foster publish the data. Good performance is 100 or less.</td>
<td>The sharp rise in SHMI is due to correcting data irregularities by NHS Digital from December 2016. Please see HSMR narrative for further detail which is also concerned with the SHMI Indicator, in addition MACIC has requested deep dive into mortality from pneumonia and UTI.</td>
<td>Quality &amp; Safety Committee</td>
<td><img src="image1" alt="Graph" /></td>
</tr>
<tr>
<td><strong>HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)</strong></td>
<td>The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100. At Trust level, good performance is 100 or less. Source = Dr. Foster. Please note: This indicator is reported monthly and is 3 months behind due to when Dr Foster publish the data.</td>
<td>HSMR &amp; SHMI are high and outside the expected limits. While both should take account of &amp; ‘even out’ factors such as age and co-morbidities that increase the risk of dying, &amp; should therefore reflect the quality of care provided, this depends on completeness of coding, itself reliant on documentation in the notes. Other technical variables also affect some of these stats, &amp; therefore acknowledged they are better regarded as a warning of possible poor care. While coding of comorbidities is continually being looked at, we can’t afford to assume that this is the reason for high rates, &amp; must therefore triangulate these with other sources of info. About 90% of deaths are reviewed to ensure that care was</td>
<td>Quality &amp; Safety Committee</td>
<td><img src="image2" alt="Graph" /></td>
</tr>
<tr>
<td><strong>C-Diff</strong></td>
<td>Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 36 for the year. Good performance is fewer than 36 for the year. Line = Last Financial Year Bar = This Financial Year</td>
<td>There was 1 C-Diff case in August, bringing the YTD figure to 3. Patient isolated and treated effectively for C-Diff infection. Bed space and room disinfected. Patient required treatment with antimicrobials due to sepsis - this case is likely to be appealable.</td>
<td>Quality &amp; Safety Committee</td>
<td><img src="image3" alt="Graph" /></td>
</tr>
<tr>
<td><strong>MRSA</strong></td>
<td>The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0. Line = Last Financial Year Bar = This Financial Year</td>
<td>There were no MRSA cases in August. Zero cases reported in 17/18.</td>
<td>Quality &amp; Safety Committee</td>
<td><img src="image4" alt="Graph" /></td>
</tr>
</tbody>
</table>
### E. Coli

**Number of Escherichia coli (E. Coli) infections for patients aged 2 or more on the date the specimen was taken.**

Indicator is for monitoring purposes as no formal target has been finalised with the CCGs. Good performance is low.

- **Line = Last Financial Year**
- **Bar = This Financial Year**

There were 2 Hospital acquired E-Coli cases in August and 12 acquired in the Community. 12 Hospital acquired cases in total for 17/18. All patients reviewed by their respective doctors with advice from the Consultant Microbiologist. Of the two hospital cases, one was due to biliary and one due to UTI in a patient who has CA bladder.

### Falls

**The number of falls within the hospital per 1,000 bed days.**

- **Threshold:** 4.5 per 1000 bed days.
- **Good performance is lower.**

- **Line = Last Financial Year**
- **Bar = This Financial Year**

Total of 60 falls reported in August, 58 of which were no harm/low harm. 2 moderate harm falls, both resulted in FNOF, one on Obs ward and one on the stroke unit. Obs ward patient stumbled at the foot of his bed (DOLs in place). Stroke patient unwitnessed fall. Medics involved in both care episodes and appropriate actions taken.

Nursing documentation and revision of falls care bundle ongoing. Continued reporting and monitoring through Trust Falls Committee. Wards have been requested to report on current numbers of working falls alarms. Shared Planned Care/Urgent Care falls reduction action plan ongoing.

### Hospital Pressure Sores

**Number of reported Trust acquired pressure sores graded between 3 and 4.**

- **Threshold:** 0.
- **Collaborative goal:** Elimination of grade 3 and 4 pressure ulcers plus 25% reduction overall.

- **Line = Last Financial Year**
- **Bar = This Financial Year**

There were no grade 3 or 4 pressures sores in August with 6 ulcers graded at a level 2. There have been 2 grade 3-4 ulcers in 17/18 thus far.

### Safe Staffing

**The ratio between the proposed number of nursing staff to ensure a safe staffing level and the actual number of nurses working those shifts.**

- **Threshold:** 95%.

- **Line = Last Financial Year**
- **Bar = This Financial Year**

Safe staffing achieved supported by continued reliance on temporary workforce inclusive bark and additional hours worked by substantive staff across the hospital settings. Block booking via Pulse further supports staffing in specialist areas such as Spinal Unit and AED with transparency of booking via NHSp portal. Overall Trust fill rate has reduced against previous month-97.08%. Planned Care 72.16%. Urgent Care 114.78%. Women and Children’s 99.53%.
## Board Report - August 2017

### Strategic Objective 2: Ensure Excellence In Treatment And Care (Page 4 of 5)

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
</table>
| Harm Free      | Safety Thermometer - Percentage of Patients With Harm Free Care.  
Threshold 98%. Higher is better.  
Line = Last Financial Year  
Bar = This Financial Year | Performance against this Indicator was 96.75% in August.  
Increase due to change in sample size since loss of community services. Previous sample size was an average of 980 which has now reduced to an average of 350 per month. This continues to be reflected in percentage compliance and has been predicted as both UTI’s and falls are more hospital based. Matrons to be given further guidance to support staff with accurate completion of data collection tool. | Quality & Safety Committee |  ![Harm Free Chart](chart1) |
| VTE (Venous thromboembolism) | VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE.  
Threshold 95%. Good performance is higher.  
Line = Last Financial Year  
Bar = This Financial Year | Compliance for VTE assessment remains above the threshold of 95%. The Trust proforma for assessment of VTE continues to be monitored using an audit approach which includes monthly point of prevalence surveys as part of the NHS Safety thermometer. It is also now part of the Southport and Ormskirk Clinical Accreditation Scheme in line with the CQC’s Key Lines of Enquiry, of which non-compliance is reported as part of feedback which initiates an individualised area action plan. Acquired hospital VTE’s continue to be reported via DATIX and any lessons learned are shared through the divisions from the completion of RCA’s. | Quality & Safety Committee |  ![VTE Chart](chart2) |
| Friends and Family Test | Friends and Family Test. The proportion of patients that would recommend the Trust to their friends and family.  
Threshold: 94%. Fail: 90%. Good performance is higher.  
Line = Last Financial Year  
Bar = This Financial Year | During August the response rate for the Trust decreased to 5.89% (was 7.67% in July). Those that would recommend also decreased to 86.65% from 88.22%. Planned Care decreased to 14.04% from 18.15%. Those that would recommend actually increased to 96.63% from 94.59%. Urgent Care decreased to 3.91% from 5.61%. Those that would recommend also decreased to 72% from 69.07%. Specialist services again decreased to 6.02% from 6.58%. Those that would recommend increased to 91.52% from 89.15%. | Quality & Safety Committee |  ![Friends and Family Test Chart](chart3) |
| Never Events | Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death.  
Line = Last Financial Year  
Bar = This Financial Year | There were no Never Events reported in August. | Quality & Safety Committee |  ![Never Events Chart](chart4) |
### Indicator Name: DSSA (Delivering Same Sex Accommodation) Breaches - Trust

<table>
<thead>
<tr>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.</td>
<td>There were 12 Mixed Sex Accommodation breaches in August. All 12 occurred within Critical Care and were all delayed discharges to an acute bed.</td>
<td>Quality &amp; Safety Committee</td>
<td><img src="image" alt="Graph" /></td>
</tr>
</tbody>
</table>

Line = Last Financial Year  
Bar = This Financial Year
### Strategic Objective 3: Deliver Performance, Within Resources, Comparable With The Best The NHS Can Offer (Page 1 of 4)

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 day GP referral to Outpatients</td>
<td>Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer.</td>
<td>In July the Trust achieved this target with performance at 95%.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image1" alt="Graph" /></td>
</tr>
<tr>
<td>31 day treatment</td>
<td>Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').</td>
<td>In July the Trust achieved this target with performance at 100%.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image2" alt="Graph" /></td>
</tr>
<tr>
<td>62 day GP referral to treatment</td>
<td>Percentage of Patients receiving first definitive treatment for cancer within two months (62 days) of urgent GP referral for suspected cancer.</td>
<td>The Trust failed to meet this standard in July at 77.9%. Breaches can be attributed to a number of reasons; 6 were determined to be unavoidable due to patient reasons or the complexity of their pathways. 5 were treated past day 104 on their pathway. They will be subject to a full harm review by the lead clinician for their tumour site. The cyber-attack impacted four patients due to delays in their pathway. The lack of capacity in the neck lump clinic has been added to the risk register. The Trust will fail the target in August.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image3" alt="Graph" /></td>
</tr>
<tr>
<td>62 day pathway view</td>
<td>All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.</td>
<td>In July there were 14 patients that breached their 62 day standard, 6 full breaches (2 each in lower GI, Urology and Haematology) and 8 half (3 Lung, 1 Urology, 1 Upper GI, 2 Head &amp; Neck, 1 Haematology).</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image4" alt="Graph" /></td>
</tr>
</tbody>
</table>
## Strategic Objective 3: Deliver Performance, Within Resources, Comparable With The Best The NHS Can Offer (Page 2 of 4)

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>Number of referrals received into the Trust. This will include referrals from GPs, other hospitals and internal referrals. Line = Last Financial Year Bar = This Financial Year</td>
<td>A more detailed breakdown of Trust referrals and subsequent activity is available at the end of the performance report. This covers the trust and a number of key specialties. Referrals are up in General and Colorectal Surgery and Gynaecology.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td>8500</td>
</tr>
<tr>
<td>First Appointments</td>
<td>The number of patients seen in a first appointment including where the patient is seen in an outpatient clinic and has a procedure undertaken. Line = Last Financial Year Bar = This Financial Year</td>
<td>The number of first appointments has risen slightly in August, historically a month with low-levels of activity. The Trust is 10% down against plan.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td>6500</td>
</tr>
<tr>
<td>Daycase/Inpatient</td>
<td>The total number of patients treated as either a day case or an elective inpatient in month. Line = Last Financial Year Bar = This Financial Year</td>
<td>The Trust has seen only a slight decrease of 10 Day case/Inpatient elective episodes in August from July's figure of 2,016. However, this current position is an improvement on April (1900) and May's (1993) figures which both under 2000. The Trust is 11% below plan for activity.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td>2000</td>
</tr>
<tr>
<td>Waiting list size</td>
<td>The number of RTT patients currently waiting. Line = Last Financial Year Bar = This Financial Year</td>
<td>Total RTT Waiting List size has decreased significantly again this month to 6998 in August which is 356 less than in July.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td>11500</td>
</tr>
</tbody>
</table>
**Board Report - August 2017**

**Strategic Objective 3: Deliver Performance, Within Resources, Comparable With The Best The NHS Can Offer**

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic waits</td>
<td>The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting.</td>
<td>In reviewing service provision, capacity and demand has a significant part to play in the activity and breaches that occur. Actions are being taken to provide a PTL pivot for all diagnostic services with the aim to manage all diagnostic activity prospectively during Fridays performance meeting and in service teams daily / weekly in order to consider providing additional capacity in advance where possible to mitigate and or reduce the risk of breaches. Some diagnostic services simply do not have the physical space or specialist kit and so other service delivery initiatives are being explored. The ECHO service has significant staffing issues as 1 member of staff is off sick and one is due to</td>
<td>Finance, Performance &amp; Investment Committee</td>
</tr>
<tr>
<td>Referral to treatment: on-going</td>
<td>Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less.</td>
<td>Trust Performance has again met the 92% threshold for August which was recorded at 90.7%. Patient are still being booked in chronological order. This does not reflect the challenges faced in some sub-speciality areas i.e. Endo at 78.7%, Respiratory 77.5%.</td>
<td>Finance, Performance &amp; Investment Committee</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>The average length of stay for all patients across the Trust.</td>
<td>Average length of stay for August was 2.68 bed days; this was an increase in previous months and an increase compared to August 16. A Daily Discharge Huddle is commencing w/c 18/9/17 with requested input from both community providers and CCGs. This meeting will be at patient level to discuss and agree next steps for onward transfers. The ICRAS model is due to be launched later next month (October 17) with the aim to reduce the number of assessments carried out in an acute setting. There are significant concerns regarding the reduction in community step down beds (in Southport &amp; Formby) and the lack of clarity regarding future provision, and how this will relate to bed occupancy and length of</td>
<td>Finance, Performance &amp; Investment Committee</td>
</tr>
<tr>
<td>Bed days post MOFD (Medically Optimised for Discharge)</td>
<td>Number of beddays used for inpatients who have passed their medically optimised for discharge date. It is taken as a snapshot on the last working day of the month.</td>
<td>The number of medically fit bed days for August was 948. As reported previously, there has been a continued drive to ensure that ‘medically optimised for discharge’ is captured on Medway at patient level. Since January there has been a significant increase. The number of patients who are flagged as being ‘medically fit’ are captured at the daily escalation meetings (an average of 35 patients per day). The Ready for Discharge meeting has been launched with membership from partner organisations.</td>
<td>Finance, Performance &amp; Investment Committee</td>
</tr>
</tbody>
</table>
## Strategic Objective 3: Deliver Performance, Within Resources, Comparable With The Best The NHS Can Offer

### DNA (Did Not Attend) rate

The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is.

- **Lower is better.**
- **Line = Last Financial Year**
- **Bar = This Financial Year**

The DNA rate has again maintained its position at 5.1% and this is still a significant improvement on Dec/Jan.

**Responsible Committee:** Finance, Performance & Investment Committee

### New: Follow Up

The Trust’s overall ratio between new outpatient appointments and follow-up outpatient appointments.

- **Threshold: monitor.**
- **Line = Last Financial Year**
- **Bar = This Financial Year**

New: FU ratio has decreased slightly this month to 2.55 and remains within threshold.

**Responsible Committee:** Finance, Performance & Investment Committee
## Board Report - August 2017

### Strategic Objective 4: Empower And Develop Staff To Achieve Their Objectives

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>WTE (Whole time equivalents) in post</td>
<td>The number of WTE staff with substantive and fixed-term contracts employed directly by the Trust. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.</td>
<td>The number of WTE staff with substantive and fixed-term contracts has reduced in month to 2464.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image1.png" alt="Graph" /></td>
</tr>
<tr>
<td>Sickness rate</td>
<td>The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better. Line = Last Financial Year Bar = This Financial Year</td>
<td>The sickness level in August decreased to 4.8%. Both Planned Care and Corporate have sickness levels running above 5%. In September 2017 a new Sickness Absence Administration team has been implemented to support HR and Managers in managing sickness absence. The team is currently being inducted into the role and there will be communication going out in October 2017.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image2.png" alt="Graph" /></td>
</tr>
<tr>
<td>Nursing vacancies</td>
<td>Number of nursing vacancies in month. Line = Last Financial Year Bar = This Financial Year</td>
<td>The number of nursing vacancies has significantly reduced in the last 6 months from 191 in February 2017 to 130 in August 2017. Trust funded WTE Registered nurse establishment = 865.7, Actual Reg nurse 767.38 Trust non reg 375.44, actual 344.1 - Trust overall vacancy against funded WTE 129.72. Urgent Care Reg nurse establishment 291.02, actual 235.91, Non reg = 154.21, actual 142.12 - CBU overall vacancy 67.20. Planned Care Reg nurse establishment 327.4, actual 294.54, non reg 167.95, actual 147.83 - CBU overall vacancy 58.77. Womens and Childrens Reg 217.88, actual 212.86, non reg 52.28, actual 53.15 - CBU overall vacancy 4.15.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image3.png" alt="Graph" /></td>
</tr>
<tr>
<td>Mandatory Training</td>
<td>The percentage of staff with up to date Mandatory Training. Threshold: 95%. Line = Last Financial Year Bar = This Financial Year</td>
<td>Core mandatory training has seen incremental improvement over the last 3 months to 82.34% as at 31st August 2017. This is due to the hard work of the training department to improve data accuracy and address system anomalies, and the determined effort of the subject matter experts for Safeguarding chasing staff individually to achieve over 90% across levels 1-3. The ESR Manager and Employee Self Service project will continue to roll out across the organisation until March 2017 within the current resources. The ESR project is on hold throughout September with a view to launching elearning in October 2017. Due to the decrease in training administrative support, the team will undertake a service review to focus on organisational priorities</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image4.png" alt="Graph" /></td>
</tr>
</tbody>
</table>
### Strategic Objective 5: Maintain Organisational Sustainability (Page 1 of 2)

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
</table>
| Spend against capital plan | Actual spend against the capital budget plan for the year.  
Green = Actual, Blue = Budget  
Line = Last Financial Year, Bar = This Financial Year | Although both the in month and cumulative spend are well below target, this indicator is flagged as green given that there is a Board approved revised capital plan which has full engagement from all the Clinical Business Units, Estates, IT and Procurement. | Finance, Performance & Investment Committee | ![Graph](image1.png) |
| Income & Expenditure  | This indicator looks at the relationship between Trust income and Trust expenditure at monthly intervals.  
Green = Expenditure, Blue = Income  
Line = Last Financial Year, Bar = This Financial Year | The plan for August was a deficit of £1.6m. The actual deficit in August was £2.8m; adverse variance of £1.2m. The month 5 Year to date (YTD) deficit is £13.6m against a plan of £9.2m giving an adverse variance of £4.4m. The adverse variance continues to be mainly related to the shortfall on income which is primarily driven by activity. Month 5 also saw an overspend on expenditure, some of which relates to CIP and additional agency costs for temporary cover within management/admin posts; pay is now £700k overspent but non-pay is balanced. | Finance, Performance & Investment Committee | ![Graph](image2.png) |
| Agency Spend  | The Total spend on agency staff compared to previous year.  
Line = Last Financial Year, Bar = This Financial Year  
Green = Trajectory, Blue = Actual | Marginal increase in agency spend in August compared to July mainly within medical staff but also senior manager/A&C to cover some vacant posts in the short term. Nurse agency is the lowest it has been over the last two years reflecting the emphasis on recruitment, use of bank and NHS Professionals for all agency when necessary. Medical staff agency spend continues to be the biggest challenge given the pressure on filling shifts within the cap or even tiered rates. Recruitment is essential to reducing the medical agency spend further but the implementation of a new bank system is expected to result in further improvement. | Finance, Performance & Investment Committee | ![Graph](image3.png) |
| Establishment vs Actual | Number of WTE posts that are required to staff the Trust against the actual number of post employed substantively.  
Green = Funded, Blue = Contract  
Line = Last Financial Year, Bar = This Financial Year | The Trust headline vacancy factor is 7.9% (down from 9.3%) in July. However, this is solely due to a vacancy level of nil within non consultant medical staff. This is a temporary blip due to the annual changeover of junior medical staff and September is expected to return to similar vacancy levels. Excluding “other medical” staff the Trust’s vacancy levels are unchanged. | Finance, Performance & Investment Committee | ![Graph](image4.png) |
### Strategic Objective 5: Maintain Organisational Sustainability

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description</th>
<th>Narrative</th>
<th>Responsible Committee</th>
<th>Month Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Liquidity</strong></td>
<td>Liquidity (days)</td>
<td>Liquidity indicates whether the provider can meet its operational cash obligations. Liquidity performance remains poor at -30.93 days (July -30.04 days). The Trust is able to borrow money each month to continue to operate, however, given the current financial performance, NHS Improvement will require a Board approved revised forecast outturn next month so that the value of loans and the forecast deficit can be aligned.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image" alt="Liquidity Trend" /></td>
</tr>
<tr>
<td><strong>CIP (Cost Improvement Programme) delivery</strong></td>
<td>Actual delivery in financial terms vs. the plan for delivery over the same period. Line = Last Financial Year, Bar = This Financial Year Green = Plan, Blue = Actual</td>
<td>The CIP plan for 2017/18 is £5.6m. The original plan profiled £1,020k to be delivered in the first five months of the year but actual delivery is £571k; a variance on the plan of £449k. Following a revision to the CIP plans the new trajectory will not deliver at the rate originally envisaged. Most of the material schemes, following Four Eyes insight assistance, are now scheduled to deliver from quarter 2 onwards. The plan is not predicted to deliver the required savings and non-recurrent run rate reductions will be required.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image" alt="CIP Delivery Trend" /></td>
</tr>
<tr>
<td><strong>% Agency Staff (cost)</strong></td>
<td>The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system. Line = Last Financial Year Bar = This Financial Year</td>
<td>The proportion of the cost of the workforce made up of Agency workers increased slightly to 5.25% in August 2017 and is significantly lower than August 2016. 3.17% relate to Doctors, 1.31% to Nurses, 0.46% to Admin and 0.17% to AHP (0.14% assigned to Other).</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image" alt="Agency Staff Trend" /></td>
</tr>
<tr>
<td><strong>Cost of staff sickness</strong></td>
<td>In month based on staff sickness records. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.</td>
<td>The cost of sickness absence has remained constant at £0.3m for the last 4 months.</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td><img src="image" alt="Sickness Cost Trend" /></td>
</tr>
</tbody>
</table>
**KEY ITEMS DISCUSSED AT THE MEETING**

**ALERT**

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

- Month 5 financial performance is consistent with previous months, making it increasingly difficult for the Trust to deliver its planned £18.1m deficit. The year-to-date overspend is £13.6m, which equates to an annual deficit run rate of £32.6m. However, work is underway to minimise the level of overshoot so it anticipated that the final outturn will be less than this figure.
- The current rate of spending is creating liquidity problems. Early discussions will need to take place with NHSI about extending the planned in-year borrowing level.
- There is an ongoing 2016/17 contractual dispute with the two local CCGs that would result in an increased deficit if the outcome is unfavourable to the Trust.
- Given its national profile and potential impact upon elective activity, the Committee supports a more detailed monthly scrutiny of the Trust's performance on emergency care targets.

**ADVISE**

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

- For a variety of reasons it has not been possible to review the IM&T Strategy at the FPI Committee for some time. However, a document will be brought to the next Committee for consideration.
- Executive Directors are working together to produce a comprehensive assessment of the Trust's short and medium term financial outlook. This exercise will include the output from the demand & capacity review, a re-assessment of the CIP and a critical analysis of the cost base.
- Performance indicators will be aligned to CQC domains, which should make interpretation more meaningful.
- The availability of more detailed activity and costing information allows performance within specialties to be examined in more detail. The Committee asked that Trauma & Orthopaedics be selected as the initial area for scrutiny, with early findings being presented to the October FPI Committee

**ASSURE**

(Detail here any areas of assurance that the committee has received)

- Additional management focus is being placed on sickness absence with encouraging early results. The Committee will closely monitor progress over the next few months.
<table>
<thead>
<tr>
<th>New Risk identified at the meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review of the Risk Register</strong></td>
</tr>
<tr>
<td>(Detail the risks on the committee's risk register that were reviewed in the meeting, including scores C&amp;L and current actions)</td>
</tr>
</tbody>
</table>
Minutes of the Finance, Performance & Investment Committee  
Held on 29 August 2017

Present:  
Mr J Birrell (Chair) Non Executive Director  
Mr G Clarke Non Executive Director  
Mrs K Jackson Interim Chief Executive  
Ms T Patten Chief Operating Officer  
Mrs J Royds* Associate Director of HR  

In attendance:  
Mr K Walsh Deputy Director of Finance  
Mr A Charles Interim Company Secretary  
Mr J Williams item 17/161 only Acting Chief Pharmacist  
Ms S Hillyard (part) Interim Improvement Director  

Observing:  
Ms J Gorry Non Executive Director  

Apologies:  
Mr S Shanahan Director of Finance  

*Indicates Non-Voting Members

<table>
<thead>
<tr>
<th>2017/18 Finance &amp; Investment Committee Attendance</th>
<th>Apr M12</th>
<th>May M1</th>
<th>Jun M2</th>
<th>Jul M3</th>
<th>Aug M4</th>
<th>Sep M5</th>
<th>Oct 3 M6</th>
<th>Nov M7</th>
<th>Jan M9</th>
<th>Feb M10</th>
<th>Mar M11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R Fraser</td>
<td>✓</td>
<td>✓</td>
<td>A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>J Birrell (Chair)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>G Clarke</td>
<td>✓</td>
<td>✓</td>
<td>A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>S Fowler-Johnson</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R Gillies **</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>J Hornby</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>K Jackson</td>
<td>✓</td>
<td>A</td>
<td>A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>S Lloyd *</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>T Patten</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>J Royds</td>
<td></td>
<td>A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>S Shanahan</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>In Attendance (as per Terms of Reference):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Filek</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Hindle</td>
<td>A</td>
<td>✓</td>
<td>A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>R McCarthy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>K Walsh</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>A Charles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Committee member per Terms of Reference, however routine attendance not required per agreement at September 2016 Trust Board

** Committee member per Terms of Reference. Routine attendance initially not required per agreement at September 2016 Trust Board, however attendance for specific agenda items requested by FP&I Committee with effect from July 2017

✓ = present;  A = apologies;  S = sickness absence;  DNA = did not attend
The meeting was opened. Apologies were accepted from Steve Shanahan.

No declarations of interest were made in relation to any agenda items.

Acknowledging that the meetings of the Finance, Performance & Investment Committee held on 26 June 2017 and 24 July 2017 had been inquorate, the Committee formally approved the minutes of the meetings held on 30 May 2017, 26 June 2017 and 24 July 2017, accepting that these were a correct record.

Action: Chief Operating Officer  
By: September FP&I Committee

Given the anomaly in the Trust's ability to record activity from one of the Walk In Centres, but not the other, it was confirmed that the Interim Chief Executive had written to both NHS Improvement and NHS England on several occasions to highlight the inconsistent application of the national guidance across the country and its adverse impact on the Trust's performance, but to no avail, the response being that this was an issue that would be looked at nationally at some time in the future.

Action: Chief Operating Officer  
By: September FP&I Committee

Due to staff sickness/death in service a solution had unfortunately not yet been found, however it was advised that this task would now be picked up by the new Interim Radiology Services Manager. It was anticipated that this work would be completed over the next few weeks. An update would therefore be provided at the next meeting.

Action: Chief Operating Officer  
By: September FP&I Committee

A response had not yet been received to the Director Finance's suggestion to the agency team at NHS Improvement that the weekly returns track breaches of the approved framework agreement rates. This would be raised at the Progress Review Meeting with NHS Improvement scheduled for 27 September 2017 and the Committee updated at its October meeting.

Action: Director of Finance  
By: October FP&I Committee

It was confirmed that the Medical Director had been reminded of the Committee's earlier request that, notwithstanding the decision made by the Trust Board in
September 2016, he should routinely attend Finance, Performance & Investment Committee meetings to provide the necessary input in relation to specific agenda items within his remit, in particular performance and IM&T. In anticipation of the commencement of routine attendance by the Medical Director going forward, it was agreed that this item should be removed from the action log.

5 24 July 2017, Min No. 17/140 ref 13: Board Assurance Framework (BAF) – the Interim Company Secretary advised that a revised outline BAF, based on 5 newly identified objectives, would be taken to the Board in September 2017 for initial review and comment. A fully populated BAF, including controls, gaps and assurances, would then be taken to the Audit Committee on 13 September 2017 prior to formal presentation to the Board again in October 2017 for formal approval.

The Chair’s concern that the Board and its Committees had last received the BAF in March 2017 was acknowledged.

Action: Interim Company Secretary
By: September Trust Board/September Audit Committee/October Trust Board

6 26 June 2017, Min No. 17/121 ref 10 and 24 July 2017, Min No. 17/140 ref 14: Director of Finance Report Month 1

- **Update to Board re reason for income for non elective activity being below plan** – the Committee was reminded that, following investigation, it had been established that income for non elective activity had been lower than plan, due in part to the level of tariff charged locally for patients attending the Ambulatory Care Unit (ACU). Recognising the benefit to patients of the introduction of the ACU it was accordingly intended to negotiate an uplift in local tariff. Noting that the Board had been updated in this regard at its meeting on 27 July 2017 it was agreed that this item should therefore be removed from the action log.

- **Membership of Task & Finish Group** - it was confirmed that the membership of the Task & Finish Group, set up to support the recovery of lost income and remove excess cost, was to be reviewed on 30 August 2017 and would be enhanced to include a member of the finance team. This item could therefore be removed from the action log.

7 24 July 2017, Min No. 17/140 ref 11: Activity & Income Assurance Group/Impact on Income of Ambulatory Care Unit (ACU) – further to the above update, it was advised that the Trust would be writing formally to the Commissioners in advance of the next contract meeting (scheduled for 20 September 2017) with a view to negotiating an uplift of the local tariff. An update would be given to the Committee at its next meeting.

Action: Director of Finance
By: September FP&I Committee

8 24 July 2017, Min No. 17/142: Revised Capital Plan 2017/18 – it was noted that a paper had been produced for review later in the meeting (agenda item 17/166).

9 24 July 2017, Min No. 17/142: Service Line Reporting (SLR) 2016/17 – whilst the team (from the Trust’s partner organisation Bellis-Jones Hill Healthcare Management Solutions) had produced the 2016/17 SLR, a number of technical anomalies had been found and the decision had therefore been taken to defer the paper to next month to enable the necessary corrections to be made.

Action: Deputy Director of Finance
By: September FP&I Committee

It was highlighted that discussions were continuing to take place with the partner organisation to resolve certain issues that had arisen over previous months. The reason for the difficulties being experienced was queried, given that other Trusts seemed not to be in a similar position. It was clarified that the Trust had been producing information at service level successfully in-house for a number of years, however the significant challenge posed by the more recent introduction of PLICS and internal staffing difficulties had led to the decision to engage the partner organisation.

In response to a query regarding the merit or otherwise of pursuing this retrospective information, it was explained that, operationally, it was necessary to be able to provide accurate information (both historical and current), for example to the Local Delivery System Alliance and Sustainability & Transformation Partnership. In addition, it was necessary to be able to provide assurance to both the Committee and
the wider organisation with regard to the robustness of the Trust’s service lines, thus also ensuring the continuation of clinical engagement. It was confirmed that SLR information will assist forward planning, both financially and clinically, both at specialty level, but in particular when drilling down to patient level.

[The Acting Chief Pharmacist joined the meeting.]

10 24 July 2017, Min No. 17/146: Performance Report Month 3:

A&E 4 hour target – as requested, a system-wide meeting had been arranged (for 21 August 2017) to raise awareness of the scale of challenge posed by the c7% increase in A&E attendances. Unfortunately, attendance at the meeting by partner organisations had been poor and a further meeting would therefore need to be arranged.

Action: Chief Operating Officer  
By: immediate

The Committee members’ concern and disappointment at the apparent lack of priority accorded to this issue by the various stakeholder organisations would be relayed to the Board.

Action: FP&I Committee Chair  
By: September Trust Board

1st Appointments and Day Cases/In Patients – it was confirmed that the information had been checked and that the high number (in June compared to previous months) was correct. This item could therefore be removed from the action log.

11 24 July 2017, Min No. 17/149: Risk 1440 Cyber Security Threats – the Committee was reminded that it had been agreed to create a new risk, that of the ability to provide diagnostics in the event of IT failure, to separate this from the other aspects of risk associated with cyber attack. This had yet to be completed.

Action: Chief Operating Officer  
By: immediate

Concurring with the Committee Chair’s view that the number of operational risks scored as ‘extreme’ or ‘high’ by the Trust seemed excessive compared with other organisations, it was confirmed that the Interim Company Secretary had been tasked with identifying a smaller number of key strategic risks to ensure the necessary focus.

17/161 DRUG EXPENDITURE REPORT – QUARTER 1 2017/18

The Committee received the paper focusing on medicines expenditure within the Trust in Quarter 1 of 2017/18 and comparing this with other recent quarterly spend. The key issues for the Committee to note were as follows:

- total expenditure of £2.327M had been incurred on medicines in Q1 of 2017/18; an increase of £32.7K (1.43%) compared with Q4 of 2016/17.
- the majority of this increase was attributable to the high cost of intravenous antibiotics following the previously reported increase in the price of Piperacillin/Tazobactam as a result of it initially having come off contract early, followed by a shortage due to supply issues in China, necessitating the use of more expensive alternatives. Going forward, whilst Piperacillin/Tazobactam was now available again, it would not be available in the same quantities as previously and the cost remained in excess of the original contract price.
- following gainshare agreements reached with the main CCGs, as predicted, savings had been realised in Q1 following the utilisation of certain rechargeable biosimilars in rheumatology, with further gainshare savings anticipated during the course of the year.

The following responses were given to queries raised:

- It was confirmed that the Trust’s expenditure on antibiotics was in line with that of other similar organisations, all of which utilise the same app to control expenditure and which would have experienced the same cost pressures for the same reasons. Reassurance was given that the Trust has a robust formulary and, whilst this had had to be altered to address the shortage of Piperacillin/Tazobactam, broadly the same changes would have been implemented by all those other organisations. Noting that national benchmarking data would be available in October/November...
2017 it was requested that this comparative data be built into the Q3/Q4 reports to the Committee.

- It was highlighted that the pharmacy department was on track to deliver its significant savings target of £300K, partially from the utilisation of biosimilars.

- The Committee was reminded that, due to changes in the application of the Cancer Drug Fund in 2016/17, with several drugs having been withdrawn and reductions in the price of those remaining, spend in this area had decreased significantly. NICE was, however, intending to fast track evidence based treatments for cancer therefore the level of spend may increase.

**The Committee:**
- a) noted the increase in antibiotic costs due to the supply shortage and the requirement to use more expensive alternatives
- b) noted the increased gainshare from switching to biosimilar drugs
- c) was assured by the continued close monitoring of expenditure.

[The Deputy Chief Pharmacist left the meeting.]

17/162 DIRECTOR OF FINANCE REPORT MONTH 4 2017/18

The Director of Finance’s Report was received, confirming that a deficit of £2.99M had been incurred in month 4 against a planned deficit of £1.58M (£1.41M adverse variance in month). The actual deficit was £10.82M year to date against a £7.56M deficit plan (adverse variance of £3.26M). Overall, expenditure had been in balance during July, however it was anticipated that the position would deteriorate over the remaining months of the financial year due in the main to under-delivery of planned CIP. It was confirmed that the adverse position was continuing to be driven by the Trust’s failure to achieve its income target, it being highlighted that 78% of the income shortfall was attributable to under-performance against commissioner contracts. Consequently, as reported earlier, a Task & Finish Group had been set up in order to support the recovery of lost income and take out excess cost.

The continuing good progress being made in improving agency controls and reducing expenditure was recognised, the year to date spend at month 4 (£2.2M) being over 50% less than in the same period in 2016/17, with the Trust being on track to achieve the total agency spend target of £6.6M set by NHS Improvement. In relation to nursing agency, steady progress was being made in reducing vacancies and increasing bank usage, it being highlighted that total nursing agency spend in month 4 had again been below £200K. However, whilst the Trust remained 100% compliant with the use of framework agencies for medical staff, it was not proving possible to secure shifts at the national ‘tier 1’ capped rates, with the Trust often having to agree ‘tier 3’ rates. Although, based on month 4 performance, the Trust would not achieve the additional target set by NHS Improvement.

It was noted that capital expenditure was behind plan at month 4, with £143K having been spent against a target of £292K. This was due to the detailed medical equipment plan having only recently
Having agreed that the Chair would meet separately with the Deputy Director Finance to review the report in detail, **the Committee:**

a) noted the in-month deficit of £2.99M (£1.41M adversely away from plan), due in the main to the activity/income shortfall.

---

**17/163 & 17/164 RECOVERY PLAN 2017/18**

The CIP report was received, setting out progress on delivery of the £5.6M target for 2017/18. This confirmed that the value of identified schemes (before adjusting for deliverability risk) remained unaltered from month 2, at £5.1M (CYE); £7.6M (FYE) and that, at month 4, £312K had been delivered against the plan of £658K (adverse variance £346K). It was highlighted that the risk adjusted forecast outturn currently stood at £2.338M. Acknowledging and echoing the Committee members’ concern at the lack of progress over the last 3 months, the Interim Chief Executive advised that she had attended the weekly CIP meeting earlier that morning to strongly express her concerns and to clearly set out her expectations of those responsible for the identification of robust schemes and the timely delivery of savings.

Given the current position, however, the Committee recognised that the likelihood of failing to achieve the £5.6M CIP target was high and consequently, as indicated earlier in the meeting, would impact on the Trust’s ability to deliver its planned deficit outturn of £18.1M. Reviewing the paper tabled to demonstrate the extent of expenditure reductions, income recovery etc required to achieve the current planned deficit, it was conceded that, realistically, the deficit outcome for the year would be in excess of this figure of £18.1M.

In seeking the Trust’s views on the expected outturn it was confirmed that, based on the current position, a £30M deficit was indicated. The Director of Finance (whose opinion had been sought in advance of the meeting) believed a lower figure could be achieved, however it was considered that this would be nearer to £30M than to £18.1M. At this stage, without having undertaken a detailed analysis, but assuming the recovery of some income (and no recovery of CIP) the Interim Chief Executive believed that the ‘most likely’ deficit outturn would be in the region of £25M.

The Chief Operating Officer offered some reassurance to the Committee, confirming that, with input from FourEyes Insight and the national RTT team, each specialty had been reviewed and that individualised income recovery plans were in place, the expectation being that an improvement would be evident by the end of September 2017. The difficulty in assessing the amount expected to be generated each month was recognised, however it was evident that it would not be possible to achieve the £0.75M/£1M per month required to achieve the current £18.1M planned deficit as identified in the paper tabled. Pushing for the Trust to identify a realistic monthly figure upon which a robust assumption could be made, it was however emphasised by the Interim Improvement Director that caution needed to be exercised in relation to any assumption of activity given GP ‘behaviour’ and the reducing referral rate.

It was acknowledged that the potential for income recovery from coding corrections and the like was limited, however it was anticipated that £0.5M could be achieved in relation to the Ambulatory Care Unit where, as discussed earlier, the current local tariff was believed to be too low. It was advised that this piece of work would be finalised shortly.

Returning to the CIP, the need similarly to confirm what realistically can be delivered in order to inform the revised forecast deficit outturn was acknowledged. Whilst the Interim Chief Executive advised that she was aware of some progress, for example within Urgent Care where there were a number of realistic schemes that would deliver in-year and recurrently, she found it frustrating that this level of progress had yet to be seen in other Business Groups. The Chair commented upon the evident lack of any consequences for the Business Groups’ failure to deliver their CIP targets.

Reiterating criticism expressed in previous meetings regarding the historical approach of back-loading the CIP targets to the latter months of the financial year, Mr Clarke was reassured that, going forward, the planning round would commence in October each year and this process would allow adequate time to validate the deliverability of proposed schemes and, if necessary, identify replacements in order to facilitate prompt achievement of more evenly profiled targets with effect from month 1.
In producing the 2017/18 Recovery Plan requested by NHS Improvement it was agreed paramount to be able to demonstrate that the Trust has the necessary ‘grip’. The identification of a realistic revised forecast outturn based on robust assumptions, which is subsequently fully delivered as promised, was therefore agreed to be fundamental to convincing NHS Improvement of the Trust’s viability and its ability to do things differently going forward. In addition, the Trust needed to be able to demonstrate to NHS Improvement that its financial performance will improve year on year, by resolving income (currently being addressed by the Task and Finish Group); improving expenditure control (to which end the Chief Operating Officer was about to commence a month on month red pen budget exercise); delivering CIPs; and by identifying transformational ways of delivering services. ‘Care for You’ would therefore be factored into the forward planning section of the Recovery Plan in order to demonstrate that the deficit would not continue to increase year on year. In this regard, it was advised that an output of the ‘Care for You’ programme would be an overarching plan to be produced by September 2017 with detailed plans for each specialty by March 2018.

In summary, it was agreed that the Recovery Plan to be submitted to NHS Improvement by close of play on Wednesday, 30 August 2017, should include the following:

- Details of what the Trust would need to achieve in terms of income recovery, expenditure reduction, addressing other cost pressures etc in order to achieve its current forecast deficit of £18.1M
- Confirmation that the Trust cannot realistically achieve a £18.1M deficit
- Confirmation of the level of deficit the Trust genuinely believes it can achieve (£25M based on earlier discussion)
- An indication of what the Trust feels it can confidently achieve in future, factoring in ‘Care for You’.

If available in time, feedback from NHS Improvement on the 2017/18 Recovery Plan would be relayed to the Board.

**Action:** Committee Chair/Deputy Director of Finance  
**By:** September Trust Board

Highlighting that Foundation Trusts are required to provide 5 year operational plans, it was confirmed other Trusts are required to produce 2 year operational plans. Noting that the Trust had submitted its initial operational plan in December 2016, followed by a refreshed plan in March 2017, the Committee asked for a longer term plan to be produced for review at the next meeting.

**Action:** Deputy Director of Finance  
**By:** September FP&I Committee

It was recognised that the services required by the commissioners for their populations were likely to be those that do not make a profit, emphasising the merit of a block contract approach going forward.

**The Committee:**

- a) noted the update on CIP planning, in particular the risks identified in relation to delivery of the 2017/18 target of £5.6M  
- b) agreed the issues to be included in the 2017/18 Recovery Plan submission to NHS Improvement

**17/165 REVISED CAPITAL PLAN 2017/18**

The Committee was reminded that the Board had approved the 2017/18 capital plan (£4.125M) in April 2017 as part of the annual operational plan. A number of revisions had now been made within the £4.125M envelope to reflect the Business Groups’ priorities and CQC ‘must dos’, in particular the reduction of the medical equipment budget from £1.39M to £1.145M to provide £245K for the ward reconfiguration scheme; the contingency of £167K within the revised medical equipment budget to manage any unexpected equipment failures between now and the end of the financial year; and the £45K reduction in the Electronic Patient Record budget to accommodate the agreed wheelchair database costs.

It was highlighted that negotiations were underway with GE, which provides a managed equipment service, and its bankers, RBS, with regard to the provision of a different range of radiology equipment and profile over the remaining 10 years of the 20 year contract to ensure the Trust’s business needs are met. Whilst the asset value and unitary charge would essentially remain the same, RBS was seeking £892K in contract breakage costs. The contract was being reviewed by the Assistant Director of
Finance as it was believed that this may be an issue between GE and RBS (not the Trust). The Committee would be updated as part of the Director of Finance’s next Capital Investment Group Assurance Report.

Action: Director of Finance  
By: October FP&I Committee

The Committee:  
a) recommended approval of the revised 2017/18 capital plan to the Board.

17/166 PERFORMANCE REPORT MONTH 4 2017/18

The Committee received the report setting out specific, key performance issues relevant to the Finance, Performance & Investment Committee for month 4 (month 3 for cancer targets). The Chair was, however, of the opinion that the Committee should receive the same, complete report that is provided to the Board each month and it was agreed that this would be provided with effect from next month’s meeting.

Action: Deputy Director of Finance  
By: September FP&I Committee

The Chair also commented that he was accustomed to a cover sheet summarising all the key performance issues of which the Committee members should be made aware. It was highlighted that, led by the Contracts & Performance Manager, who would be attending Finance, Performance & Investment Committee meetings going forward, the Trust was in the process of introducing revised performance management monitoring/reporting, as part of which it was planned to provide summary sheets for each of the Business Groups. It was anticipated that this would be in place for the September meeting, prior to which a draft would be shared with the Chair.

Action: Interim Chief Executive  
By: prior to September FP&I Committee

In addition, the Chair felt that the report in its current format rendered it more difficult to read and understand than it could be. It was agreed that the Contracts & Performance Manager would contact the Chair to discuss a more readily understandable format.

Action: Contracts & Performance Manager  
By: immediate

In relation to certain key metrics, it was noted as follows:

**TIA/Stroke** – the Trust had failed to comply with both the 60% threshold for treating patients diagnosed with a TIA within 24 hours and the 90% target for patients’ stay on a dedicated stroke ward. In the absence of the Medical Director to provide his update, it was believed that performance should improve as a result of the work being done on Ward 15, the work being led by the Assistant Medical Director, the establishment of a hyper-acute base and, working with the Stroke Network, the anticipated implementation of joint weekend cover with Aintree in October 2017.

**A&E 4 hour target** – compliance of 88.1% had been achieved at Trust level during July. Work was continuing to improve patient flow and experience against a backdrop of increased A&E attendances during the summer months. As indicated earlier in the meeting, a meeting called to address this (before the commencement of winter planning) had been inadequately attended by the commissioners and other stakeholders and was thus unfortunately having to be re-scheduled. On a positive note, recalling the (reluctant) introduction some months ago of ‘corridor nurses’, an area had now been made available for use at peak times of demand, thus no patients should now need to be accommodated on trolleys in the corridor.

**Bed days post medically optimised for discharge** – in July, the number of bed days attributable to inpatients who had exceeded their medically optimised for discharge date had increased from 700 in June to 947. Recognising the need for significant improvement before pressures increase further in the winter months, it was advised that a work programme had been developed, including ‘Ready for Discharge’ meetings attended by members from partner organisations. It was confirmed that, although the Trust did have an arrangement with the Local Authority, this was insufficient to accommodate the number of patients who, whilst they may remain unwell to a certain extent, do not require acute hospital care.

**Cancer targets** – having recovered from the impact of the cyber attack which occurred in May 2017, the Trust had since returned to compliance with the 14 day GP referral to Out-Patients target in June and...
would again be compliant for July. Meeting the 62 day standard for GP referral to treatment remained challenging due to capacity issues in endoscopy and radiology, which the Trust was seeking to address, combined with the usual lack of patient availability during the summer months. It was confirmed that a detailed analysis of cancer waiting time breaches would be provided for consideration by the Committee at its next meeting.

**Waiting List Size** – the number of patients waiting had reduced significantly in July. The Interim Chief Executive was concerned that the Trust may not have sufficient ‘grip’ in this area, considering that the Trust’s access policy may need to be revised. An Intensive Support Team would be assessing the position shortly and would provide the Trust with advice on any action that may be required. The Committee was reminded that Choose & Book had been managed differently at the Trust, one of the actions of the Task & Finish Group (referred to earlier) being to ensure the availability of slots within 10 days as opposed to the current 40 day window. It was confirmed that a piece of work on capacity & demand was to be undertaken which should show the number of patients going onto and coming off the waiting list each month and the length of the ‘tail’. A paper would accordingly be produced for the next meeting.

**Sickness Absence** – sickness levels had increased again in July 2017, to 5.31%. It was confirmed that the process had commenced to change the policy to bring it more into line with that in place at St Helens & Knowsley and that a sickness absence monitoring team was in place. The data was being reviewed and verified to ensure that all staff sickness is being appropriately addressed in line with the policy, including the requirement for the Occupational Health team to identify alternative roles to enable staff on long term sickness absence to return to work. The focus would be both on identified ‘hotspots’ and specific cases and the Associate Director of HR anticipated that a significant improvement would be evident in 6 months’ time. The Chair felt this timescale to be excessive and looked forward to seeing a far earlier improvement.

**Mandatory Training** – performance was improving, however remained significantly below the 95% target, with a compliance rate of 80.04% in July. It was noted that a significant piece of work had been undertaken over the last 6 months to match job profiles to the necessary training requirements, although some more work was still needed to address a number of anomalies. It was highlighted that the performance data, by specialty/group, was being routinely reviewed each month by the Executive Team, ensuring focus on ‘hotspots’. It was confirmed that, following concerns raised by the CQC and the commissioners, performance in respect of safeguarding training had improved. Similarly, there had been an improvement in the compliance rates for Information Governance training.

**Income & Expenditure and CIP** – performance had been discussed earlier in the meeting (agenda item 17/162).

A breakdown of mandatory training compliance rates was requested for the next meeting.

The Committee:

a) noted performance against the metrics relevant to it and the corrective action being taken.
Committee was received and noted, it being reiterated by the Chair that, in his opinion, the scoring of many of the risks listed appeared too high and/or incorrectly scored in terms of likelihood and consequence. As indicated earlier in the meeting, all corporate risks were due to be reviewed by the Interim Company Secretary with a view to rationalising the number of key extreme risks upon which the Board and its Committees are required to focus.

The Committee:
   a) noted the extreme risks currently on the Risk Register.
   b) took assurance that the risks had been reviewed and that a further review would soon take place.

17/169 IM&T PROGRAMME BOARD 21 AUGUST 2017 – ASSURANCE REPORT

In the absence of the Medical Director, the Committee received and noted the highlight report setting out a number of key issues discussed at the meeting of the IM&T Programme Board held on 21 August 2017. The following matters were highlighted:

Order Comms Results Reporting – ‘go live’ had been delayed due to data quality concerns. Acknowledging the need for a trial of the new interface feed to ensure accurate results, the Committee felt that a 3 month trial period was excessive, a 1 week trial being the norm. The Chief Operating Officer would ascertain the reason for this lengthy trial period and report back to the Committee at its next meeting.

New Telephony System – disappointingly, the 2nd attempt to move to the new telephony system had failed, again due to issues with Vodaphone. Given the continuing delay, the need to refresh staff training was highlighted. It was advised that any possibility of compensation from Vodaphone would be pursued once the installation had been successfully completed.

IM&T Strategy – it was confirmed that this was due to be presented to the Committee in September 2017.

The rationale for IM&T being within the remit of the Medical Director was again queried as this appeared somewhat unusual, although it was acknowledged that clinical engagement in IM&T had probably been a key factor. It was advised that the Executive Directors’ current portfolios were due to be reviewed at the Time Out scheduled for 26 September 2017 and that there may be some changes.

The Committee:
   a) noted the highlight report
   b) took assurance from the work done with NHS Digital in relation to a cyber security penetration test which had provided further insight into how best to improve overall network security.

17/170 ITEMS FOR ESCALATION TO THE BOARD

It was agreed that the following matters required escalation to the Board:

Finance:
   ▪ Recovery plan:
     ▪ Revised assessment of outturn: impact on cash management plans. Link to ‘Care For You’ which should assist in delivering an improved position going forward.
     ▪ Progress on CIP: the need to identify additional schemes and implement urgently
     ▪ Medicines expenditure: comparative cost of antibiotics to be provided in Q3/Q4 reports
     ▪ Service Level Reporting 2016/17: delay due to technical problems

Performance:
   ▪ A&E- system-wide support for A&E: poor attendance of meeting to review the emergency care pathway. Importance of collective engagement to be reiterated.
   ▪ Capacity planning: work being undertaken by the Task & Finish Group re activity productivity and
income
▪ Detailed analysis of cancer waiting time breaches to be brought to next FP&I Committee
▪ FP&I Committee to receive full Integrated Performance Report going forward

BAF & Extreme Risk Register – under review to reflect revised corporate objectives.

17/171 ITEMS FOR ESCALATION TO THE AUDIT COMMITTEE

No items were identified requiring escalation to the Audit Committee.

17/172 ITEMS FOR THE RISK REGISTER/CHANGES TO THE BOARD ASSURANCE FRAMEWORK

No items were identified for inclusion on the Risk Register. In the absence of the Board Assurance Framework, no changes were identified.

17/173 ANY OTHER BUSINESS

No items of additional business were raised.

17/174 DATE AND TIME OF NEXT MEETING

9am
Monday, 25 September 2017
Boardroom, Corporate Management Office, Southport & Formby DGH
PUBLIC TRUST BOARD

4 OCTOBER 2017

Agenda Item | TB206/17 | Report Title: Director of Finance Report Month 5
---|---|---
Executive Lead | Steve Shanahan, Director of Finance
Lead Officer | Kevin Walsh, Deputy Director of Finance
Action Required | ☑ Note ☐ Approve ☐ Assure

Key Messages of this Report:

a) The Trust planned a deficit of £1.6m in month 5. The actual deficit was £2.8m; adverse variance of £1.2m.
b) The actual year to date (YTD) deficit is £13.6m against YTD plan of £9.1m; adverse variance of £4.5m.
c) The YTD shortfall on income is the main reason why the Trust is adverse (£3.7m) against plan at the end of month 4. £2.9m of this relates to the shortfall on commissioning income.
d) CIP is behind plan at month 5 YTD.
e) Agency spend remains lower but further improvements are possible.

Key & Recommendations of this Report:

The Board is asked to:
f) Review and discuss the month 5 performance and note the financial impact of activity delivered in the YTD position.
g) Note the potential forecast outturn position unless both income and expenditure can be improved over the remaining months.
h) Note the drawdown of the cash loan is earlier than originally planned and the impact this has on the remainder of the financial year.

Strategic Objective(s) (The content provides evidence for the following strategic objectives)

- Lifelong integrated care ☐
- Excellence in Treatment and Care ☐
- Best Performance within Resources ☑
- Develop Staff ☐
- Organisational Sustainability ☑

Governance (the report supports a…..)

- Statutory requirement ☑
- Annual Business Plan Priority ☐
- Linked to a Key Risk on BAF/HLRR – Ref 011 ☐
- Service Change ☐
- Best Practice ☐
- Other List (Rationale) ☐
### Impact (is there an impact arising from the report on the following?)
- Quality ☐
- Finance ✗
- Workforce ☐
- Equality ☐
- Risk ☐
- Compliance ☐
- Legal ☐

### Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)
- Strategy ☐
- Policy ☐
- Service Change ☐

### Next Steps (List the required actions following agreement by Board/Committee/Group)
1 Introduction

1.1 This report provides the Board with the financial position of the Trust for the financial period ending 31st August 2017.

1.2 The report asks the Board to discuss the contents, note the performance and the month 5 financial position.

1.3 The Trust plan for the year is a deficit of £18.1m. This is £3.0m more than the control total set by NHS Improvement (£15.1m deficit) which means the Trust will not receive any support from the Sustainability and Transformation Fund (STF). Achieving the deficit plan is also dependent on:
  ▪ A Cost Improvement Programme (CIP) of £5.6m delivered in year;
  ▪ Any additional risks within the plan or arising in-year being mitigated by any additional savings or income.

1.4 It should be noted that community services transferred to Virgin Care and Lancashire Care on 1st May 2017. Therefore, months 2 to 5 finances exclude both the income and expenditure associated with this transaction. In addition, the majority of service provided by Human Resources transferred to St Helens and Knowlsey NHS Trust on 1st July 2017. This has resulted in a reduction in pay and an increase in non-pay spend (approx £145k per month).

2 Month 5 Financial Performance

2.1 The Trust has performed as follows:
  ▪ **In month** - Deficit of £2.823m against a £1.588m deficit plan delivering an adverse variance of £1.235m.
  ▪ **Year to date** - Deficit of £13.645m against a £9.152m deficit plan delivering an adverse variance of £4.492m.

2.2 The financial statements at the end of this report show the performance against this plan in more detail.

2.3 The table below is August’s I&E statement:
2.4 The key reason for the adverse performance to date is activity underperformance and the consequent impact on income although expenditure is beginning to contribute to the adverse position as the CIP profile begins to take effect. The majority of the income shortfall relates to commissioning income.

2.5 In response to the activity shortfall a Task and Finish Group has been set up which is led by the Chief Operating officer. The group are tasked with developing a plan to discuss the constituent elements of the adverse performance to date and will be the key driver of the Trust recovery plan.

2.6 Overall the Trust is £2.9m below CCG contract plan. Referrals remain down against plan in August 2017 and YTD are 12.4% down against last year’s monthly average. GP referrals being 29.7% below plan YTD.

2.7 Elective activity is £1m (12%) below plan at month 5.

2.8 Highlighted below are the top five specialties for elective underperformance:
2.9 Planned Care 12% (£1.01m) below plan split 60% daycase and 40% elective inpatients. Trauma and Orthopaedics accounts for 25% (£582k) of this underperformance reflecting the impact of Joint Health. Pain Management £137k below plan YTD due to capacity issues resulting from being unable to recruit to key vacancies and the service is facing significant risk to future income as a result of changes to the Procedures of Limited Clinical Value (PLCV) from October 2017. General surgery £191k below plan YTD although referrals have seen an increase of 6% against last year’s monthly average.

2.10 A&E attendances are 1.63% above plan YTD and 3.03% (£125k) above the financial plan reflecting the increasing complexity of patients presenting.

2.11 Urgent Care activity 8% (£1,420k) below plan although partially mitigated by ACU activity which is £866k over plan leaving a shortfall of £554k. An increased flow of patients through ACU, which avoids an admission, is having a negative impact on income and evidence collated during an audit of ACU activity points to the fact that local tariff arrangements are driving approx. £500k less in income than would have been received from national PbR tariffs. Of the £554k non elective underperformance YTD £163k relates to reduced births, £123k Trauma and Orthopaedics and £115k Paediatrics.

2.12 Outpatient activity 9.6% (£823k) below plan, increase observed in outpatient procedures as a result of introduction of HRG 4+. Dermatology 19% (£161k) below plan due to capacity issues as observed across the North Mersey patch.

2.13 Income from Road Traffic Accidents (RTA) is not performing to plan. The focus on deriving more income from this source, through the Health Cost Recovery process is being addressed to deliver an improvement in future months’ income recovery.

2.14 Although expenditure had remained in budget up to month four, August’s performance has seen an in month adverse variance in excess of £600k. This is split across a number of pay and non pay lines. The CIP profile is now increasing and underperformance has contributed as well as medical and nursing staff and some non pay areas. The back pay for consultant PA’s (wef 1st April 2017) is unfunded and this will now show as an overspend unless
savings in excess of the CIP plan can be found. SAS doctors PA increase are currently being accrued. Any reductions to consultant PA’s has not yet been applied. A net full year cost pressure of approximately £700,000 was forecast for both consultants and SAS doctor PA’s. It should be noted that this is an area of focus by the Four Eyes Insight team and is part of the 2017/18 CIP programme so further adjustments will be required. The decision regarding back pay prior to 1st April 2017 has not been finalised and remains a risk.

2.15 Gaps in the middle grade rotas are being filled with agency staff above the capped rates as well as consultant staff acting down and being paid at premium rates. Nursing staff are balanced in month. Some pressure is being incurred within some senior manager/A&C roles with agency staff currently filling vacancies resulting in overspending in this area.

2.16 The following section reports on the financial performance of each CBU at month 5 and will be developed over the next few months.

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget £000</th>
<th>Year to Date</th>
<th>In Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £000</td>
<td>Actual £000</td>
<td>Variance £000</td>
</tr>
<tr>
<td>Corporate</td>
<td>116,645</td>
<td>49,279</td>
<td>44,691 (4,588)</td>
</tr>
<tr>
<td>Specialist</td>
<td>(38,137)</td>
<td>(15,996)</td>
<td>(16,534) (538)</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>(42,681)</td>
<td>(18,462)</td>
<td>(18,955) (493)</td>
</tr>
<tr>
<td>Community</td>
<td>(1,871)</td>
<td>(1,871)</td>
<td>(1,914) (43)</td>
</tr>
<tr>
<td>Planned Care</td>
<td>(52,070)</td>
<td>(22,100)</td>
<td>(21,502) (598)</td>
</tr>
<tr>
<td>Other</td>
<td>(5)</td>
<td>(2)</td>
<td>569 571</td>
</tr>
<tr>
<td>Deficit</td>
<td>(18,119)</td>
<td>(9,152)</td>
<td>(13,645) (4,493)</td>
</tr>
</tbody>
</table>

2.17 The majority of the in month variance on Urgent Care is within the General Medicine Directorate. Staffing costs across a number of wards and additional blood products have contributed (this will be corrected in September as £68k is rechargeable).

2.18 Specialist services CBU is also high in month due to a number of overspends across support services (radiology, pathology), sexual health (drugs) and Obstetrics/gynaecology (medical staff PA’s).

3 Agency costs

3.1 During 2016/17 there have been a number of requirements to improve agency control and increase transparency through reporting to NHS Improvement. This has continued in 2017/18 and good progress has been made in reducing agency spend.

3.2 At the month 5 YTD position in 2016/17 the Trust spent £5.6m on agency. This has reduced by over 50% to £2.7m in the same period this financial year. The Trust is on target to achieve the total agency spend target set by NHS Improvement (£6.6m).

3.3 At month 5 YTD in 2016/17 9.3% of the Trust’s paybill was on agency staff (£2.7m); in 2017/18 this has reduced to 5.1%. In addition, during the same period, 34.3% (£1.592m) of the agency spend was on medical staff in 2016/17.
but this has now risen to 53% (£1.441m) in 2017/18. Although the percentage has risen this is due to the significant reduction in agency in other areas.

4 Nurse Agency

4.1 All acute nurse agency staff is engaged via NHS Professionals (NHSP); therefore all shifts are given to bank as a priority before going out to agency and steady progress has been made in reducing nurse vacancies and increasing bank usage. The Board has been assured in previous months of the progress made in reducing the number of shifts filled by agency.

4.2 The following tables have been provided from the monthly NHSP report:

### Registered Nursing

<table>
<thead>
<tr>
<th>Current YTD &amp; Month Year</th>
<th>Net Hours Requested *</th>
<th>NHSP Filled Hours</th>
<th>% NHSP Filled Hours</th>
<th>Agency Filled Hours</th>
<th>% Agency Filled Hours</th>
<th>Overall Fill Rate</th>
<th>Unfilled Hours</th>
<th>% Unfilled Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>17,592</td>
<td>8,144</td>
<td>46.3 %</td>
<td>3,935</td>
<td>22.4 %</td>
<td>68.7 %</td>
<td>5,513</td>
<td>31.3 %</td>
</tr>
<tr>
<td>May 2017</td>
<td>17,363</td>
<td>8,311</td>
<td>47.9 %</td>
<td>4,238</td>
<td>24.4 %</td>
<td>72.3 %</td>
<td>4,813</td>
<td>27.7 %</td>
</tr>
<tr>
<td>June 2017</td>
<td>17,937</td>
<td>8,500</td>
<td>47.4 %</td>
<td>4,884</td>
<td>27.2 %</td>
<td>74.6 %</td>
<td>4,554</td>
<td>25.4 %</td>
</tr>
<tr>
<td>July 2017</td>
<td>17,321</td>
<td>8,496</td>
<td>49.0 %</td>
<td>4,405</td>
<td>25.4 %</td>
<td>74.5 %</td>
<td>4,420</td>
<td>25.5 %</td>
</tr>
<tr>
<td>August 2017</td>
<td>18,752</td>
<td>7,523</td>
<td>40.1 %</td>
<td>4,557</td>
<td>24.3 %</td>
<td>64.4 %</td>
<td>6,672</td>
<td>35.6 %</td>
</tr>
<tr>
<td>Total</td>
<td>88,965</td>
<td>40,974</td>
<td>46.1 %</td>
<td>22,019</td>
<td>24.8 %</td>
<td>70.8 %</td>
<td>25,971</td>
<td>29.2 %</td>
</tr>
</tbody>
</table>

### Non Registered Nursing

<table>
<thead>
<tr>
<th>Current YTD &amp; Month Year</th>
<th>Net Hours Requested *</th>
<th>NHSP Filled Hours</th>
<th>% NHSP Filled Hours</th>
<th>Agency Filled Hours</th>
<th>% Agency Filled Hours</th>
<th>Overall Fill Rate</th>
<th>Unfilled Hours</th>
<th>% Unfilled Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>16,473</td>
<td>13,221</td>
<td>80.3 %</td>
<td>0</td>
<td>0.0 %</td>
<td>80.3 %</td>
<td>3,252</td>
<td>19.7 %</td>
</tr>
<tr>
<td>May 2017</td>
<td>16,083</td>
<td>12,748</td>
<td>79.3 %</td>
<td>0</td>
<td>0.0 %</td>
<td>79.3 %</td>
<td>3,335</td>
<td>20.7 %</td>
</tr>
<tr>
<td>June 2017</td>
<td>14,720</td>
<td>12,171</td>
<td>82.7 %</td>
<td>0</td>
<td>0.0 %</td>
<td>82.7 %</td>
<td>2,549</td>
<td>17.3 %</td>
</tr>
<tr>
<td>July 2017</td>
<td>15,057</td>
<td>13,503</td>
<td>89.7 %</td>
<td>0</td>
<td>0.0 %</td>
<td>89.7 %</td>
<td>1,554</td>
<td>10.3 %</td>
</tr>
<tr>
<td>August 2017</td>
<td>16,121</td>
<td>13,930</td>
<td>86.4 %</td>
<td>0</td>
<td>0.0 %</td>
<td>86.4 %</td>
<td>2,191</td>
<td>13.6 %</td>
</tr>
<tr>
<td>Total</td>
<td>78,454</td>
<td>65,573</td>
<td>83.6 %</td>
<td>0</td>
<td>0.0 %</td>
<td>83.6 %</td>
<td>12,881</td>
<td>16.4 %</td>
</tr>
</tbody>
</table>
The following table shows the success the Trust is having in recruiting bank staff compared to others. The unfilled percentage is lower compared to the north west position and the percentage filled by agency is lower than both the national and north west position.

<table>
<thead>
<tr>
<th>Month</th>
<th>% Bank</th>
<th>% Agency</th>
<th>% Unfilled</th>
<th>% Overall Fill</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>56.5%</td>
<td>18.1%</td>
<td>25.4%</td>
<td>74.6%</td>
</tr>
<tr>
<td>NorthWest</td>
<td>55.8%</td>
<td>13.8%</td>
<td>30.5%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Southport</td>
<td>61.3%</td>
<td>13%</td>
<td>25.7%</td>
<td>74.3%</td>
</tr>
</tbody>
</table>

4.2 Total nursing agency spend is £136k in August which is much lower than previously incurred for some time.

5 Medical Agency

5.1 The Trust remains 100% compliant in the use of framework agencies for medical staff. However, it is not possible to secure any shifts at the national (Tier 1) capped rates and in many cases the Trust has to go to Tier 3.

5.2 An escalation process remains in place for any essential shifts that can only be filled using higher rates than those allowed under the HTE agreement.

5.3 The changes associated with IR35 have had an impact on the recruitment of medical staff as they seek to increase pay rates. The Trust is resisting all attempts by agency/doctors to increase the rates to mitigate the impact of IR35 but prices paid have risen where the service is in danger of being closed due to safety concerns. Neighbouring Trusts are paying higher prices to secure medical staff in hard to fill specialties and this is impacting on the ability to reduce agency spend. Recent appointments of locum consultants in A&E should assist.

5.4 NHS Improvement has set the Trust an additional target to reduce medical agency spend by a further £600k in addition to the savings identified in the financial plan submitted in March. Given the month 5 YTD position this target will not be achieved. However, a substantial saving (£1.7m) was already
assumed in the Trust’s plan before the £650k stretch target was applied.

6 Cost Improvement Plan (CIP)

6.1 The Trust was required to deliver a CIP plan of £5.6m at the start of the year. Following the full review of all schemes, the current value on the CIP tracker is £4.1m leaving a shortfall of £1.5m. Work is underway to review all Hopper schemes, establishment reductions and 2018/19 schemes to consider bringing forward to close the gap.

6.2 Each of the schemes has been risk adjusted for delivery confidence and the current risk adjusted position stands between £2.5 and £3.0m. As confidence on delivery increases, this position improves. The table below details the departmental split of schemes against the revised plan position, the month 5 YTD performance and forecast outturn.

<table>
<thead>
<tr>
<th>CBU</th>
<th>Plan Identified £'000</th>
<th>Gap £'000</th>
<th>Month 5 YTD Performance Against Identified plan</th>
<th>FOT Forecast £'000</th>
<th>Variance £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>524</td>
<td>1,111</td>
<td>587</td>
<td>339</td>
<td>319</td>
</tr>
<tr>
<td>Planned Care</td>
<td>2,160</td>
<td>1,175</td>
<td>(925)</td>
<td>100</td>
<td>81</td>
</tr>
<tr>
<td>Specialist</td>
<td>930</td>
<td>691</td>
<td>(239)</td>
<td>110</td>
<td>99</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>2,046</td>
<td>1,186</td>
<td>(860)</td>
<td>104</td>
<td>72</td>
</tr>
<tr>
<td>Grand Total</td>
<td>5,600</td>
<td>4,163</td>
<td>(1,437)</td>
<td>601</td>
<td>571</td>
</tr>
</tbody>
</table>

Note - Corporate includes Estates & Facilities

6.3 As can been seen above, the CIP delivery at month 5 YTD is not achieving the planned position with a gap of £91k against the identified plan position. The forecast outturn position is £3,330k giving an overall shortfall of £833k against the identified plan and £2,270 against target plan. All business units have been tasked with support of the Delivery Managers to find additional schemes to bridge the gap.

6.4 The schemes that now remain on the tracker are more robust than the Pre-review phase however there are still risks associated with delivery in some areas, hence a risk adjusted position of between £2.5 and £3.0m. The risks are broadly made up of input risks relating to the internal capacity to deliver the programme and output risks relating to our ability to transact the savings. This is more evident within the cross cutting programmes as they require a significant improvement in operational processes to trigger the CIP outcome. Work is underway to mitigate these risks on a weekly basis via operational programme boards.

6.5 There remains a gap of £1.5m between the target plan of £5.6m, and the value of identified schemes £4.1m and the work that Four Eyes have carried out indicate that there are a number of other areas that can be brought forward to mitigate this gap. This is being reviewed via the Scrutiny meetings.

7 Cash
7.1 The Trust continues to require cash support as it is trading with a deficit each month.

7.2 A rolling 13 week cash forecast is updated monthly and sent to NHS Improvement on the second Monday or Wednesday of the month and this forms the basis of any cash draw downs in the future month (August’s cash flow sent on 12th July).

7.3 The Trust borrowed £1.998m in August. Note that as the Trust has not agreed its control total with NHS Improvement, there is a punitive interest rate charge of 3.5% (normally 1.5%).

7.4 Performance against the cash target in August was as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Target £’000s</th>
<th>Actual £’000s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening balance</td>
<td>1,000</td>
<td>1,223</td>
<td>Monies received after final monthly payment run.</td>
</tr>
<tr>
<td>Cash inflows</td>
<td>16,268</td>
<td>16,350</td>
<td>Actual is within 0.5% of target.</td>
</tr>
<tr>
<td>Cash outflows</td>
<td></td>
<td>16,459</td>
<td>Utilised some of the additional monies brought forward in the final payment run.</td>
</tr>
<tr>
<td>Closing balance</td>
<td>1,000</td>
<td>1,114</td>
<td>Monies received on last day of the month after the final payment run.</td>
</tr>
</tbody>
</table>

7.5 Future draw downs for September and October are based on the actual reported deficit plus plan. For example, the Trust has just submitted its October request and the cumulative funding is based on April to August’s actual deficit plus planned September and October. This gives the Trust a maximum borrowing figure.

7.6 Note that the most recent cash flow submitted to NHS Improvement on 11th September covering the period October 17 to January 18 shows that the Trust will need to borrow in excess of its entire planned deficit before the end of November.

7.7 In order to be able to continue to borrow monies required to operate, the Trust must agree a revised forecast outturn with NHSI. This will need full Board approval at its meeting in October.

8 Capital

8.1 In month capital spend for August was £77k against a target of £300k. The low spend wasn’t unexpected as the Capital Investment Group could not commit any expenditure until the revised plan was approved by the Board in early September.
8.2 There was some in month benefit from the reversal of a prior year accrual but note the overall effect against prior year schemes is a net £3k cost.

8.3 The Procurement team are progressing the medical equipment orders and there is a Project Board set up for the Ward reconfigurations (also known as Safe at all Times - SAAT). Expenditure is expected to increase rapidly in the coming months and this will bring the spend more into line with the plan.

9 Commissioning for Quality and Innovation payments (CQUINS)

9.1 The CQUIN targets and quarter one performance for 2017/18 have been discussed at Finance, Performance & investment committee last week. These have been shared with CQUIN leads within the Trust and performance will be monitored on a quarterly basis. The next update will be provided after quarter 2 results are known.

9.2 As at the end of quarter one CQUIN achievement was £499k against a plan of £669k. Of this £170k underperformance, £150k relates to the 0.5% which has been set aside by CCG’s to be held in a risk reserve. As the Trust did not hit its control total for 2016/17 no plan was set for the 0.5% and so this is already factored into the financial position. The remaining £20k under performance is as a result of not hitting the 90% Sepsis target.

10 Financial Risks

10.1 This section will identify the risks attached to delivering the financial plan of £18.1m deficit so that the Board has sight of them and can seek assurance on how they are being managed.

10.2 CIP

The CIP planned to achieve £1,020k savings at month 5. The savings achieved to date is £571k. Despite the recent workshops that have increased focus on CIP plans and delivery this represents a significant risk to achieving the financial plan as expenditure was profiled to reduce significantly from month 5 onwards. The forecast is that the required reduction in expenditure as a result of CIP will not deliver within this financial year.

10.3 Contract performance – main contract

Current financial performance already includes the shortfall on activity and resultant loss on income. The Income Task and Finish Group are being tasked with addressing this risk which will continue to contribute adversely if not addressed. This piece of work has not yet included but any improvement as a result of actions will impact favourably on the current income performance.
10.4 **Contract performance - CQUIN/penalties**

No income deductions have been made in respect of CQUIN underperformance (except for the 0.5% for non compliance with the control total) although there is no material financial impact from quarter 1. It remains unclear whether any contract penalties will be imposed for non-performance against performance standards. Potentially commissioners can apply penalties if the control total has not been signed up to. It is estimated that, if CCG’s applied penalties to the contract, this could amount to £200k per month.

10.5 **Additional pressures**

The 2017/18 financial plan highlighted some additional pressures that could materialise during the year which would require resources (either found from within budget, additional CIP or income). Consultant and SAS doctor PA’s are now being incurred and are within the monthly expenditure figures although any back pay prior to 1st April 2017 has not been included. Other key pressures without a funding source at this stage include 24/7 security at Southport DGH and expansion of the PMO facility (in excess of the £200k funded by NHS Improvement).

10.6 **2016/17 Contract**

The Trust was in dispute with both Southport & Formby CCG and West Lancashire CCG relating to CQUIN and coding and counting issues.

11.0 **Forecast outturn**

The month 5 YTD position of £13.8m deficit is significantly adverse against the trajectory required to achieve £18.1m deficit year end plan. Unless the Trust can make the necessary changes to income (through increased activity) and expenditure then the outturn is likely to be far in excess of the plan. At this stage it is estimated that the final year-end position could be between £27m and £31m deficit. This forecast position will be revised in more detail over the coming weeks.

11 **Recommendations**

11.1 The Board is asked to discuss the contents of the report and in particular:

- The in month deficit of £2.8m, £1.6m worse than plan.
- The year-end deficit of £13.6m, £4.5m worse than plan.
- Expenditure performance and the impact of the CIP programme and its profile.
- The impact activity and income is having on current performance and impact for the year-end.
- Risks currently being incurred that may continue as well as any new risks that may contribute adversely in future months.
- The impact the higher deficit is having on the Trust’s cash position.
### Statement of Comprehensive Income (Income & Expenditure Account)

<table>
<thead>
<tr>
<th>I&amp;E (including R&amp;D)</th>
<th>Annual Budget £000</th>
<th>Year to Date</th>
<th>In Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Budget £000</td>
<td>Actual £000</td>
</tr>
<tr>
<td>Operating Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioning Income</td>
<td>148,708</td>
<td>62,726</td>
<td>59,812</td>
</tr>
<tr>
<td>PP, Overseas &amp; RTA</td>
<td>2,305</td>
<td>960</td>
<td>506</td>
</tr>
<tr>
<td>Other Income</td>
<td>15,009</td>
<td>6,268</td>
<td>5,904</td>
</tr>
<tr>
<td>Total Income</td>
<td>166,022</td>
<td>69,954</td>
<td>66,222</td>
</tr>
<tr>
<td>Operating Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>(121,565)</td>
<td>(52,663)</td>
<td>(53,364)</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>(53,334)</td>
<td>(22,592)</td>
<td>(22,521)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>(174,899)</td>
<td>(75,255)</td>
<td>(75,885)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>(8,877)</td>
<td>(5,301)</td>
<td>(9,663)</td>
</tr>
<tr>
<td>Non-Operating Expenditure</td>
<td></td>
<td>(9,237)</td>
<td>(3,849)</td>
</tr>
<tr>
<td>Retained Surplus/(Deficit)</td>
<td></td>
<td>(18,114)</td>
<td>(9,150)</td>
</tr>
<tr>
<td>Technical Adjustments</td>
<td>(5)</td>
<td>2</td>
<td>570</td>
</tr>
<tr>
<td>Break Even Surplus/(Deficit)</td>
<td></td>
<td>(18,119)</td>
<td>(9,152)</td>
</tr>
</tbody>
</table>

- Elective, non-elective and outpatients monthly average underperformance has continued into month 5.
- Adverse variance due to RTA income underperformance. 1617 YTD = £590k
- YTD adverse variance consistent with CIP underperformance although pressure in month from medical and other staff overspends
- adverse variance in month on clinical supplies and services
KEY MESSAGES OF THIS REPORT & RECOMMENDATIONS
The Board acting as Corporate Trustee for the charity is required to approve all charitable fund expenditure requests over £10,000.

There is one request that meets the charitable fund objectives and there is sufficient funding available.

The Board is asked to approve the following:

1. Course fees re Advanced Paediatric Nurse Practitioners; £14,400

**Strategic Objective(s)** *(The content provides evidence for the following strategic objectives)*

- Lifelong integrated care
- Excellence in Treatment and Care
- Best Performance within Resources
- Develop Staff
- Organisational Sustainability

**Governance (the report supports a.....)**

- Statutory requirement
- Annual Business Plan Priority
- Linked to a Key Risk on BAF/HLRR
- Service Change
- Best Practice
- Other List (Rationale)

Current corporate governance requires the Corporate Trustee (Trust Board) to approve expenditure requests above £10,000.

**Impact (is there an impact arising from the report on the following?)**

- Quality
- Finance
- Workforce
- Equality
- Risk
- Compliance
- Legal

**Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)**

**Next Steps** *(List the required actions following agreement by Board/Committee/Group)*

The appropriate paperwork including VAT exemption forms (if appropriate) will be passed to Procurement/Estates so that orders can be raised.
1 Introduction

1.1 As per the Trust’s Corporate Governance manual, all Charitable Fund requests over £10,000 require approval by the Trust Board.

1.2 The following request has been approved by the Director of Finance and the Chair of the Charitable Fund Committee.

- University course fees to support the development of 2 advanced paediatric nurse practitioners, £14,400.

2 Course fees Advance Paediatric Nurse Practitioners

2.1 This request is to enroll 2 nurses on an MSc Advanced Paediatric Nurse Practitioner course at Liverpool John Moores University.

2.2 Note this request was originally approved by Charitable Fund Committee at their meeting on 26th June based on a value of £3,840. However, following discussion with the department it transpired that this was only for one module and the total cost of this 2 year course, for 2 people, is £14,400.

2.3 At the Board meeting held on 6th September members asked if this course could be funded by the Trust’s apprenticeship levy account. Unfortunately, as the students are already enrolled on a ‘traditional’ degree programme, they are not eligible for funding via the apprenticeship levy.

2.4 The Education and Training Manager has advised that there are currently no local training providers that are running nursing apprenticeships.

2.5 Funding is requested from the Ormskirk General fund. The balance available is 36,394.

3 Conclusion

3.1 The requests meet the charitable fund objectives as they will enhance the patient experience with their advance skills and knowledge. This training will greatly benefit the department allowing the individuals to undertake some of the roles undertaken by junior doctors thus freeing up more time to improve the patient experience.

3.2 Sufficient funding has been identified within charitable funds.

3.3 The appropriate governance processes have been followed and all have gone either through the Director of Finance or the Charitable Fund Committee.

4 Recommendation

4.1 It is recommended that the Trust Board acting as the Corporate Trustee approve the above charitable fund request.
Public Trust Board
4th October 2017

Agenda Item: TB209/17

Report Title:
Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2017

Executive Lead: Therese Patten (Chief Operating Officer)

Lead Officer: Chris Pilkington (Emergency Preparedness Manager)

Action Required:
☑ Note  ☑ Approve  ☑ Assure

Strategic Objective(s) (The content provides evidence for the following strategic objectives)

☐ Lifelong integrated care
☑ Excellence in Treatment and Care
☑ Best Performance within Resources
☐ Develop Staff
☑ Organisational Sustainability

Governance (the report supports a…..)

☑ Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on BAF/HLRR – Ref 011
☐ Service Change
☐ Best Practice
☐ Other List (Rationale)

Impact (is there an impact arising from the report on the following?)

☐ Quality
☐ Finance
☐ Workforce
☐ Equality
☐ Risk
☑ Compliance
☑ Legal

Equality Impact Assessment (If there is an impact on E&D, an Equality Impact Assessment must accompany the report)

☐ Strategy
☐ Policy
☐ Service Change

Next Steps (List the required actions following agreement by Board/Committee/Group)

Assure: Following self-assessment, and in line with the definitions of compliance, the organization declares itself as demonstrating Substantial compliance against the EPRR Core Standards. There is an action plan supporting further improvements. The Board is asked to take assurance that the Trust is prepared for an emergency.
### Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

#### ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

<table>
<thead>
<tr>
<th>Core standard reference</th>
<th>Core standard description</th>
<th>Improvement required to achieve compliance</th>
<th>Action to deliver improvement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Preparedness ensures all incident commanders (on-call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident/exercise participation</td>
<td>External training delivered by NHS England to On-Call Managers Individuals are responsible for their own development and recording however this is not recorded centrally</td>
<td>On-Call Training already in progress Training evidence to be discussed with Head of Training to ensure training records for On-Call Directors and Managers are stored on ESR</td>
<td>January 2018</td>
</tr>
<tr>
<td>60</td>
<td>There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment</td>
<td>There is a named role responsible for ensuring these checks take place. This is currently done jointly between A&amp;E staff (when time permits) and the EP Manager</td>
<td>Resilience Group to decide who should take responsibility for routine checks and create a programme showing frequency of when checks are completed</td>
<td>January 2018</td>
</tr>
<tr>
<td>61</td>
<td>There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment</td>
<td>When equipment is checked any maintenance, repairs, out of date equipment are identified and replaced</td>
<td>PPM to be created 2017/2018</td>
<td>January 2018</td>
</tr>
<tr>
<td>65</td>
<td>The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.</td>
<td>More staff are needed to become trainers so they can provide internal training to other members of staff</td>
<td>A&amp;E Staff to be allowed protected time to enable them to complete the ‘Hospital CBRN Train the Trainers’ course delivered by NWAS</td>
<td>April 2018 or whenever the courses are provided by NWAS</td>
</tr>
</tbody>
</table>
## PUBLIC TRUST BOARD

**4th October 2017**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>TB210/17</th>
<th>Report Title: Statement of Compliance 2017/2018 Emergency Preparedness, Resilience and Response (EPRR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Lead</td>
<td>Therese Patten (Chief Operating Officer)</td>
<td></td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Chris Pilkington (Emergency Preparedness Manager)</td>
<td></td>
</tr>
<tr>
<td>Action Required</td>
<td>✓ Note □ Approve ✓ Assure</td>
<td></td>
</tr>
</tbody>
</table>

To **approve** the compliance statement to be submitted to NHS England

### Strategic Objective(s) *(The content provides evidence for the following strategic objectives)*

- □ Lifelong integrated care
- ✓ Excellence in Treatment and Care
- ✓ Best Performance within Resources
- □ Develop Staff
- ✓ Organisational Sustainability

### Governance *(the report supports a.....)*

- ✓ Statutory requirement
- □ Annual Business Plan Priority
- □ Linked to a Key Risk on BAF/HLRR – Ref 011
- □ Service Change
- □ Best Practice
- □ Other List (Rationale)

### Impact *(is there an impact arising from the report on the following?)*

- □ Quality
- □ Finance
- □ Workforce
- □ Equality
- □ Risk
- ✓ Compliance
- ✓ Legal

### Equality Impact Assessment *(If there is an impact on E&D, an Equality Impact Assessment must accompany the report)*

### Next Steps *(List the required actions following agreement by Board/Committee/Group)*

*Note*: There is a requirement that this Statement of Compliance is noted annually at Trust Board.
Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Southport and Ormskirk Hospital NHS Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

<table>
<thead>
<tr>
<th>Compliance Level</th>
<th>Evaluation and Testing Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.</td>
</tr>
<tr>
<td>Substantial</td>
<td>Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.</td>
</tr>
<tr>
<td>Partial</td>
<td>Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.</td>
</tr>
<tr>
<td>Non-compliant</td>
<td>Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.</td>
</tr>
</tbody>
</table>

The results of the self-assessment were as follows:

<table>
<thead>
<tr>
<th>Number of applicable standards</th>
<th>Standards rated as Red</th>
<th>Standards rated as Amber</th>
<th>Standards rated as Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX</td>
<td>XX</td>
<td>XX</td>
<td>XX</td>
</tr>
</tbody>
</table>

Acute providers: 60**
Specialist providers: 51**
Community providers: 50**
Mental health providers: 48**
CCGs: 38

**Also includes HAZMAT/CBRN standards applicable to providers: Standards: Acutes 14 / Specialist, Community, Mental health 7
Ambulance Service are required to report statements for 3 compliance levels as stated on page 6 of the Gateway letter 06967

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation’s EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation’s board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation’s Accountable Emergency Officer

04/10/2017 22/09/2017
Date of board / governing body meeting Date signed
**PUBLIC TRUST BOARD**

4th October 2017

<table>
<thead>
<tr>
<th>Agenda Item (Ref):</th>
<th>TB211/17</th>
<th>Report Title:</th>
<th>Board Assurance Framework (BAF)</th>
</tr>
</thead>
</table>

**Executive Lead**
Karen Jackson, Interim Chief Executive.

**Lead Officer**
Audley Charles, Interim Company Secretary

**Action Required**
- [ ] Note
- [x] Receive
- [x] Approve
- [ ] Assure
- [ ] For Information

**Summary and Recommendations:**

The purpose of the report is to present the BAF for 2017/18 with its updated strategic objectives and principal risks. The Board will be asked to approve it.

Key items in the report are:
- Rationale for the BAF and its place in the governance framework of the Trust
- Its link with the Extreme Risk Register and how risks are escalated to the BAF
- Refreshed objectives
- New principal risks that could prevent the objectives being achieved
- A summary report based on the new objectives and principal risks
- The scoring matrix for the Consequence and Likelihood at Appendix 1a
- A detailed BAF showing controls, assurances, effectiveness of controls, gaps in both controls and assurances at Appendix 1b
- Action plan to address gaps shown
- Allocated scores
- Summary BAF Report for Month 7

Following a timeout by the Board in July when the strategic objectives of the Trust were reviewed, a revised Board Assurance Framework (BAF) is required to map the ‘new’ objectives against the principal risks that could prevent the Trust from achieving those strategic/corporate objectives.

There are 5 newly phrased objectives for 2017/18 contrasted against the old objectives for 2016/17. These are mapped against:
- Key areas of concern
- Potential Principal Risks
- Cause, Impact and Effect related to each risk if they are realized

The Board is asked to:
- **Approve** the revised/refreshed strategic objectives
- **Approve** the principal risks that may potentially threaten the achievement of the objectives
- **Receive** Month 7’s report on the BAF
<table>
<thead>
<tr>
<th>Strategic Objective(s) (The content provides evidence for the following strategic objectives)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Lifelong integrated care</td>
</tr>
<tr>
<td>✓ Excellence in Treatment and Care</td>
</tr>
<tr>
<td>✓ Best Performance within Resources</td>
</tr>
<tr>
<td>✓ Develop Staff</td>
</tr>
<tr>
<td>✓ Organisational Sustainability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Governance (the report supports a.....)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Statutory requirement</td>
</tr>
<tr>
<td>✓ Annual Business Plan Priority</td>
</tr>
<tr>
<td>✓ Linked to a Key Risk on BAF/HLRR</td>
</tr>
<tr>
<td>✓ Service Change</td>
</tr>
<tr>
<td>✓ Best Practice</td>
</tr>
<tr>
<td>✓ Other List (Rationale)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact (is there an impact arising from the report on the following?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Quality</td>
</tr>
<tr>
<td>✓ Finance</td>
</tr>
<tr>
<td>✓ Workforce</td>
</tr>
<tr>
<td>✓ Equality</td>
</tr>
<tr>
<td>✓ Risk</td>
</tr>
<tr>
<td>✓ Compliance</td>
</tr>
<tr>
<td>✓ Legal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equality Impact Assessment (if there is an impact on E&amp;D, an Equality Impact Assessment must accompany the report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Strategy</td>
</tr>
<tr>
<td>□ Policy</td>
</tr>
<tr>
<td>□ Service Change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next Steps (List the required actions following agreement by Board/Committee/Group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To cascade, train relevant groups and individuals and embed on the significance and use of the BAF at appropriate levels in the Trust.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previously Presented at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Board-Date:6 September 2017 Action taken: Reviewed and recommendations made</td>
</tr>
<tr>
<td>Audit Committee-Date: 13 September 2017 Action taken: Reviewed &amp; recommendations made.</td>
</tr>
</tbody>
</table>
INTRODUCTION

The objectives for 2016/17 were as shown below:

<table>
<thead>
<tr>
<th>Strategic Objectives</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1</td>
<td>Embed an integrated model across the local health economy</td>
</tr>
<tr>
<td>SO2</td>
<td>Ensure excellence in treatment and care</td>
</tr>
<tr>
<td>SO3</td>
<td>Deliver performance within resources</td>
</tr>
<tr>
<td>SO4</td>
<td>Empower and develop staff to achieve their objectives</td>
</tr>
<tr>
<td>SO5</td>
<td>Maintain organisational sustainability</td>
</tr>
</tbody>
</table>

Based on the discussions held and the key concerns raised by the Board at its timeout in July 2017, the following are the proposed objectives for 2017/18 and the associated principal risks for approval.

<table>
<thead>
<tr>
<th>Key Area of Concern</th>
<th>Proposed Objective</th>
<th>Potential Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Strategic Direction</td>
<td><strong>SO1 Agree with partners a long term acute services strategy</strong></td>
<td>Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards</td>
</tr>
<tr>
<td>Aspects of Clinical Quality, e.g. mortality figures</td>
<td><strong>SO2 Improve clinical outcomes and patient safety</strong></td>
<td>Poor clinical outcomes and safety records</td>
</tr>
<tr>
<td>Financial Performance</td>
<td><strong>SO3: Provide care within agreed financial limit</strong></td>
<td>Failure to live within resources leading to increasingly difficult choices for commissioners</td>
</tr>
<tr>
<td>Performance on statutory targets</td>
<td><strong>SO4 Deliver high quality, well-performing services</strong></td>
<td>Failure to meet key performance targets leading to loss of services</td>
</tr>
<tr>
<td>Staffing Issues, including morale, sickness levels and need to meet safe staffing levels</td>
<td><strong>SO5 Ensure staff feel valued in a culture of open and honest communication</strong></td>
<td>Failure to attract and retain staff</td>
</tr>
<tr>
<td>Managerial capacity and capability</td>
<td><strong>SO6 Establish a stable, compassionate leadership team</strong></td>
<td>Inability to provide direction and leadership</td>
</tr>
</tbody>
</table>

Board Assurance Framework (BAF)

Board assurance is a systematic method of:
- Identifying
- Analysing
- Evaluating, treating (mitigating), monitoring and reviewing
- Communicating clinical and non-clinical risks and the integration and management of both.

Risk management by the Board is underpinned by four (4) interlocking systems of internal control:
- BAF
- Extreme Risk Register (informed by Directorates, Clinical Business Units (CBUs) and Teams)
- Audit Committee
- Annual Governance Statement

This Board Assurance Framework is designed and operates to meet the requirements of the 2017/18 Annual Governance Statement. The BAF, which is board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust’s strategic objectives being achieved. Risks to be monitored over the year include are listed above and in the BAF at Appendix 1b. Properly designed, the BAF is the basis for the Board agenda and vice versa.
The BAF is determined by the Board of Directors and is approved by the Trust Board. It is the means by which the Board holds itself to account and identifies the principal risks that could prevent the Trust delivering its strategic objectives and therefore the operational plan. It also provides a structure for the evidence to support the Chief Executive’s *Annual Governance Statement (AGS)* within the *Annual Report*. The BAF maps out the control systems in place to mitigate these risks and confirms the assurances that the Board wishes to receive either directly or via its statutory and assurance Committees (Audit; Quality & Safety; Nomination & Remuneration; Finance Performance & Investment (FP&I) and Workforce & Organisational Development) to evidence the effective operation of these controls.

Board assurance is a systematic method of:
- Identifying
- Analysing
- Evaluating, treating (mitigating), monitoring and reviewing
- Communicating clinical and non-clinical risks and the integration and management of both.

Risk management by the Board is underpinned by four (4) interlocking systems of internal control:
- BAF
- Extreme Risk Register (informed by Directorates, Clinical Business Units (CBUs), Wards and Teams)
- Audit Committee
- Annual Governance Statement

There is a clear process for escalating high or significant risks to the BAF. The Trust does not have a static risk appetite. The Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. In any event there must be consultation with the Board if there needs to be material altering of significant risk scores by directorates, CBUs or departments. The statutory and assurance committees have regular oversight and scrutiny of all relevant risks from the corporate trust risk register and hold the relevant executive directors to account for the management of their directorate risks. The BAF should be robustly discussed and analysed at the Board. Updates of progress against actions should be provided at the Audit Committee and monthly (quarterly, later) to the Board.

Allied to the management of risk is learning from situations. There needs to be a clear system of shared learning that rapidly transfers knowledge across the organisation. The Trust should be able to demonstrate this with practical examples of how working practices have changed as a consequence of good risk management allied to shared-learning. The Risk Management Strategy and Policy should reflect this. Below is the *Floor to Board Risk Escalation Process*: 
ASSURANCE

A schedule of assurances received during the month/quarter against each BAF’s high risk agreed by the Board will be presented. These assurances will be derived by taking into account the content of the Board statutory and assurance committees’ Assure, Alert and (AAA) Highlight Reports to Board and also the assurance reports delivered directly to the Board.

At the end of each month/quarter an overall assurance RAG rating will be assigned to each risk based on an aggregation of the quarterly rating.

Required assurances will be mapped against each risk. Assurances received will be listed and where they were obtained and where there are gaps an action plan will be included. Scores will be allocated as analysis of controls and assurances dictate. The summary report will include details for the high level risks and will be delivered in the following format.

Assurance Summary

1. Board Assurance Framework for the delivery of Objectives

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. Levels of Assurance explanations are set out in the table below:

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Operational (management)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Oversight functions-Board Committees</td>
</tr>
<tr>
<td>Level 3</td>
<td>Independent (Audits/Reviews/Inspections)</td>
</tr>
</tbody>
</table>

This Table below shows assurances reported to Board Committees for September

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Assurance on the Effectiveness of Control</th>
<th>Level1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR2/3/6</td>
<td>Audit</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>PR1</td>
<td>External and Internal Audit</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>PR2</td>
<td>Quality &amp; Safety</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>PR3</td>
<td>Finance, Performance &amp; Investment Committee</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>PR4/5/6</td>
<td>Workforce &amp; OD</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mortality Assurance &amp; Clinical Improvement</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

For Month 7 there were five Amber/Red and one Amber scores allocated to the Principal risks. The scores range and RAG ratings are shown below
## Board Assurance Framework - current level of assurance
At October 2017

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Principal Risk</th>
<th>Description</th>
<th>RAG</th>
<th>Current Score (L x C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1 Agree with partners a long term acute services strategy</td>
<td>PR1</td>
<td>Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards</td>
<td>AMBER/RED</td>
<td>3 x 5 15</td>
</tr>
<tr>
<td>SO2 Improve clinical outcomes and patient safety</td>
<td>PR2</td>
<td>Poor clinical outcomes and safety records</td>
<td>AMBER/RED</td>
<td>3 x 5 15</td>
</tr>
<tr>
<td>SO3 Deliver high quality, well-performing services</td>
<td>PR3</td>
<td>Failure to live within resources leading to increasingly difficult choices for commissioners</td>
<td>AMBER/RED</td>
<td>4 x 5 20</td>
</tr>
<tr>
<td>SO4 Ensure staff feel valued in a culture of open and honest communication</td>
<td>PR4</td>
<td>Failure to meet key performance targets leading to loss of services</td>
<td>AMBER/RED</td>
<td>3 x 5 15</td>
</tr>
<tr>
<td>SO5 Establish a stable, compassionate leadership team</td>
<td>PR5</td>
<td>Failure to attract and retain staff</td>
<td>AMBER</td>
<td>3 x 4 12</td>
</tr>
<tr>
<td>SO6 Establish a stable, compassionate leadership team</td>
<td>PR6</td>
<td>Inability to provide direction and leadership</td>
<td>AMBER/RED</td>
<td>3 x 5 15</td>
</tr>
</tbody>
</table>
## Appendix Ia: Risk grading criteria

<table>
<thead>
<tr>
<th>Risk Type</th>
<th>Very low 1</th>
<th>Low 2</th>
<th>Moderate 3</th>
<th>High 4</th>
<th>Very High 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Patient Harm</td>
<td>Minimal physical or psychological harm, not requiring any clinical intervention. Eg: Discomfort</td>
<td>Minor, short term injury or illness, requiring non-urgent clinical intervention (e.g. extra observations, minor treatment or first aid). Eg.: Bruise, graze, small laceration, sprain. Grade 1 pressure ulcer. Temporary stress / anxiety. Intolerance to medication.</td>
<td>Significant but not permanent injury or illness, requiring urgent or ongoing clinical intervention. e.g.: Substantial laceration / severe sprain / fracture / dislocation / concussion. Sustained stress / anxiety / depression / emotional exhaustion. Grade 2 or3 pressure ulcer. Healthcare associated infection (HCAI)); Noticeable adverse reaction to medication.; Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reportable incident</td>
<td>Significant long-term or permanent harm, requiring urgent and on-going clinical intervention, or the death of an individual. e.g.: Loss of a limb Permanent disability. Severe, long-term mental illness. Grade 4 pressure ulcer. Long-term HCAI. Retained instruments after surgery. Severe allergic reaction to medication.</td>
<td>Multiple fatal injuries or terminal illnesses</td>
</tr>
<tr>
<td>B. Self-harm OR</td>
<td>Noticeable disruption to essential aspects of service. Temporary service closure or disruption across one or more divisions.</td>
<td>Extended service closure or prolonged disruption across a division.</td>
<td>Hospital or site closure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Public Harm</td>
<td>Noticeable disruption to essential aspects of service. Temporary service closure or disruption across one or more divisions.</td>
<td>Extended service closure or prolonged disruption across a division.</td>
<td>Hospital or site closure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Services</td>
<td>Noticeable disruption to essential aspects of service. Temporary service closure or disruption across one or more divisions.</td>
<td>Extended service closure or prolonged disruption across a division.</td>
<td>Hospital or site closure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Reputation</td>
<td>Noticeable disruption to essential aspects of service. Temporary service closure or disruption across one or more divisions.</td>
<td>Extended service closure or prolonged disruption across a division.</td>
<td>Hospital or site closure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Finances</td>
<td>Noticeable disruption to essential aspects of service. Temporary service closure or disruption across one or more divisions.</td>
<td>Extended service closure or prolonged disruption across a division.</td>
<td>Hospital or site closure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Financial impact on achievement of annual control total of up to £50k

Financial impact on achievement of annual control total of between £50k - 100k

Financial impact on achievement of annual control total of between £100k - £1m

Financial impact on achievement of annual control total of between £1 - 5m

Financial impact on achievement of annual control total of more than £5m
### Likelihood score & descriptor with examples

<table>
<thead>
<tr>
<th>Very unlikely</th>
<th>Unlikely</th>
<th>Possible</th>
<th>Somewhat likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Less than 1 chance in 1,000</td>
<td>Between 1 chance in 1,000 and 1 in 100</td>
<td>Between 1 chance in 100 and 1 in 10</td>
<td>Between 1 chance in 10 and 1 in 2</td>
<td>Greater than 1 chance in 2</td>
</tr>
<tr>
<td>Statistical probability below 0.1%</td>
<td>Statistical probability between 0.1% - 1%</td>
<td>Statistical probability between 1% and 10%</td>
<td>Statistical probability between 10% and 50%</td>
<td>Statistical probability above 50%</td>
</tr>
</tbody>
</table>

**Very good control**

**Good control**

**Limited effective control**

**Weak control**

**Ineffective control**

### Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Consequence</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td>20</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>20</td>
<td>15</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

### Rating

<table>
<thead>
<tr>
<th>Rating</th>
<th>Very low (1-3)</th>
<th>Low (4-6)</th>
<th>Medium (8-9)</th>
<th>High (10-12)</th>
<th>Significant (15-25)</th>
</tr>
</thead>
</table>

### Oversight

<table>
<thead>
<tr>
<th>Specialty / Service level</th>
<th>Annual review</th>
<th>CBU</th>
<th>Quarterly review</th>
<th>Committee / Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oversight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reporting

<table>
<thead>
<tr>
<th>None</th>
<th>Board and Risk Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ref No.</td>
<td>Principal Risk Description</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
<td>Principal Risk 1: Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards may result in:</td>
</tr>
<tr>
<td></td>
<td>Potential Cause: Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels  • Lack of robust plans across healthcare systems  • Loss of Commissioner support  • Inability to respond to requirements to flex capacity as there is a mismatch with their plans.</td>
</tr>
<tr>
<td></td>
<td>Potential Effect: Loss of existing market share.  • Stranded fixed costs due to poor demand management / QIPP.  • Difficult to manage capacity plans.</td>
</tr>
<tr>
<td></td>
<td>Potential Impact: Reduced financial sustainability.  • Inability to meet quality goals.  • Reduced operational performance.</td>
</tr>
<tr>
<td>Ref No.</td>
<td>Principal Risk Description</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Strategic Objective 2: Improve clinical outcomes and patient safety</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Principal Risk 2: Poor clinical outcomes and safety records may result in:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Potential Cause:</strong></td>
</tr>
<tr>
<td></td>
<td>• Staff may develop a siege mentality</td>
</tr>
<tr>
<td></td>
<td>• Conspiracy theories may be high across the Trust</td>
</tr>
<tr>
<td></td>
<td>• There may be a disconnect between the executive and board on one hand and operational staff on the other.</td>
</tr>
<tr>
<td></td>
<td>• The public may feel isolated from the Trust</td>
</tr>
<tr>
<td></td>
<td><strong>Potential Effect:</strong></td>
</tr>
<tr>
<td></td>
<td>• Poor staff Survey</td>
</tr>
<tr>
<td></td>
<td>• Inaccurate information about the Trust in the public domain</td>
</tr>
<tr>
<td></td>
<td>• Reduction or loss of public support generally and in consultations regarding service improvement and design.</td>
</tr>
<tr>
<td></td>
<td>• Poor staff morale resulting in poor quality of service</td>
</tr>
<tr>
<td></td>
<td><strong>Potential Impact:</strong></td>
</tr>
<tr>
<td></td>
<td>• Potential loss of good will locally and politically</td>
</tr>
<tr>
<td></td>
<td>• Negative impact on quality of patient services</td>
</tr>
<tr>
<td></td>
<td>• Negative impact on recruitment and retention of staff.</td>
</tr>
</tbody>
</table>

Staff engagement strategy.
- Quality Visits by NEDs and EDs
- Meet the Chief Executive Sessions
- Duty of Candour
- Healthwatch Review
- Executive Blog
- Freedom to Speak Up
- Speak Up Champion
- Speak Up Guardian
- Stakeholder Engagement Strategy

Workforce & Organisational Development Committee (L3)
- STEIS and Incident Reporting (L2)
- Developing gap in Care Strategy (L1)
- FPPT Report (L3)
- Governance Reports (L2)
- Staff Magazine (L1)

Survey
- Complaints, Compliments and Litigation Reports (L3)
- Healthwatch Reports (L3)
- CEO’s Blog (L2)
- CEO/Staff Forum (L2)
- Workforce & OD Committee Report (L2)

Lack of robust Feedback from Staff and patients
- Clinical leadership development to provide a culture of trust and candour.
- Perceived inequity of treatment or rewards between and within staff groups.

Workforce Strategy
- Engagement Strategy

Freedom to Speak Up Policy
- Improve Champions across the organisation
- Implement Recommendations of Culture Review
- Robust medical job planning process.

MD/DoN
<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Principal Risk Description</th>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Assurance on the Effectiveness of Controls</th>
<th>Gaps in Control</th>
<th>Gaps in Assurance</th>
<th>Action Plans for Gaps</th>
<th>Risk/ Action Plan Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO3</td>
<td><strong>Principal Risk 3:</strong> Failure to live within resources leading to increasingly difficult choices for commissioners may result in:</td>
<td>Monthly CIP report to Board and Quarterly to Audit and FP&amp;I committees</td>
<td>Reported to Board: • Director of Finance Reports to the Board (L1).</td>
<td>Reported to Board: • Finance reports (L1). • Integrated Performance Reports (L1) • Director of Clinical Services reports re review of services (L1). • Emergency Planning Annual Report (L1) • Audit Committee Report (L2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potential Cause: • Failure of national performance target (cancer, RTT)</td>
<td>• Internal weekly DTOC meetings.</td>
<td>• Emergency Planning Annual Report (L1)</td>
<td>Integrated Performance Report not robust and showing cross directorate cooperation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Failure to reduce delayed transfers of care in the changing NHS environment</td>
<td>• Supported Discharge Service in place with 8 work streams.</td>
<td>• Audit Committee Report (L2)</td>
<td>Integrated Performance Report methodology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potential Effect: • High numbers of people waiting for transfer from inpatient care.</td>
<td>• Provider Action Plan (DTOC)</td>
<td>• Winter Plan (L1)</td>
<td>Board reporting of performance to be reviewed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Delays in patient flow, patients not seen in a timely way.</td>
<td>• Long term financial model.</td>
<td></td>
<td>Revised Integrated Performance Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduced patient experience.</td>
<td>Working capital support through agreed loan arrangements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Failure of KPI’s and self-certification</td>
<td>Annual plan, including control total consideration and reduction of underlying financial deficit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reputational damage leading to difficulty in recruitment.</td>
<td>Financial governance and performance arrangements in place at Trust, divisional and service line levels and with contracted partners. CIP planning processes and PMO coordination of delivery.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potential Impact: • Services may be unaffordable.</td>
<td>Reported elsewhere: • Chief Executives’ Meetings (L2).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quality of care provided to patients may fall.</td>
<td>• Winter Plan (L1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Loss in reputation.</td>
<td>• Winter Plan (L1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Failure to meet contractual requirements.</td>
<td>• Winter Plan (L1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic Objective 3: Provide care within agreed financial limits.
Strategic Objective 4: *Deliver high quality, well-performing services*

**Principal Risk 4:** Failure to meet key performance targets leading to loss of services may result in:

**Potential Cause:**
- Failure to meet the Trust’s Quality Strategy goals
- Failure to deliver the quality aspects of contracts with the commissioners
- Patients experience indicators may show a decline in quality
- Breach of CQC regulations
- CIPs impact on safety or unacceptably reduce service quality
- Poor Bed Management processes impact on patient safety

**Potential Effect:**
- Poor patient experience and standards of care
- Inaccurate or inappropriate media coverage or reputational damage
- Duplication of services with negative impact on CIP

**Potential Impact:**
- Potential loss of licence to practise
- Potential loss of reputation
- Financial penalties may be applied

---

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Principal Risk Description</th>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Assurance on the Effectiveness of Controls</th>
<th>Gaps in Control</th>
<th>Gaps in Assurance</th>
<th>Action Plans for Gaps</th>
<th>Risk/Action Plan Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <em>Safety Thermometer</em> data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <em>Observations of care</em> reviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient feedback via complaints &amp; claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Friends &amp; Family test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Incident reporting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trust Values</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quality Strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CQUIN &amp; Contract monitoring process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quality impact review process of all CIP plans.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Raising Concern policy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clinical governance meetings at service level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Benchmarked outcomes data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quality meetings between executives and CCGs/NHSI CQC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Appraisal / revalidation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• QA priorities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• STP and Regional Alliance involvement Care For You: Local population Engagement Quality Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reported elsewhere</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Annual nursing skill mix review (L1). Safe Staffing Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient and Staff Surveys (L2). PROMs (L3). GMC Trainee survey (patient safety) (L3). National Clinical Audits/ (L3).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Audit Committee Review Clinical Audit (L2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Board Assurance Framework (BAF) (L2)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extreme Risk Register (L2) Annual Internal Audit of Risk Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Control Gap:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Plan to be refreshed and monitored</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Implementation of Clinical Strategy to be further embedded.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Enhanced monitoring process to be developed to ensure local quality goals are attained.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Implementation of Developing Experience of Care Strategy 2017-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop a Recruitment Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref No.</td>
<td>Principal Risk Description</td>
<td>Key Controls</td>
<td>Sources of Assurance</td>
<td>Assurance on the Effectiveness of Controls</td>
<td>Gaps in Control</td>
<td>Gaps in Assurance</td>
<td>Action Plans for Gaps</td>
<td>Risk/Action Plan Owner</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>-------------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>• Poor NHSI Governance Risk Rating</td>
<td>Strategy CQC Improvement Plan CIP Programme Freedom to Speak Up Developing Experience of Care Strategy Clinical Strategy Operational Plan Quality Visits of Non-Executive and Executive Directors Fit &amp; Proper Persons’ Test Directors’ Code of Conduct Lack of Recruitment &amp; Retention Plan</td>
<td>(L3) Board Assurance Escalation Framework Education Provider Feedback on Medics Workforce and Organisational Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal Risk Description</td>
<td>Key Controls</td>
<td>Sources of Assurance</td>
<td>Assurance on the Effectiveness of Controls</td>
<td>Gaps in Control</td>
<td>Gaps in Assurance</td>
<td>Action Plans for Gaps</td>
<td>Risk/Action Plan Owner</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>---------------------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Principal Risk 5.</strong> Failure to attract and retain staff may result in:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Potential Cause:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Difficulty recruiting and retaining high-quality staff in certain areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low levels of staff satisfaction, health &amp; wellbeing and engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Insufficient provision of training, appraisals and development.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Potential Effect:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low levels of staff involvement and engagement in the trust’s agenda.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• High than average vacancy rates.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Failure to deliver required activity levels / poor staff effectiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Higher than average sickness rates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Potential Impact:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poor patient experience and outcomes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poor CQC assessment results.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poor patient survey results.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Loss of reputation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduced ability to embed new ways of working.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEO/Senior Team Visits CEO Focus Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Assurance on the Effectiveness of Controls**

- Reported to Board
  - Director of Workforce Reports to Board (L1).
  - Integrated Performance Report to the Board (L1).
  - Staff survey and values update work reported specifically and through Quarterly workforce reports (L1).
  - Annual H&S Report (L1)
  - HR & Workforce Report (L1)
- Adhoc reports to Board:
  - Staff Survey (L3)
  - Board Development (L1)
  - Board Induction (L2)
  - Corporate Induction (L2)
  - NHSI’s Single Oversight Framework- Workforce metrics Appraisal and PDRs
  - Staff Induction
  - Board Development
  - Strategy Board Development Workshops
  - Business Planning Cycle
  - Communication Strategy
  - Board Induction

**Gaps in Control**

- Lack of local in year feedback in relation to staff views / staff surveys
  - IPR to include information in relation to vacancy levels by CBU and by staff group
  - Temporary status of staff in leadership roles can have an adverse impact on staff engagement
  - Recruitment & Retention of staff. Strategy
- No formal comprehensive Exit Interview Procedure

**Action Plans for Gaps**

- Staff Communication & Engagement Strategy
  - Organisational Development Strategy
  - Survey Action Plans.
    - Value based interviewing project
  - Inability to finance key projects relating to staff development

- New Policy to be developed, approved, cascaded and embedded by 30 September 2017

- Workforce Strategy to be developed

- Succession Planning Strategy
  - CIP/Sustainability Plan
  - Communication & Engagement Strategy to be developed

- Work with NHIS to improve Recruitment and Retention

- Workforce a key part of the planning cycle

- Exit Interview Procedure

**Sources of Assurance**

- Regular reports to Board:
  - Integrated Performance Report (L1)
  - Annual H&S Report (L1)
  - HR & Workforce Report (L1)
- Adhoc reports to Board:
  - Staff Survey (L3)
  - Board Development (L1)
  - Board Induction (L2)
  - Corporate Induction (L2)
  - NHSI’s Single Oversight Framework- Workforce metrics
  - Appraisal and PDRs
  - Staff Induction
  - Board Development
  - Strategy Board Development Workshops
  - Business Planning Cycle
  - Communication Strategy
  - Board Induction

**Key Controls**

- Organisational Development Strategy
- Staff
  - Improved recruitment and induction processes.
  - Staff engagement and awareness programme in place.
  - Divisional Staff.
  - Education and development processes in place.
  - Appraisal compliance and training attendance monitored
  - Sickness Absence Policy
- Robust employment checks
- Disclosure Barring Service
- Professional Bodies Checks and Balances for clinicians

*Strategic Objective 5: Ensure staff feel valued in a culture of open and honest communication*
### Strategic Objective 6: Establish a stable leadership team, deliver a living, compassionate leadership in the Trust and embed a culture of openness & honesty

#### Principal Risk 6: Inability to provide direction and leadership may result in:

**Potential cause:**
- Ineffective leadership
- Inadequate management practice

**Potential Effect**
- In low staff morale.
- Poor outcomes & experience for large numbers of patients;
- Less effective teamwork;
- Reduced compliance with policies and standards;
- High levels of staff absence; and
- High staff turnover

**Potential Impact**
- Poor quality of patient service
- Poor recruitment and retention of staff
- Inability to provide viable patient care

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Principal Risk Description</th>
<th>Key Controls</th>
<th>Sources of Assurance</th>
<th>Assurance on the Effectiveness of Controls</th>
<th>Gaps in Control</th>
<th>Gaps in Assurance</th>
<th>Action Plans for Gaps in Assurance</th>
<th>Risk/Action Plan Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO2</td>
<td><strong>Inability to provide direction and leadership may result in:</strong></td>
<td>Trust’s Mission &amp; Values</td>
<td>Workforce &amp; Organisational Committee (L1)</td>
<td>Regular reports to Board:</td>
<td>Lack of local in year feedback in relation to staff views / staff surveys</td>
<td>Staff Engagement Strategy</td>
<td>CEO/ADHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training, education and development (TED) strategy &amp; programmes based on training needs analysis.</td>
<td>Staff Survey (L2)</td>
<td>• Integrated Performance Report (L1)</td>
<td>IPR to include information in relation to vacancy levels by CBU and by staff group</td>
<td>Workforce Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leadership and people management policies, processes &amp; professional support (including management training &amp; toolkits)</td>
<td>Staff Side Meeting with Management (L2)</td>
<td>• Annual H&amp;S Report (L1)</td>
<td>Temporary status of staff in leadership roles can have an adverse impact on staff engagement</td>
<td>Staff Survey Action Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff support and occupational health and wellbeing arrangements at Trust, CBU and service levels.</td>
<td>Trust’s Vision and Values (L2)</td>
<td>• HR &amp; Workforce Report (L1)</td>
<td>Recruitment &amp; Retention of staff.</td>
<td>New Conflict of Interest Guidance not yet formalised in an approved policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly and quarterly monitoring of workforce performance</td>
<td>Internal Audit Reports (L3)</td>
<td>Adhoc reports to Board:</td>
<td>Organisational Development Strategy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deep dive reports to Committee investigating specific issues when required. Staff communication</td>
<td>Fit and Proper Persons’ Test(FPPT) (L3)</td>
<td>• Staff Survey (L3)</td>
<td>Workforce Strategy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Directors’ Code of Conduct (L2)</td>
<td>• Board Development (L1)</td>
<td>Equality &amp; Diversity Policy Monitoring and reporting to Board and committees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Declaration of Interest for Board and Senior Managers (L2)</td>
<td>Board Induction (L2)</td>
<td>Engagement Policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Standard of Business Conduct and Conflict of Interest Policy (L2)</td>
<td>Corporate Induction (L2)</td>
<td>OD Strategy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gifts and Hospitality &amp; Commercial Interest Policy (L2)</td>
<td>NEDs Development (L2)</td>
<td>Develop and Implement R &amp; R Strategy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PDRs (L1)</td>
<td>Bi-Annual Staffing Report (L2)</td>
<td>Implement Work on above with NHSI’s Workforce Lead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Staff and Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref No.</td>
<td>Principal Risk Description</td>
<td>Key Controls</td>
<td>Sources of Assurance</td>
<td>Assurance on the Effectiveness of Controls</td>
<td>Gaps in Control</td>
<td>Gaps in Assurance</td>
<td>Action Plans for Gaps</td>
<td>Risk/Action Plan Owner</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>------------------------------------------</td>
<td>---------------</td>
<td>-----------------</td>
<td>---------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>Grievance &amp; Disciplinary Policies</td>
<td></td>
<td>Board of Directors Annual FPPT and Code of Conduct (L2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Freedom of Information Policy</td>
<td></td>
<td>Internal Audit Checks (L3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Protection Policy</td>
<td></td>
<td>Workforce &amp; OD Committee (L2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff Survey</td>
<td></td>
<td>Audit Committee (L3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>External Auditors Reports (L3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Counter Fraud Report to Audit Committee (L3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Declaration of Interests at every Board and Committees (L2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PUBLIC TRUST BOARD
4th October 2017

<table>
<thead>
<tr>
<th>Agenda Item (Ref):</th>
<th>TB212/17</th>
<th>Report Title:</th>
<th>Trust Board Extreme Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Lead</td>
<td>Sheila Lloyd, Director of Nursing and Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Officer</td>
<td>Mandy Power, Assistant Director Integrated Governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Required</td>
<td>☑ Note ☑ Approve ☑ Assure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key Messages of this Report & Recommendations:**
The risk register has been reviewed by the Risk leads and there are currently 14 risks on the Extreme risk register.
The Committee is asked to:
- Review the Risk Register
- Approve the changes that have been made to the Risk Register.

**Strategic Objective(s) (The content provides evidence for the following strategic objectives):**
- ☑ Lifelong integrated care
- ☑ Excellence in Treatment and Care
- ☑ Best Performance within Resources
- ☑ Develop Staff
- ☑ Organisational Sustainability

**Governance (the report supports a.....)**
- ☑ Statutory requirement
- ☑ Annual Business Plan Priority
- ☑ Linked to a Key Risk on BAF/HLRR
- ☑ Service Change
- ☑ Best Practice
- ☑ CQC standards
- ☑ National Reporting and Learning System (NRLS)

**Impact (is there an impact arising from the report on the following?):**
- ☑ Quality
- ☑ Finance
- ☑ Workforce
- ☑ Equality
- ☑ Risk
- ☑ Compliance
- ☑ Legal

**Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report):**
- ☐ Strategy
- ☐ Policy
- ☐ Service Change

**Next Steps (List the required actions following agreement by Board/Committee/Group):**
Monthly review of the Risks on the Risk register by the risk leads.
Quality & Safety Committee Extreme Level Risk Register

Within the Trust, there is one Risk Register which is a composite register of all risks across the Trust and includes all Business Units and departments across the Trust. The risk register is linked to the strategic objectives which have recently been updated across the Trust and within the risk register. The risks on the extreme risk register now link to more than one new Strategic Objective. The report has been presented with the objectives listed.

All owners of extreme risks have been contacted to review the risk prior to submission of the risk register to the Quality and Safety Committee to ensure the risk and actions are up to date. Some risks are showing out of date and require updates on actions. The review of the whole risk register is an ongoing piece of work with the relevant leads and Business Units, this is scheduled over 4 dates in October.

All Extreme level risks have been reviewed across the Trust in order to ensure the Quality & Safety Committee are cited of all the current extreme level risks (above 15), as described in the Risk escalation processes reflected in the Trust Risk Management Strategy. There are currently 14 Risks aligned to the Quality and Safety Committee. This risk register was run on 27th September.

1. New risks to the Extreme Level Risk Register

<table>
<thead>
<tr>
<th>Risk ID No</th>
<th>Title of the Risk</th>
<th>Current Risk level</th>
<th>Target Risk level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1614</td>
<td>Cyber attack may impact diagnostic services affecting patient care delivery</td>
<td>Extreme Risk</td>
<td>High level risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Catastrophic 5</td>
<td>Catastrophic 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Possible 3 =15</td>
<td>Unlikely 2 =10</td>
</tr>
</tbody>
</table>

Reason for new risk

A cyber attack may impact diagnostic imaging devices because they run embedded Microsoft operating systems. Many of the devices are running legacy versions due to the age of the devices and these cannot be patched easily (without supplier support). Furthermore remediation of infection or imminent risk of infection is dependent on the system supplier/ vendor and this may incur prolonged impact of downtime.

2. Reduced Risks in month

No new extreme risks reduced on the risk register since the last meeting of the Quality and Safety Committee.

3. Risks closed in month

No closed extreme risks since the last Quality and safety Committee.

4. Recommendations

The Quality & Safety Committee is requested to:

- Review the Risk Register
- Approve the changes that have been made to the Risk Register.
- Review the strategic objectives aligned to the risks.
- Note the ongoing work through October on the composite risk register to align reporting structures to the Risk register.

Page 129 of 190
## Trust Board Risk Register

### Strategic Objective
- **SO1**: Design, deliver and lead in partnership, sustainable safe quality services based on current and future needs of local people.
- **SO3**: Deliver the best possible performance within available resources

### Link to BAF
- BAF002

### Opened ID ADO/Exec Lead Risk Lead Title
10/05/2016 1327 Director of Finance Head of Facilities Replacement medical equipment programme

### Description
The Trust needs to have a 3 year rolling programme for replacement medical equipment to enable sufficient capital resources to be allocated otherwise the quality of patient care may be compromised.

### Controls
- 2 policies, 1 for training, 1 for ownership
- Medical Devices Committee
- CAS Alerts Process for managing medical device alerts
- Planned asset replacement cycle prioritised over 3 years.
- Capital Investment Group established and meet up every month. This is led by the Director of Finance.
- Equipment register (RAM software)
- NHSI only allowing spending from internally generated sources.

### Gaps in Controls
- Asset register not complete
- Planned 3 year medical equipment programme based on the equipment register (RAM) not yet complete.

### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely (4)</td>
<td>Major (4)</td>
<td>16</td>
<td>16</td>
<td>Extreme risk</td>
<td>6</td>
<td>Moderate risk</td>
<td>07/09/2017</td>
<td>18/09/2017</td>
</tr>
</tbody>
</table>

### Assurance
- CAS alerts presented to Q and S Committee
- Capital Investment Group (CIG) monthly meeting
- Finance, Performance & Investment Committee who receive the minutes from the CIG meeting.

### Gaps in Assurance
- MIAA action plan

### Action Plan
- Introduction of a rolling 3 year replacement programme for medical equipment. This will be monitored through Capital Investment Group.
- Further checks need to be completed by all users to reconcile their actual holding of medical devices against the list for their area from the RAM system.

### Action Plan Due Date
- 31/12/2016
- 30/06/2017

### Action Plan Rating
- Moderate Progress Made

---

*Notes:
- Trust Board Risk Register
- Southport and Ormskirk Hospital
- NHS Trust*
**Strategic Objective**: SO3 Deliver the best possible performance within available resources

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/05/2016</td>
<td>1329</td>
<td>Director of Finance</td>
<td>Director of Finance</td>
<td>Returning to financial balance by 2021</td>
</tr>
</tbody>
</table>

**Description**: If we do not have a plan to return to financial balance by 2021, then potentially the Organisation will not exist in its current form.

**Controls**: We now have a long term financial model and an estate solution from the Deloitte sustainability report. The Care for You programme will build on the Deloitte work with a view to achieving a more financially sustainable service. Trust is part of the Cheshire & Mersey STP and a member of the Alliance local delivery system (LDS) implementing the 5 year forward view locally.

**Gaps in Controls**: We need to feed the STP/LDS assumption into our LTFM. We need to update LTFM for 2016/17 outturn and 2017/18 plan.

**Risk Levels**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely (4)</td>
<td>Major (4)</td>
<td>16</td>
<td>16</td>
<td>Extreme risk</td>
<td>6</td>
<td>Moderate risk</td>
<td>08/09/2017</td>
<td>18/09/2017</td>
</tr>
</tbody>
</table>

**Assurance**: Monthly report to Trust Board re STP and Alliance Transformation Committee. Work with the Alliance LDS and the Cheshire & Mersey STP.

**Gaps in Assurance**: No agreed clinical model for reconfiguration of services within the STP.

**Action Plan**

- Development of Estate plan for reconfiguration of services; identification of land sales to support capital development costs.
- Development of a financial revenue plan with savings for the reconfiguration of services.
- Submission of Trust 2 year operational plans by 23/12/16.
- Submission of STP plan.

**Action Plan Due Date**: 01/09/2017
- 23/12/2016
- 16/10/2016

**Action Plan Rating**: Moderate

**Progress Made**: Completed

**Completed**
### Strategic Objective SO2

**Empower and develop our people to deliver continuous service improvement (safe).**

<table>
<thead>
<tr>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1366</td>
<td>Director of HR</td>
<td>Assistant Director HR</td>
<td>Mandatory and Job Specific Training Compliance</td>
</tr>
</tbody>
</table>

**Opened Date:** 22/09/2016

**Description:** If the current levels of mandatory and job specific training do not improve then the Trust will not achieve its target of 90% compliance. The compliance target was amended to 85% at the Trust Board in March 2017.

**Controls:**

- All mandatory training attendance sheets and readers that are returned to the Training Department are recorded prior to the next report (5th of following month)
- Reports are pulled within 5 days of end of previous month to ensure data as real time as possible
- Raised SR for OLM system issue - system failure to update competence if learner refreshes above 1 month in advance - awaiting IBM response
- Courses advertised via Trust News (every Thursday)
- You Choose dates available - sufficient places offered
- Reader available for most courses to supplement face to face training
- Increase in the number of M&H and conflict resolution courses to provide sufficient places
- Recruitment of a permanent ESR Administrator to the team (Dec 2016)
- Launch of ESR Manager Self Service Training (February 2017) - to improve compliance monitoring online for managers
- Launch of ESR Employee Self Service (July 2017) all staff and manager will have individual access to view their mandatory training record, book directly online and access eLearning for core mandatory training due to launch in October 2017 - improved accessibility 24/7 from any pc or mobile device
- Due to the unfilled vacancy, the Head of E&T will undertake a review of workload in the department and subjects not monitored by the Board will be removed from the workload.
- New process in place for new starters/job profiles to the Trust to ensure accurate alignment of competences to new job profiles

**Gaps in Controls:**

- Training Administrator left the Trust Sept 2017 - StH&K not replacing
- The band 7 budget approved to support the delivery of mandatory training has now been navigated towards the recruitment of an OD Manager (Sept 2017)
- Regular changes to workforce structures in ESR impacts on monthly reports
- Insufficient number of training administrators to manage the increasing volume of mandatory training data management alongside other Trust priorities/requirements/expectations on the department

**Risk Levels**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely (4)</td>
<td>Major (4)</td>
<td>16</td>
<td>16</td>
<td>Extreme Risk</td>
<td>6</td>
<td>Moderate risk</td>
<td>18/09/2017</td>
<td>18/10/2017</td>
</tr>
</tbody>
</table>

**Assurance:**

- Performance data being monitored through Trust Board monthly
- PERS 43 Induction & Mandatory Training Policy
- Quarterly HRD Report to Board
- Managers are accountable for mandatory training as per Mandatory Training policy
- New educational governance structure agreed June 2017 - Mandatory training to be monitored quarterly at the Trust Education Committee (commences Sept 2017)
- Weekly mandatory training reports sent to HRD for monitoring purposes

**Gaps in Assurance:**

- Removal of staff and DNA mandatory training reports from publication on intranet has had a significant impact on the ability to share real time data with managers - insufficient capacity in training department to circulate CBU/departmental reports

**Action Plan:**

- To ensure effective governance arrangements are in place and escalation of issues is managed effectively
- ESR Administrator to develop current RAG reports to remove anomalies and ensure data accuracy.
- To develop RAG reports for all job specific training
- To develop communication methods which inform staff of all training requirements and their role and responsibilities
- To further expand the training needs analyses to cover job specific mandatory training i.e. DoLS, MCA, medicines management, IV dugs, venepuncture, ANTT, resuscitation etc
- To develop the induction processes identified in the revised policy and embed them in the E&T team daily/monthly work programmes
- To adopt & implement the RoSTA assessment system from HENW to monitor student & junior doctors

**Action Plan Due Date**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/2016</td>
</tr>
<tr>
<td>01/09/2016</td>
</tr>
<tr>
<td>01/11/2017</td>
</tr>
<tr>
<td>31/03/2017</td>
</tr>
<tr>
<td>31/05/2017</td>
</tr>
<tr>
<td>02/10/2017</td>
</tr>
<tr>
<td>31/07/2017</td>
</tr>
</tbody>
</table>

**Action Plan Rating**

- Completed
- Completed
- Completed
- Moderate
- Progress Made
- Completed
- Moderate
- Progress Made
- Completed
- Completed
<table>
<thead>
<tr>
<th>mandatory training</th>
<th>22/12/2017</th>
<th>Moderate</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that all processes have a SOP accessible to relevant staff in the department</td>
<td>01/11/2017</td>
<td>Progress Made</td>
</tr>
<tr>
<td>To increase capacity and skill mix within the training department to fully staff the service</td>
<td>01/11/2016</td>
<td>Completed</td>
</tr>
<tr>
<td>To improve manager's effectiveness in the management of mandatory training</td>
<td>01/09/2017</td>
<td>Moderate</td>
</tr>
<tr>
<td>To allow for 24 hour access to mandatory training online for staff to remain compliant</td>
<td>29/09/2017</td>
<td>Progress Made</td>
</tr>
<tr>
<td>To review with SME's a backfill process to ensure business continuity</td>
<td>31/10/2016</td>
<td>Completed</td>
</tr>
<tr>
<td>Increase access to training through the implementation of eLearning options for 24 hour access to reduce DNA's.</td>
<td>Completed</td>
<td>Little or No Progress Made</td>
</tr>
<tr>
<td>To work with Cheshire &amp; Merseyside streamlining project to deliver pre-hire mandatory training, reduce time to hire, &amp; reduce repetitive mandatory training through IAT management.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Strategic Objective

**SO4** Delivering and living compassionate leadership throughout the Trust.

**SO5** Establish a culture of open and honest communication for all.

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>22/09/2016</td>
<td>1367</td>
<td>Director of HR</td>
<td>Assistant Director HR</td>
<td>Failure to have a motivated and engaged workforce (culture).</td>
</tr>
</tbody>
</table>

**Description**
If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, high turnover.

#### Controls
- Leadership Master Classes
- Annual Pride Awards
- Workforce Strategy
- Junior Doctors Survey
- Engagement and Culture Strategy
- Equality and Diversity Working Group
- New post created for support of records system, recruitment process is on going.

#### Gaps in Controls
- Uncertainty of CEO post

#### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely (4)</td>
<td>Major (4)</td>
<td>16</td>
<td>16</td>
<td>Extreme risk</td>
<td>8</td>
<td>High Risk</td>
<td>07/09/2017</td>
<td>28/09/2017</td>
</tr>
</tbody>
</table>

#### Assurance
- Quarterly HRD report to Trust Board
- Result of Staff Attitude Survey
- Coaching in the workplace
- Values based recruitment based on guidance from NHS England
- PDR Process which includes Trust values
- Charter for Staff and Managers
- Review of culture in the Trust, being carried out by external adviser. HR Director agreed extension of project, report is expected in February 2017.

#### Gaps in Assurance
- Nil Identified

#### Action Plan
- Cultural Review as commissioned by the Board

<table>
<thead>
<tr>
<th>Action Plan Due Date</th>
<th>Action Plan Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/10/2017</td>
<td>Actions Almost Completed</td>
</tr>
</tbody>
</table>
### Strategic Objective

SO1 Design, deliver and lead in partnership, sustainable safe quality services based on current and future needs of local people.

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>22/09/2016</td>
<td>1368</td>
<td>Director of HR</td>
<td>Director of HR</td>
<td>Safe Staffing Levels - Impact on Quality and Finance</td>
</tr>
</tbody>
</table>

### Description

If the Trust is not able to attract and recruit nursing and medical staff with the knowledge, skills and experience required there is a risk to the Trust of not providing safe levels of staffing and an impact on finance due to reliance on agency staff.

### Controls

- Introduction of a nationally capped rate for agency for both medical and nursing staff
- Policies and processes around bank/agency staff usage
- Development of a nurse bank in conjunction with existing NHSP bank supply
- Edge Hill additional cohort for training nurses
- Executive oversight at weekly meetings
- Monthly review at FP & I Committee
- Monthly review at Board
- Individual authorisation of requests above cap for agency staff
- Strategic Alliances with other health care providers
- Targeted advertising campaign for qualified nursing staff (HEI)
- Workforce planning methodology agreed
- Planned recruitment campaigns agreed
- NHSP cohorts for HCA recruitment
- Recruitment and Selection Policy
- Assistant Director of Nursing role leads on Nurse recruitment
- Discussions with Southport College regarding "Acorns" project for Nurse development
- Consider joint consultant appointments with local partners, either in specialty units or within the Local Delivery Service framework

### Gaps in Controls

- Draft HR Strategy requires approval
- Further work to be commenced around more robust workforce planning, engaging service managers.
- Continuing staff groups that are difficult to recruit to requiring different solutions

### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely (4)</td>
<td>Major (4)</td>
<td>20</td>
<td>16</td>
<td>Extreme risk</td>
<td>9</td>
<td>High Risk</td>
<td>07/09/2017</td>
<td>21/09/2017</td>
</tr>
</tbody>
</table>

### Assurance

- Monitoring of fill rates of bank and agency staff through weekly ED meetings
- Monitoring of fill rates through monthly Trust Board
- Shared arrangements with other Trusts for Consultant posts
- Agency Spend Review Undertaken. Project Co-Ordinator appointed for 6 months to progress actions
- Monitoring of Recruitment Action Plan through quarterly HR Report to Trust Board
- Workforce Plan submitted to HE England as approved by the Medical Director.
- Ongoing targeted advertising campaigns.
- Trust HR Governance Committee provided with information on Workforce Plan
- Nurse recruitment campaigns in Higher Education institutes. DON working with NHSP
- Joint appointments for Senior Consultant with St Helens & Knowsley Hospital NHS Trust, Liverpool Heart & Chest
- Exit interview process review carried out, with action plan as a result.
- 2017 - 2019 Workforce Plan submitted to NHSI

### Gaps in Assurance

- Status of workforce plan

### Action Plan

```markdown
<table>
<thead>
<tr>
<th>Action Plan</th>
<th>Action Plan Due Date</th>
<th>Action Plan Rating</th>
</tr>
</thead>
</table>
```
Strategic Objective | SO3 Deliver the best possible performance within available resources.
---|---
Description | Inception of modern job planning for consultants and SAS doctors, produces a potential on going risk to the Trust, with the additional risk of back pay. Aggregate increased PA's, for consultants is 27. SAS job planning on going scheduled to complete November 2016, may increase financial pressure. March 2017: significant financial commitment to prospective recognition of all additional PAs identified. Back pay issue not yet agreed - meeting to be held in early April with consultant representatives to discuss. April update: meeting held with consultant reps. Agreed to honour new job plans prospectively. Further information to be gathered about potential cost of backdating pay to when job plans were originally agreed with CDs, and further meeting planned to discuss when potential costs are clearer.
 | Update 25/05/17 (Paul Mansour): potential back-pay costs still being evaluated. Next meeting with LNC and MSC chairs due mid-June to assess likely cost and agree reasonable way forward.
 | Update 27/06/2017 (Paul Mansour): meeting has not yet taken place. PM will ask about the cause of the delay.
 | Update 07/08/17: meeting with LNC reps still awaited.
 | Update 06/09/17 (Paul Mansour): CEO organising meeting for end of October.

Controls | Review of job plans by COO, EMD & DoF during December 2016, aligned to business planning. Development of new job planning policy September 2017
---|---
Risk Levels | Likelihood | Consequence | Risk Rating (Initial) | Risk Rating (Current) | Risk Level (Current) | Risk Rating (Target) | Risk Level (Target) | Date of Last Review | Date of Next Review
---|---|---|---|---|---|---|---|---|---
Likely (4) | Major (4) | 16 | 16 | Extreme risk | 6 | Moderate risk | 06/09/2017 | 06/10/2017

Assurance | To be monitored through existing business management processes, with reports to EMT & FP&I Committee
---|---

Action Plan | Job plans to be agreed by 28/02/2017
---|---
Action Plan Due Date | 28/02/2017
Action Plan Rating | Completed
---|---
### Strategic Objective
SO1 Design, deliver and lead in partnership, sustainable safe quality services based on current and future needs of local people.

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/01/2006</td>
<td>385</td>
<td>Chief Operating Officer</td>
<td>Matron A &amp; E</td>
<td>Mental Health Patients Attending A&amp;E</td>
</tr>
</tbody>
</table>

**Description**
If timely psychiatric assessments are not provided to A&E patients, then there is an increased risk of harm to the patient and failure to meet performance targets.

**Controls**
- If assessment delayed patients requiring on-going physical health care & monitoring are admitted to Obs ward as clinically appropriate
- Partnership agreement between Merseycare and Lancashire care in place
- Adhere to NICE guidelines for mental health patients
- Patients nursed in observable location in A&E
- Consider use of friends and family to support transfer if appropriate
- Staff training in dealing with sections of Mental Health Act
- Information/ mental health section box available in A&E for use by all staff
- SLA with Mersey Care to provide assessment service at SDGH
- Locally agreed RAG rated police attendance for 136 patients
- Staff attend Trust conflict resolution training
- Dedicated mental health room now available for section 136 patients and other patients requiring mental health assessment
- 24/7 Security in place

**Risk Levels**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible (3)</td>
<td>Catastrophic (5)</td>
<td>20</td>
<td>15</td>
<td>Extreme risk</td>
<td>10</td>
<td>High Risk</td>
<td>16/08/2017</td>
<td>19/09/2017</td>
</tr>
</tbody>
</table>

**Assurance**
- Breach analysis of waits for mental health patients in A&E
- Escalation process
- Mental Health Group

**Gaps in Assurance**
- Details of SLA and inability to hold Mersey care to account
- No Trustwide operational lead for Mental Health
- No Trustwide plan

**Action Plan**
- Mersey care are applying for additional funding to increase service provision at Southport A&E
- Identify Trust lead to represent S&O Trust at local provider meetings
- The Service level agreement with Mersey care requires review and renegotiation
- Funding for Security 24/7 to be secured for consistent presence in A&E

**Action Plan Due Date**
- 23/08/2017
- 31/10/2017
- 19/12/2017
- 30/06/2017

**Action Plan Rating**
- Completed
- Actions Almost Completed
- Moderate
- Progress Made
- Completed
### Strategic Objective

**SO1** Design, deliver and lead in partnership, sustainable safe quality services based on current and future needs of local people.

**SO3** Deliver the best possible performance within available resources.

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/07/2012</td>
<td>482</td>
<td>Chief Operating Officer</td>
<td>Matron A &amp; E</td>
<td>No Outflow from AED for Admitted Patients</td>
</tr>
</tbody>
</table>

#### Description

No outflow from AED for admitted patients.

Resulting in:
- Delays offloading Ambulances
- Delays in clinical assessment and treatment
- Potential for Serious Untoward incident occurring whilst waiting for assessment/treatment and/or bed.

#### Controls

- Emergency Department escalation policy
- Request for diverts from UCAT
- Open escalation beds
- Consider suitability for AEC
- Ensure all aspects of community support is available
- Implementation of A/E site performance action plan
- Monitor ambulance turn around times
- Pilot for ED safety checklist with Patient Safety Collaborative
- Intentional Rounding in place for patients in ambulance queue
- Daily huddle at 11am focusing on performance and ward discharges to improve discharges and flow

#### Gaps in Controls

- Limit to the number of trolleys which we have the capacity to accept from NWAS crews
- Delay to see patient may cause harm to the patient
- Real time data

#### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible (3)</td>
<td>Catastrophic (5)</td>
<td>25</td>
<td>15</td>
<td>Extreme risk</td>
<td>5</td>
<td>Moderate risk</td>
<td>29/08/2017</td>
</tr>
</tbody>
</table>

#### Assurance

- Policies and procedures
- 3 x daily Trust escalation meetings/bed meetings
- Real time staffing levels assessed daily by Matron
- CBU Governance meetings
- HARM meetings 1/52
- ED performance meetings

#### Gaps in Assurance

#### Action Plan

- Review of discharge medicines pathway to be undertaken by ECIP
- Trial of patient transfer Nurse
- Develop case for Discharge Lounge and implement discharge lounge model
- Options for implementing real-time information management should be explored to increase visual management and minimise the slow process of hunting and gathering data by senior staff. An electronic bed management system may support this and an options
- Matrons to attend at least 2 board rounds per week to coach and provide managerial support.
- Establish and Embed a ready for Discharge Forum
- Introduction of ED Safety Checklist with support from Patient Safety Collaborative
- Test pilot the model for using red/green days on Wards 14a and 14b
- Home for Lunch.

#### Action Plan Due Date

| 28/06/2017 | 30/06/2017 | 31/06/2017 | 30/07/2017 | 31/07/2017 |
| 30/06/2017 | 31/07/2017 | 29/08/2017 | 31/08/2017 | 29/09/2017 |
| 29/09/2017 | 29/09/2017 | 30/09/2017 | 31/09/2017 | 01/10/2017 |

#### Action Plan Rating

- Completed
- Completed
- Completed
- Progress Made
- Progress Made
- Completed
- Completed
- Completed
- Moderate
- Moderate
- Progress Made
- Progress Made
### Strategic Objective

**SO3** Deliver the best possible performance within available resources.

**Link to BAF** BAF011

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/05/2016</td>
<td>1328</td>
<td>Director of Finance</td>
<td>Director of Finance</td>
<td>Reliance on external cash support</td>
</tr>
</tbody>
</table>

**Description**

If the Trust continues to borrow over plan, then the Trust may have insufficient cash to meet its current liabilities.

**Controls**

- Monthly loan applications to NHSI/DH
- Daily cashbooks received and weekly forecasts used to ensure we don't go overdrawn.
- Three main CCGs - Southport & Formby, West Lancashire and South Sefton pay contract invoices on 1st working day of the month.
- Debt levels monitored constantly with the aim to have greater than 90 day debt under 5% of total debt.
- Financial controls on income/expenditure and capital
- Thirteen week rolling cash flow forecast sent to NHS Improvement (NHSI) every month.

**Gaps in Controls**

Trust does not have a plan for 2017/18 that meets its control total and therefore cannot access Sustainability & Transformation funding of £4.9m.

<table>
<thead>
<tr>
<th>Risk Levels</th>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible (3)</td>
<td>Catastrophic (5)</td>
<td>15</td>
<td>15</td>
<td>Extreme risk</td>
<td>6</td>
<td>Moderate risk</td>
<td>07/09/2017</td>
<td>18/09/2017</td>
<td></td>
</tr>
</tbody>
</table>

**Assurance**

Monthly monitoring with DH and NHSI
Finance, Performance & Investment Committee review.

**Gaps in Assurance**

- Trust does not have a plan for 2017/18 that meets its control total and therefore cannot access Sustainability & Transformation funding of £4.9m.

**Action Plan**

- Develop 2 year Financial Recovery Plan with robust cost improvement plans
- Receiving guidance from NHSI on external cash. Now submitting loan requests on a monthly basis.

**Action Plan Due Date**

- 01/09/2017
- 31/03/2017

**Action Plan Rating**

- Little or No Progress Made
- Completed
## Strategic Objective

**SO3** Deliver the best possible performance within available resources.

### Description

Stranded overhead costs remaining with the Trust which has a negative impact on our financial position.

### Controls

- Review of March 2017, Corporate Benchmarking (NHSI) and reviewed with Corporate leads to identify potential savings.
- Review overhead cost base including Estates and Facilities, and opportunities to scale back Trust overheads.
- Review the normalised monthly spend at the end of July 2017 (as 3 months data will be available following transfer on 01/05/2017).

### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Certain (5)</td>
<td>Moderate (3)</td>
<td>15</td>
<td>15</td>
<td>Extreme risk</td>
<td>6</td>
<td>Moderate risk</td>
<td>07/09/2017</td>
<td>18/09/2017</td>
</tr>
</tbody>
</table>

### Assurance

- Monitoring of CIP programme by FP&I Comm

### Action Plan

- Audit of identified stranded costs
- To initiate stranded overheads work stream to address issues, including engagement with STP.
- To reassess the level of stranded overhead costs in August 2017, following publication of July 2017 financial position.

### Action Plan Due Date

- 30/06/2017
- 31/03/2018
- 31/08/2017

### Action Plan Rating

- Moderate
- Progress Made
- Little or No Progress Made
### Strategic Objective

**SO1** Design, deliver and lead in partnership, sustainable safe quality services based on current and future needs of local people.

**SO3** Deliver the best possible performance within available resources.

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>26/06/2017</td>
<td>1570</td>
<td>Chief Operating Officer</td>
<td>Matron paeds</td>
<td>Limited out of hours cover from West Lancashire CAHMS service</td>
</tr>
</tbody>
</table>

#### Description

Inequity of CAHMS service provision across West Lancashire. Sefton provision includes cover 24 hours per day 7 days a week whilst West Lancashire has limited hours. Gaps in service include:

- **Monday - Friday 9pm - 9am** no provision
- **Weekends & Bank Holidays no attendance to ward to assess child after 2pm until 9am next day**
- CAHMS service will not always attend to assess child until behaviour is deescalating
- CAHMS sickness absence not covered

This results in risks to:

- Safety of child when behaviour escalates
- Risk to staff in managing child
- Risk to other patients and families
- Risk to environment due to damage

#### Controls

Maintain security in the ward and provision of 1:1 staff in the event of a CAHMS patient

Sefton CAHMS provide crisis and emergency out of hours support as appropriate

Conflict resolution training for staff in place

Staff adhere to conflict resolution policy

Out of hours on site security and police called as necessary

All CAHMS patients have risk assessment completed

CAHMS training identified for staff

West Lancs provide sat and sun 10am to 6pm outside of this EDT needs to be contacted who obtain advice/support from the in-patients unit at the cove

#### Gaps in Controls

No robust process in place for managing CAHMS in West Lancashire out of hours

Restraint policy in draft because corporate view regarding training in process

No secure room in which to manage child

#### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible (3)</td>
<td>Catastrophic (5)</td>
<td>20</td>
<td>15</td>
<td>Extreme risk</td>
<td>4</td>
<td>Moderate risk</td>
<td>12/09/2017</td>
<td>11/10/2017</td>
</tr>
</tbody>
</table>

#### Assurance

Review of incidents and lessons learnt

Review of clinical records regarding risk assessment completed

Secure room plans passed, funding in place and building work to commence Sept 2017

#### Gaps in Assurance

No cover provided out of hours to support CAHMS children

#### Action Plan

- CAMHS link worker to work with the Mental Health Practitioners and CCG, to improve service and training
- Risk assessments completed on all patients on admission. 1:1 care provision as identified on RA

Conflict Resolution training

Funding has been secured from CCG, plans have been passed

#### Action Plan Due Date

- 11/09/2017
- 11/09/2017
- 11/08/2017
### Strategic Objective

**SO3** Deliver the best possible performance within available resources.

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>22/08/2017</td>
<td>1614</td>
<td>Chief Operating Officer</td>
<td>Head of IM &amp; T</td>
<td>Cyber attack may impact diagnostic services affecting patient care delivery</td>
</tr>
</tbody>
</table>

#### Description

A cyber attack may impact diagnostic imaging devices because they run embedded Microsoft operating systems. Many of the devices are running legacy versions due to the age of the devices and these cannot be patched easily (without supplier support). Furthermore remediation of infection or imminent risk of infection is dependent on the system supplier/ vendor and this may incur prolonged impact of downtime.

#### Controls

- Documented asset list for each diagnostic device
- Remediation plan / business continuity arrangements for instances of downtime
- Agreed funding / Capital investment plan to replace legacy diagnostic devices
- Effective supplier management / support arrangements
- Clearly identified Information Asset Owner within Radiology and effective management of devices

#### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible (3)</td>
<td>Catastrophic (5)</td>
<td>15</td>
<td>15</td>
<td>Extreme risk</td>
<td>12</td>
<td>High Risk</td>
<td>08/09/2017</td>
<td>09/10/2017</td>
</tr>
</tbody>
</table>

#### Assurance

- Review of IMT risks at IMT programme board
- Review of risks within Radiology CBU meetings
- Updated Radiology BCP plans approved at Resilience group
- MIAA audit of diagnostic IT resilience and support arrangements

#### Gaps in Controls

Understanding within IT of the priority devices and configuration/ infrastructure dependencies

#### Action Plan

**Action Plan Due Date**

**Action Plan Rating**
Strategic Objective

| SO1 | Design, deliver and lead in partnership, sustainable safe quality services based on current and future needs of local people. |
| SO2 | Empower and develop our people to deliver continuous service improvement (safe). |
| SO3 | Deliver the best possible performance within available resources. |
| SO4 | Delivering and living compassionate leadership throughout the Trust. |
| SO5 | Establish a culture of open and honest communication for all. |

| Link to BAF | BAF003 |

Opened | ID | ADO/Exec Lead | Risk Lead | Title |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>26/09/2016</td>
<td>1362</td>
<td>Director of Nursing &amp; Quality</td>
<td>Deputy Director Nursing</td>
<td>CQC Registration</td>
</tr>
</tbody>
</table>

Description
If the Trust fails to respond to the CQC report in relation to areas of non compliance identified, then patient safety and experience will not improve.

Controls
Support from an external consultant to formulate action plans for each CBU, arising from report of inspection in April 2016. Action plans reviewed and agreed by Executive Team. Supportive measures with planned care. Embedding the structure and holding to account. Commitment to complete MUST DO’s by June 2017. Commitment to complete SHOULD DO’s by December 2017.

Gaps in Controls
Delay in Estates plan to complete and embed recommendations in relation to Dementia friendly site. Adequate storage facilities on some wards.

Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely (4)</td>
<td>Major (4)</td>
<td>16</td>
<td>16</td>
<td>Extreme risk</td>
<td>4</td>
<td>Moderate risk</td>
<td>07/09/2017</td>
</tr>
</tbody>
</table>

Assurance
Q&S Committee Dashboard / balanced scorecard monthly to Q&S. Monthly review of CQC action plan. Monthly relationship meeting with CQC. External review of services (CQC, NHSI, NHSE). Divisional Governance meetings. Assurance on the effective implementation of CBU action plans to be received by Quality & Safety Committee. All must do actions, will be completed by the end of June 2017, with the exception of those that have been escalated to the Trust Board. Annual self assessment of required improvements submitted to CQC 30/07/2017.

Gaps in Assurance
Delivering the schemes estate. Security provision. Staffing.

Action Plan
Weekly CQC action planning meetings via telephone or meetings. To carry out peer review of evidence of completion of actions. Quality visits to be carried out to evidence completion of MUST do’s. CCG, NHSI to carry our a review of MUST DO’s. Standard Operating procedure to be put in place. KPI framework put in place and demonstrate compliance with CQC actions. Development of a CQC compliance dashboard.

Action Plan Due Date

<table>
<thead>
<tr>
<th>Action Plan Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/10/2017</td>
</tr>
<tr>
<td>31/08/2017</td>
</tr>
<tr>
<td>01/10/2017</td>
</tr>
<tr>
<td>01/10/2017</td>
</tr>
<tr>
<td>24/05/2017</td>
</tr>
<tr>
<td>30/06/2017</td>
</tr>
<tr>
<td>19/06/2017</td>
</tr>
</tbody>
</table>

Action Plan Rating
### Strategic Objective

**SO1** Design, deliver and lead in partnership, sustainable safe quality services based on current and future needs of local people.

**Link to BAF**

<table>
<thead>
<tr>
<th>Opened</th>
<th>ID</th>
<th>ADO/Exec Lead</th>
<th>Risk Lead</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/02/2017</td>
<td>1491</td>
<td>Chief Operating Officer</td>
<td>Radiology Manger</td>
<td>Lack of Chaperones For Sonographers Performing Intimate Examinations</td>
</tr>
</tbody>
</table>

### Description

If the Sonographers do not have a the availability of a chaperone to offer patients when performing intimate ultrasound examinations then it leaves Sonographers at risk of alleged inappropriate behaviour continued anxiety and distress of staff members and patients undergoing procedures without the presence of an independent third party.

### Controls

Radiology Department Assistants being redirected where possible for use in intimate Sonographer examinations, from under utilised Radiologist Ultrasound capacity at ODGH due to Radiology Consultant vacancies. Business case has been completed regarding proposal to increase the radiological establishment in order to facilitate chaperones for intimate procedures. Trust wide chaperone policy in place. The latest guidance from the Society of Radiographers and Royal College of Radiologists - published 05/05/16.

### Gaps in Controls

- Current establishment of Radiology Department Assistants does not allow provision of chaperones for Sonographers performing intimate examinations.
- Current practice in ultrasound does not comply with the Trust Chaperone Policy (CLIN CORP 63).
- Current practice does not comply with the latest guidance from the Society of Radiographers and Royal College of Radiologists - published 05/05/16.
- Radiology Department Assistant recruitment, retention and sickness.
- HCA's being provided from NHSP for chaperoning has been withdrawn until Business case decided.

### Risk Levels

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Consequence</th>
<th>Risk Rating (Initial)</th>
<th>Risk Rating (Current)</th>
<th>Risk Level (Current)</th>
<th>Risk Rating (Target)</th>
<th>Risk Level (Target)</th>
<th>Date of Last Review</th>
<th>Date of Next Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely (4)</td>
<td>Major (4)</td>
<td>20</td>
<td>16</td>
<td>Extreme Risk</td>
<td>8</td>
<td>High Risk</td>
<td>13/09/2017</td>
<td>13/10/2017</td>
</tr>
</tbody>
</table>

### Assurance

This risk will be reviewed and monitored on a monthly basis at the Radiology Management Meeting. This risk will be reported and monitored on a monthly basis to the Planned Care Governance committee.

### Gaps in Assurance

### Action Plan

See progress notes and attached document. Awaiting feedback from college staff and lead in apprenticeships LD as to whether there is an apprenticeship framework option that fits the job description of a radiographic imaging assistant/chaperone. Apprenticeship involves 20% off-job training and levy does not cover wages. JW to discuss option of apprentice for role of chaperone in ultrasound. To decide if we use apprentices as radiology chaperones?

### Action Plan Due Date

<table>
<thead>
<tr>
<th>Date</th>
<th>Action Plan Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/08/2017</td>
<td>Moderate</td>
</tr>
<tr>
<td>03/08/2017</td>
<td>Progress Made</td>
</tr>
</tbody>
</table>

### Action Plan Rating

- Moderate
- Progress Made
The Intelligent Board, NHS Governance Handbook and respected governance organisations like the Good Governance Institute and good practice recommend that good governance and decision making are enhanced when boards receive the right information in the right format and on time.

Having an Annual Business Cycle of activities for the board and its committees enable these to be realized.

Attached is an Annual Business Cycle for the Board and its statutory and assurance committees (The Workforce & Organisational Committee and the Mortality & Clinical Improvement Committee cycle will be sent later ahead of the Board meeting) from October 2017 to March 2019. Some of these will be subject to change as new directives are issued from the Centre, contingencies arise and local needs dictate. Notwithstanding those, the Business Cycle aids in agenda planning and enable directors and their direct reports to plan ahead and submit their papers and reports on time.

We are finalizing the dates for the Board and committees for the same period and the full list will be brought to the November board but individual committees meeting before the November Board will receive theirs when they meet for review.

The updated Governance Structure is also attached showing:

- The Board
- Regulators and Partners
- Committees and Groups reporting into them

Recommendation:
The Board is asked to approve the Business Cycle and the Governance Structure

**Strategic Objective(s)** (The content provides evidence for the following strategic objectives)

- ✔ Lifelong integrated care
- ✔ Excellence in Treatment and Care
- ✔ Best Performance within Resources
- ✔ Develop Staff
- ✔ Organisational Sustainability
### Governance (the report supports a.....)

- [x] Statutory requirement
- [ ] Annual Business Plan Priority
- [ ] Linked to a Key Risk on BAF/HLRR – Ref
- [ ] Service Change

- [ ] Best Practice
- [ ] Other List (Rationale)

### Impact (is there an impact arising from the report on the following?)

- [x] Quality
- [x] Finance
- [x] Workforce
- [ ] Equality

- [x] Risk
- [ ] Compliance
- [ ] Legal

### Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)

- [ ] Strategy
- [ ] Policy
- [ ] Service Change

### Next Steps (List the required actions following agreement by Board/Committee/Group)

...
## Cycle of Business - Master Record 2017-2019

### HEADINGS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>Chair/CEO/Company Secretary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BOARD OF DIRECTORS

#### STANDARD BUSINESS

1. **Chair’s, Welcome & Noting of Apologies**
   - Notes present:
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair

2. **Declarations of Interest**
   - Review / Update:
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair

3. **Minutes of Previous Meeting**
   - Approve:
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair

4. **Matters Arising Action Log**
   - Review / Update:
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair
   - Chair

### STRATEGIC CONTEXT

#### CHIEF EXECUTIVE'S REPORT

- **Patient Story**
  - Discuss / Note:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **CQC Improvement Plan**
  - Discuss / Note:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **Care for You Update**
  - Receive:
    - CEO
    - Chair of Quality & Safety
    - Medical Director
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **AAA Highlight Report from Quality & Safety Committee**
  - Receive:
    - Chair of Quality & Safety
    - Medical Director
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **Mortality Report**
  - Receive:
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director
    - Medical Director

- **Annual Review of CQC ‘Statement of Purpose’**
  - Receive:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **Safe Staffing Report**
  - Receive:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **Quarterly Nursing Report**
  - Receive:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **Quarterly Patient Safety Report**
  - Receive:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **Quarterly Safeguarding Report**
  - Receive:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

- **Safeguarding Annual Report**
  - Receive:
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing
    - Director of Nursing

---

**Page 147 of 190**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management Annual Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of NHSLA Contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Company Secretary / Director of Finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaints &amp; Service Experience Report-Quarterly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly Complaints &amp; Compliments Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Complaints &amp; Compliments Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly Infection Prevention &amp; Control Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Infection Prevention &amp; Control Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Health &amp; Safety Report including Annual Security Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational Development Strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Associate Director of Workforce &amp; OD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Staff Survey Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receive</td>
<td>Associate Director of Workforce &amp; OD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PERFORMANCE**

<p>| Integrated Performance Report (IPR)                                     |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | All Excs                  |
| Strategic Plan                                                          |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Chief Operating Officer   |
| Annual Plan (Operational)                                               |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Chief Operating Officer   |
| Quarterly Workforce &amp; Organisational Development Performance Indicators Report (including Mandatory Training Compliance) |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Associate Director of Workforce &amp; OD |
| Director of Finance Report                                              |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Director of Finance       |
| Finance &amp; Investment Committee, Alert, Advise &amp; Assure (AAA) Report     |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Chair, Finance &amp; Investment Committee |
| Audit Committee, Alert, Advise &amp; Assure (AAA) Report                    |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Chair of Audit Committee  |
| National A&amp;E Survey                                                     |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Chief Operating Officer   |
| PLACE (formerly PEAT) Report (Estates)                                  |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Director of Finance       |
| NHSI Quarterly Performance Report                                       |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve  | Director of Finance       |
| Director Visit Feedback Report (Quarter 4)                               |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Director of Finance       |
| Internal Sustainability Update to Trust Board                           |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Director of Finance       |
| Charitable Fund Requests (Ad hoc)                                       |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve  | Director of Finance       |
|-------------------------------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|---------|---------------------------|
| Board Assurance Framework                                              | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | Approve  | Company Secretary         |
| Trust Risk Register                                                     | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | Receive | Director of Nursing       |
| Annual Review of Strategic Objectives &amp; Principal Risks                | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Chief Executive / Company Secretary |
| Annual Emergency Preparedness, Resilience &amp; Response (EPRR) Report      | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Chief Operating Officer   |
| Statement of Compliance for Emergency, Preparedness, Resilience &amp; Response (EPRR) | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Chief Operating Officer   |
| Annual Fit &amp; Proper Persons’ Test Declaration                          | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Company Secretary         |
| Annual Code of Conduct for Directors                                  | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Company Secretary         |
| Draft Annual Report                                                   | ✓      | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review/Update | Director of Finance/ Company Secretary |
| Draft Annual Report of Audit Committee                                | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review    | Chair of Audit Committee   |
| Draft Annual Governance Statement                                      | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review    | Chief Executive / Company Secretary |
| Draft Quality Account                                                  | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review    | Director of Nursing / Medical Director |
| Draft Annual Accounts                                                  | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review    | Director of Nursing / Medical Director |
| Final Annual Report &amp; Accounts (including Annual Governance Statement &amp; Quality Accounts) | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Director of Finance / Company Secretary |
| Revalidation of Doctors Annual Report to the Trust Board              |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Medical Director           |
| Annual Review of Trust’s Regulatory Documents:                         |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |            |                              |
| Standing Orders                                                        | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Company Secretary         |
| Scheme of Delegation                                                  | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Company Secretary         |
| Standing Financial Instructions                                         | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Director of Finance        |
| Annual Compliance with Provider License                                | ✓      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Company Secretary         |
| Quarterly Governance Report (incl. FOIA, DPA, Claims &amp; Policies)        | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | ✓      | Approve | Company Secretary         |</p>
<table>
<thead>
<tr>
<th>Quarterly Governance Declaration to NHSI</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>Approve</th>
<th>Director of Finance / Company Secretary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom of Information Audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Annual Report on the Use of the Trust Seal</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Annual Review of Trust’s Statutory Registers:</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Declaration of Interests</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Register of Gifts &amp; Hospitality</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Register of Commercial Sponsorships</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Register of Declaration of Outside Work</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Annual Report on Waivers</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Annual Report on Losses &amp; Special Payments</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Annual Review of Board Performance &amp; Effectiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve</td>
<td>Trust Chair</td>
</tr>
<tr>
<td>Annual General Meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Approve/Receive</td>
<td>Chair</td>
</tr>
<tr>
<td><strong>AUDIT COMMITTEE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Dates for Audit Committee 2018: February, April, (Extraordinary Meeting in May), July and October. For 2019: January, April (Extraordinary Meeting May), July and October.**

**Standing Items**

| Internal Audit                                                          |        |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve       | Director of Finance     |
|------------------------------------------------------------------------|--------|--------|--------|        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve       | Director of Finance     |
| Material changes to internal audit plans                                |        | ✔      |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve       | Director of Finance     |
| Internal Audit Charter (in Terms of Reference)                         |        | ✔      |        | ✔      | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve       | Director of Finance     |
| Head of Internal Audit Opinion (Verbal Update the Month Prior to Receipt)|        |        | ✔      | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive       | Director of Finance     |
| Internal audit progress reports, including follow up reports on management actions | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review        | Company Secretary / Director of Finance |
| Audit Committee Updates – Events & Briefing                              |        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Receive       | Director of Finance     |

**External Audit**

<p>| Interim external audit findings (as part of verbal progress report)     |        |        | ✔      |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        | Review        | External Audit          |
| External Audit Plan and Fees                                           |        |        | ✔      |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve       | Director of Finance     |
| Material Changes to external audit plans                                |        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Approve       | Director of Finance     |
|------------------------------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------------------------|
| External Audit Annual Audit Letter                                    |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Director of Finance         |
| External Auditor's report to those charged with governance – ISA 260   |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Director of Finance         |
| External audit report on the Quality Accounts                          |        |        |        |        | ✔      | ✔      | ✔      |        |        |        |        |        |        |        |        |        |        | Receive | External Audit             |
| External audit progress                                                 | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Director of Finance         |
| Technical Updates (twice per annum)                                    | ✔      | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | ✔      | ✔      | Receive | Director of Finance         |
| Anti-Fraud – Frequency of Attendance†b                                |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | ✔      | ✔      | Receive | Director of Finance         |
| Annual counter fraud plan                                              |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Counter Fraud Specialist    |
| Counter fraud annual report                                            |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Counter Fraud Specialist    |
| Counter fraud progress reports                                         | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Counter Fraud Specialist    |
| Security Management                                                    |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve | Director of Finance         |
| Security management annual work plan                                   |        |        |        |        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Director of Finance         |
| Security management progress reports                                   |        |        |        |        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Director of Finance         |
| Security management annual report                                      |        |        |        |        |        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Receive | Director of Finance         |
| Governance                                                             |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review  | Company Secretary           |
| Board Assurance Framework (BAF)                                        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Company Secretary           |
| Trust Risk Register                                                    | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Director of Nursing         |
| Trust Corporate Governance Manual (i.e. changes to the Standing Orders) |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review  | Company Secretary           |
| Compliance with the UK Corporate Governance Code                       |        |        |        |        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Company Secretary           |
| Register of Director's Interests                                       | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Company Secretary           |
| Register of Gifts, Hospitality &amp; Sponsorship                           | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Receive | Company Secretary           |
| Gifts, Hospitality &amp; Sponsorship Policy                                |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review  | Company Secretary           |
| Whistleblowing Annual Report                                           |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive | Company Secretary           |
| Whistleblowing Register (twice annually)                               | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Receive | Company Secretary           |
| Whistleblowing Policy                                                  | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Company Secretary           |
| Corporate governance policies as appropriate                           |        |        | ✔      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | ✔      | ✔      | Review  | Company Secretary           |
| Annual Governance Statement (Draft to April, Final to May)             | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Company Secretary           |
| Trust Annual Report                                                   |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review  | Company Secretary           |
| Quality Accounts                                                       |        |        |        |        |        |        |        |        |        |        |        |        |        |        | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | ✔      | Review  | Medical Director / Director of Nursing |</p>
<table>
<thead>
<tr>
<th>HEADINGS</th>
<th>ACTION</th>
<th>LEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Management Annual Report</td>
<td>Receive</td>
<td>Director of Nursing / Company Secretary</td>
</tr>
<tr>
<td>Items for Escalation from Other Committees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Audit Annual Report</td>
<td>Receive</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Financial Focus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounting Policies</td>
<td>Review</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Accounts Timetable &amp; Plans (note: never available until March at earliest)</td>
<td>Approve</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Review Draft Accounts (By E-mail in April)</td>
<td>Review</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Review Final Audited Annual Accounts &amp; Financial Statements &amp; Receive Management Representatives Letter</td>
<td>Review</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Losses &amp; Special Payments</td>
<td>Review</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Waiver Report</td>
<td>Review</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Annual Report on Waivers</td>
<td>Receive</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Annual Report on Losses &amp; Special Payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit Committee Business</td>
<td>Approve</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Audit Committee Cycle of Business &amp; Dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectiveness of Internal Audit</td>
<td>Review</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Terms of Reference of the Audit Committee</td>
<td>Approve</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Self-assess the Committee’s Performance &amp; Effectiveness</td>
<td>Approve</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Review the Audit Committee Self-Assessment Development Plan</td>
<td>Review</td>
<td>Director of Finance</td>
</tr>
<tr>
<td>Audit Committee Annual Report</td>
<td>Approve</td>
<td>Chair of Audit Committee</td>
</tr>
<tr>
<td>Private discussion with internal and external auditors (15 minutes at the end of meetings)</td>
<td>Discuss</td>
<td>Audit Chair &amp; Non-Executive Directors</td>
</tr>
<tr>
<td>Topical / Legal / Regulatory updates</td>
<td>Receive</td>
<td>Company Secretary</td>
</tr>
<tr>
<td>Issues to be highlighted to Trust Board</td>
<td>Note</td>
<td>Chair of Audit Committee</td>
</tr>
<tr>
<td>Issues to be added to the BAF/Risk Register</td>
<td>Note</td>
<td>Chair of Audit Committee</td>
</tr>
<tr>
<td>----------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>General Business</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcome, Apologies &amp; Declarations of Interests</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Minutes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Matters Arising</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Financial Strategy</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Commercial Strategy</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Committee Chair Reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIP Board</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>IM&amp;T Programme Board</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SLR Steering Group</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Themes from PMF meetings</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance Director’s Report (incl run rate, SLR Quarterly, Cash, CIP/Recovery Plan, Activity &amp; Contract)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Service Review</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Procurement Update</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Income &amp; Assurance Group Updates</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ERIC Benchmarking</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Final Accounts Timetable</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Budget Setting Timetable</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Revenue Budget</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Capital Programme</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reference Costs</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Performance Issues</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Investment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Cases</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Risk Assurance to Board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP&amp;I Annual Work Plan</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Finance Corporate Risk Register</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Review Board Assurance Framework (BAF) Financial Risks</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Board Compliance Statements</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Terms of Reference</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Review of Finance, Performance &amp; Investment Committee Effectiveness</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

QUALITY AND SAFETY COMMITTEE (Taken from V6 15.08.17)

Standing Items

| Apologies                                                             | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Note        | Chair             |
| Declarations of Interest                                             | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Update      | Chair             |
| Action Log/Matters arising                                            | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Review / Update | Chair             |
| Clinical Dashboard                                                   | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Receive     | Director of Nursing |
| Items for Any Other Business                                         | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Note        | Director of Nursing |

CBU Quality and Safety

| CBU Exception (AAA) Report from each CBU                               | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Receive     | Chief Operating Officer |

Safe

| Quality & Safety Committee Risk Register                              | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Receive     | Director of Nursing |
| CQC Service Improvement Plan                                          | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Receive     | Director of Nursing |
| Safeguarding Annual Report                                            | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Receive     | Director of Nursing |
| Health & Safety Annual Report                                         | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | ✔️     | Receive     | Director of Nursing |
|-------------------------------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|----------|---------------------------|
| Safety of Medicines & Controlled Drugs - Annual Report                  |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Medical Director           |
| Infection, Prevention and Control Annual Report                         |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Medical Director           |
| Quality Impact Assessment Report                                        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| Safer Staffing (Nursing)                                                |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| **Effective**                                                           |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Medical Director           |
| Research and Development Annual Report                                  |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Medical Director           |
| Clinical Audit - Annual Report & (Year Ahead) Programme                 |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Medical Director           |
| **Caring**                                                              |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| Patient Experience - Annual Report                                      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| Place Audits                                                            |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| **Responsive**                                                          |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| Integrated Governance Report                                           |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing / Company Secretary |
| Freedom to Speak up action plan                                         |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Approve    | Director of Nursing / Company Secretary |
| National Inpatient Survey Results                                       |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| Cancer Services Annual Report                                           |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| National Maternity Services Survey                                      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| National A&E Survey                                                    |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| Cancer Services Patient Survey                                         |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Note       | Director of Nursing        |
| National Children and Young Peoples Survey                              |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| **Well-led**                                                            |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review     | Company Secretary          |
| Review of Board Assurance Framework (BAF) Risks                          |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Associate Director of Workforce & OD |
| Committee Effectiveness Review (Assessment against Terms of Reference to be reported to Board of Directors) |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review     | Company Secretary          |
| Annual Statutory & Mandatory Training Report                            |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Associate Director of Workforce & OD |
| Quality Account                                                        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Review     | Director of Nursing        |
| **Reports from Task and Finish Groups**                                 |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        | Receive    | Director of Nursing        |
| To be established                                                      |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |        |            |                            |
**TRUST BOARD**

- **Health & Wellbeing Board**
- **Health Overview Scrutiny Committee**
- **Clinical Quality Commission**
- **NHS England**
- **NHS Improvement**
- **Southport & Formby Clinical Commissioning Group**
- **West Lancashire Clinical Commissioning Group**
- **Executive Management Team**

**Governance Structure**

**Trust Governance & Assurance Committee (TGAC)**
- Purpose: Responsible for clinical quality, risk management, patient safety. The Committee is established to provide assurance regarding the effectiveness of all aspects of the clinical governance arrangements of the Trust, with a particular focus on quality and risk management.

**Mortality Assurance & Clinical Improvement Committee (MACIC)**
- Purpose: Reducing mortality has been identified as a key corporate priority within Southport and Ormskirk Hospital NHS Trust. In accordance with established good practice and in order to ensure that the Trust has in place a coordinated and effective approach to reducing mortality, a Board level Mortality performance Committee with oversee the work streams identified in the Mortality action plan.

**Quality & Safety**
- Purpose: Responsible for clinical quality, risk management, patient safety. The Committee is established to provide with assurance regarding the effectiveness of all aspects of the clinical governance arrangements of the Trust, with a particular focus on quality and risk management.

**Finance Performance & Investment Committee**
- Purpose: In accordance with established good practice, responsibility for oversight, challenge and assurance the use of resources and sustainability.

**Nominations & Remuneration Committee**
- Purpose: To determine the levels of remuneration, allowances, and other terms and conditions of service for the employees of the Trust.

**Audit Committee**
- Purpose: To oversee the establishment and maintenance of Integrated Governance, risk management and internal control across the whole organisation’s activities that supports the achievement of the organisation’s objectives.

**Charitable Funds Committee**
- Purpose: To oversee the management of the affairs of Southport and Ormskirk Hospital NHS Hospital charity. This is a delegated duty carried out on behalf of the Trust which is the Corporate Trustee of the Charity. The role is to ensure that the charity acts within the terms of its declaration of trust and appropriate legislation.

**Workforce and OD**
- Purpose: To oversee the workforce & OD developments and provide assurance that the Trust has in place a co-ordinated and effective approach to meeting the requirements of the Trust workforce.

**Mortality & Morbidity by CBU – Adhoc Meetings**

**Clinical Effectiveness**

**Clinical Pathways By CBU – Adhoc Meetings**

**Infection Prevention and Control**
- Andrew Chalmers – Bimonthly

**Patient Experience**
- Gill Murphy DDON – Monthly

**Health and Safety**
- Mandy Power – Bimonthly

**Estates and Facilities**
- Simon Williams – Not Currently Active

**Drugs and Therapeutics**

**Quality & Safety**
- Simon Williams – Not Currently Active

**Quality Control**
- Simon Williams – Not Currently Active

**PPI & TAPP**
- Dr Marsou – Quarterly

**GIRFT**
- Dr Kirby – One Off Workshop with Follow Up Action Plans

**Clinical Quality Control**
- Gill Murphy DDON – Monthly

**Clinical Effectiveness**

**Resilience**
- Mandy Power – Bimonthly

**Health & Safety**
- Mandy Power – Bimonthly

**E & D Assurance**

**Retention & Recruitment**

**HR Contract with Whiston**

**HR Governance**

**Education Assurance**

**JNC**

**JMSNC**

**Business Unit Governance**

Page 156 of 190
## PUBLIC TRUST BOARD

### 4th October 2017

<table>
<thead>
<tr>
<th>Agenda Item (Ref):</th>
<th>TB214/17</th>
<th>Report Title:</th>
<th>Risk Management Strategy</th>
</tr>
</thead>
</table>

### Executive Lead
Name: Sheila Lloyd, Director of Nursing and Quality

### Lead Officer
Name: Mandy Power, Assistant Director Integrated Governance

### Action Required
- [x] Note
- [x] Approve
- [x] Assure

### Key Messages of this Report & Recommendations:
The Risk Management Strategy was updated and presented to April Quality and Safety where the Strategy was agreed by the CEO and the Committee due to minimal changes. The Strategy has been updated with the relevant new Governance Structures.

The Board are asked to:
- Review and approve the Risk Management Strategy.

### Strategic Objective(s) (The content provides evidence for the following strategic objectives)
- □ Lifelong integrated care
- ✔ Excellence in Treatment and Care
- ✔ Best Performance within Resources
- ✔ Develop Staff
- ✔ Organisational Sustainability

### Governance (the report supports a…..)
- ✔ Statutory requirement
- □ Annual Business Plan Priority
- ✔ Linked to a Key Risk on BAF/HLRR
- □ Service Change
- ✔ Best Practice
- ✔ CQC standards
- ✔ National Reporting and Learning System (NRLS)

### Impact (is there an impact arising from the report on the following?)
- ✔ Quality
- □ Finance
- ✔ Workforce
- □ Equality
- ✔ Risk
- ✔ Compliance
- □ Legal

### Equality Impact Assessment (if there is an impact on E&D, an Equality Impact Assessment must accompany the report)
- □ Strategy
- □ Policy
- □ Service Change

### Next Steps (List the required actions following agreement by Board/Committee/Group)
Monthly review of the Risks on the Risk register by the risk leads.
Risk Management Strategy
2017 – 2020

Date: April 2017 - April 2020
Author: Corporate Governance

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit
This document sets out the Risk Management Strategy for Southport and Ormskirk Hospital NHS Trust. The Trust is committed to the elimination and/or control of all identified risks therefore risk identification, assessment and management is a fundamental part of effective governance in all aspects of Trust activity.

Risk management is seen as an integral part of:

- delivering the highest standard of patient care
- continuous quality improvement
- protecting the Trusts resources ensuring that these remain available for investment in patient services; and
- maintaining the statutory obligation to maintain safe systems of work
- meeting and maintaining internal & external service standards.

The Trust acknowledges that risk is inherent in every activity. Our processes allow for the identification of risk in all spheres and at every level of the organisation and which arise from any of the activities with which the organisation is involved.

By approaching the control of such risk in a systematic and organised manner it is intended that wherever reasonably practicable this will be eliminated or when this is not possible any residual risk is reduced to the lowest level practicable and continually reviewed and managed. This will result is a better quality service for patients and a safer environment for everybody receiving and delivering care.
# Table of contents

1. Introduction                                           Page 3
2. Strategic Aims and Objectives                         Page 4
3. Organisational Risk Management Structure             Page 5
4. Responsibilities and Duties of Key Individuals for Risk Management Activities Page 5
6. Assurance Framework                                  Page 13
8. Communications and Stakeholders                      Page 23
9. Education & Training                                 Page 24
10. Consultation                                        Page 24
12. Monitoring & Review                                 Page 27
13. Version                                             Page

## Figure

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Board Escalation Assurance Framework</td>
</tr>
<tr>
<td>2</td>
<td>Risk Management Strategic Framework</td>
</tr>
</tbody>
</table>

## Appendices

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Trust Committee Structure</td>
</tr>
<tr>
<td>B</td>
<td>Quality and Safety Reporting Structure</td>
</tr>
<tr>
<td>E</td>
<td>Summary Risk Management Process</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

The Trust has embraced the principles of Risk Management and Governance and strives to continually improve the quality of services offered, safeguard standards of care, minimise risk and thereby improve outcomes for our patients and ensure a sustainable business. Toward this end the Trust has, over a number of years, cultivated an open and just climate in which Risk Management is seen as an integral part of the continued and systematic improvement in clinical care as well as sound business sense in terms of organisational sustainability. Within this context the Trust will continue to recognise the management of risk as a key organisational responsibility which facilitates the continued compliance with statutory and mandatory requirements.

The Trust Risk Management Strategy is built around the following statement:

“Southport and Ormskirk Hospital NHS Trust is committed to the control of risks in a structured and organised manner to ensure that risks can be eliminated, reduced and/or controlled to an acceptable level thereby improving the experience and safety of patients, visitors and staff. This commitment is commensurate with the Trust aim to provide high quality care which is responsive to the needs and preferences of individual patients.”

The Trust is mindful of its obligation to manage its principal and potential risks to ensure the achievement of the Strategic Domains and ensure effective operational management.

2. AIMS AND OBJECTIVES

This Strategy will provide a framework to ensure that patients, visitors and staff are protected from harm and that systems are in place to ensure that all risks are proactively managed to safeguard against impropriety, malpractice, waste or failure to provide value for money.

The key aims of the Strategy will be to:

- provide the highest quality care without risk to the health of those involved and within resource allocations;
- understand the risks that the Trust faces, their causes and measures to control them so that resources can be appropriately directed;
- enhance the Trust’s stakeholder confidence;
- ensure that the Trust is compliant with statutory and regulatory requirements;
- achieve best value for money, thereby maximising resources for patient services and care;
• minimise the total cost of claims and other losses to the Trust through negligence and fraud and ensure that lessons are learned and changes in practice are implemented;

• encourage and develop risk management as an integral part of the Trust’s culture; and

• ensure links to the organisational objectives.

• Clearly define the organisational arrangements to promote Clinical Business Units (CBU)/ Business Units (BU) and the individual’s responsibilities in order to maintain an active risk register which is reviewed, monitored, and updated to ensure that actions are implemented to control, reduce and/or eliminate identified risks.

• Ensure that the Board Assurance Framework is utilised by the Trust Board as a planned, systematic approach to the identification, assessment, and mitigation of the risks that could hinder the Trust achieving its strategic domains providing assurances that the risks are being adequately controlled.

• Publish an annual Governance Statement which describes the arrangements to identify and manage risks to the organisations objectives and the effectiveness of internal control covering Clinical, Corporate and Financial Governance.

The Trust has adopted an Integrated Governance Model through which all risks associated with the Organisational Imperatives, are effectively identified and managed at all levels of the organisation. The Organisational Imperatives are as follows:

| Comply with registration requirements | QUALITY |
| Generate a Surplus | FINANCE |
| Comply with Terms of Authorisation | PERFORMANCE |

3. ORGANISATIONAL RISK MANAGEMENT STRUCTURE

The organisational risk management structure detailing committee/sub committees and groups with overarching responsibility for risk management is shown in Appendix A and B.

Overall responsibility for management of risk within the Trust rests with the Trust Board. Levels of delegated responsibility are clear in all spheres of the organisation. The Chief Executive Officer has delegated responsibilities to individual directors as shown in the section below.
It is a fundamental principle of this strategy that overall responsibility for risk management lies with the Trust Board and as such they must approve this strategy. The Chief Executive of the Trust has delegated responsibilities within the portfolios of the Executive Directors. Responsibility is then delegated to individuals/Clinical Business Units/ Business Units e.g. Assistant Director Integrated Governance, Head of Risk, Associate Director of Operations, Senior Managers, Associate Medical Directors, Clinical Directors, Heads of Nursing, Risk Leads, Matrons, Ward and Department Managers.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Executive Officer</strong></td>
<td>The Chief Executive Officer is responsible for ensuring a robust system of internal control.</td>
</tr>
</tbody>
</table>
| **Non-Executive Directors**               | • The role of the Non-Executive Directors is to provide scrutiny of the work of the organisation and to hold Executive Directors to account for their performance.  
• Specific Non Executive members of the Board are members of the Trust’s Audit Committee and the Quality and Safety Committee, which has responsibility for ensuring that effective systems are maintained for governance, risk management, and internal control across the whole organisation’s activities and that underlying assurance processes are in place to demonstrate the achievement of the corporate objectives. Identified Non-Executive Directors act as Chair and Deputy Chair for the Quality & Safety Committee. |
| **Executive Directors with Specific Responsibilities for Risk Management** | • The Director of Nursing and Quality is responsible for all aspects of risk management and will report on all associated matters to the Chief Executive and Trust Board on a monthly basis or more frequent as deemed appropriate.  
• The Chief Executive has delegated responsibility for all aspects of Health and Safety to the Director of Nursing, Midwifery, AHP, Governance and Quality.  
• The Executive Medical Director has a responsibility to work with the Director of Nursing and Quality on aspects of risk management. |
| Executive Director of Finance/Senior Information Risk owner (SIRO) | • The Director of Finance will have overall responsibility for overseeing management of financial risk and advising the Trust Board of its implications through the Audit Committee and the Finance, Performance and Investment Committee and ensuring that financial risks feature in the Board Assurance Framework.  

The role of Senior Information Risk Owner (SIRO) is one of several nationally recognised controls to strengthen data handling and ensure accountability of information risk at Board Level. The SIRO, who must therefore be a member of the Executive Board, and is the Director of Finance at the Trust.  

Senior level ownership of information risk is a key factor in successfully raising the profile of information risks and to embedding information risk management into the overall risk management culture of the organisation. Senior leadership demonstrates the importance of the issue and is critical in obtaining the resources and commitment necessary to ensuring information security remains high on the agenda of the Board and senior management committees.  

The key responsibilities of the SIRO are to:  

• Oversee the development of Information Policy, and a Strategy for implementing the policy within the existing Information Governance Framework  
• Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk assessment to support and inform the Statement of Internal Control  
• Review and agree action in respect of identified information risks  
• Ensure that the organisation’s approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff  
• Provide a focal point for the resolution and/or discussion of information risk issues.  
• Ensure the Board is adequately briefed on information risk issues. |

| Executive Directors | Executive Directors have overall responsibility for the management of clinical and non-clinical risks ensuring that:  

• All incidents and near misses are investigated in accordance with Trust Policy ensuring |
participation in the Root Cause Analysis of Serious Incidents.

- All identified risks are assessed according to the Trust Risk Assessment Model.

- All risk is controlled either by its elimination or its reduction to the lowest level reasonably practicable within the Clinical Business Units and Business Units.

- All risk assessments are reviewed when there is a change of conditions within the assessment.

- Systems are in place to ensure that all employees within the Clinical Business Units and Business Units are able to attend training in risk management.

- Risks are prioritised dependent on the risk grading.

- All Extreme risks are monitored on a monthly basis through the Executive Management Team meetings (EMT).

- All corporate risks have an Executive Director as an assigned lead.

- There is an up to date, effectively managed Risk Register within each Business Unit, linked to the strategic objectives.

<table>
<thead>
<tr>
<th>Deputy and Associate Directors and Associate Medical Directors, Head of Nursing/Service</th>
<th>Responsible for ensuring that:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- All identified risks are assessed according to the Trust Risk Assessment model and principle risks to the Strategic Domains identified and effectively monitored.</td>
</tr>
<tr>
<td></td>
<td>- Trust's risk management processes are fully implemented within their services and that risk registers are maintained and will therefore be able to ensure principal risks to the Trust's objectives are systematically identified, evaluated, eliminated, reduced, prioritised, and/or controlled. On behalf of their Business Units, they report unacceptable and serious risks and the effectiveness of controls within the monthly Quality and Safety reports which are</td>
</tr>
</tbody>
</table>
- encourage the proactive management of risks through the development, implementation and monitoring of the delivery of risk education and instruction.

- ensure functioning of the Business Unit Governance Committee is effective.

- Managing clinical and environmental risk related issues arising out of Trust’s Risk Management systems such as incidents, complaints, claims, risk assessments, audits, and information received from other agencies.

- Ensuring that all incidents and near misses within the Business Units are investigated in accordance with Trust Policy and that a Root Cause Analysis is completed for serious Incidents.

- Reviewing complaints, claims, incident summaries and trend analyses to ensure issues are discussed, action plans produced, implemented and monitored.

- Monitor staff attendance at mandatory risk training in accordance with the Training Need Analysis (TNA).

- Provide advice on Trust wide policies and protocols.

- Ensure effective communication links on risk related issues within the Business Unit and feedback to the Risk Management Department.

- Distributing Device and Medical Alerts and NPSA notices ensuring completion of baseline assessment and action is taken where appropriate and feedback given to the Risk Management Department.

| Company Secretary | The Company Secretary is responsible for development, monitoring and maintenance of the Board Assurance Framework (BAF) document. |
### Assistant Director
**Integrated Governance**

Responsible for:
- Appropriate participation in the investigation and analysis of Serious Incidents.
- All identified corporate risks are assessed according to the Trust Risk Assessment model and principle risks to the Strategic Domains identified and effectively monitored.
- Trust’s risk management processes are fully implemented within the services and that risk registers are maintained and will therefore be able to ensure principal risks to the Trust’s objectives are systematically identified, evaluated, eliminated, reduced, prioritised, and/or controlled. On behalf of their Business Units, they report unacceptable and serious risks and the effectiveness of controls to the Risk Assurance Group meetings.
- Encouraging the proactive management of risks through the development, implementation and monitoring of the delivery of risk education and instruction.
- The functioning of the Business Unit Governance Committee is effective.
- The Business Unit’s Risk Register is managed effectively.
- Ensuring all incidents and near misses are investigated and escalated in accordance with the Trust Policy ensuring Chairing the Health and Safety Committee ensuring that the terms of reference and membership of the Committee remains current. The Assistant Director of Integrated Governance will report to the Safety Committee on Health and Safety matters.
- Escalating of risk issues to the Director of Nursing and Quality.
- Implement the risk management systems and processes as per Trust policy.

### Head of Risk

In conjunction with the Risk Managers are responsible for:
- Ensuring that the Trust’s incident reporting procedure is followed for all clinical and non-clinical incidents.
• Development of policies, procedures, and guidelines relating to risk management.
• Ensure that the Trust’s approach to risk management is compliant with good practice, national and regulatory legislation, national standards, NPSA, NHSLA Risk Management Standards, Care Quality Commission, and other such organisations.
• Dissemination of new legislative requirements and approved codes of practice affecting the management of risk throughout the Trust.
• Providing specific expertise and advice to support managers and staff within the organisation in discharging their responsibilities for the management of risk.
• To process and analyse incident data to identify emergent trends and process reports for relevant committees. Where appropriate, initiate action to prevent or reduce further risk within the organisation.
• Overseeing the administration, development of the Risk Register via the Datix risk management system.
• Ensure the Corporate Risk register is maintained.
• Developing, implementing and delivering Trust wide risk management education and training programmes.
• Supporting Trust and staff in respect of incidents, complaints, and claims and in dealing with other legal related issues in accordance with approved policy.
• Co-ordinating internal investigations of accidents and incidents and promoting the use of Root Cause Analysis as part of that process.
• Ensuring that Serious Incidents that meet Strategic Intelligence Reporting System (StEIS) criterion are reported to the relevant organisations.
Ensuring safety alerts and notices are acknowledged, disseminated and actioned within the defined timescales and outcomes reported through the Quality & Safety Committee.

<table>
<thead>
<tr>
<th>Matrons, Ward and Departmental Managers</th>
<th>Responsible for those elements of risk management which relate to their areas of responsibility ensuring that:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• There is compliance with risk management policies.</td>
</tr>
<tr>
<td></td>
<td>• All risks are assessed within the ward or department according to the Trust Risk Assessment model.</td>
</tr>
<tr>
<td></td>
<td>• Immediate action is taken to control risk where required.</td>
</tr>
<tr>
<td></td>
<td>• Staff are released to attend Mandatory Training</td>
</tr>
<tr>
<td></td>
<td>• The risk assessment process is completed for all identified risks.</td>
</tr>
<tr>
<td></td>
<td>• All risk within the ward/department is eliminated or reduced to the lowest level reasonably practicable.</td>
</tr>
<tr>
<td></td>
<td>• All staff are made aware of any risks within the workplace.</td>
</tr>
<tr>
<td></td>
<td>• Risk assessments are reviewed and updated every six months or as and when necessary if the risk or risk grading change.</td>
</tr>
<tr>
<td></td>
<td>• The Line Manager is kept informed of all residual risk management issues arising from the risk management process.</td>
</tr>
<tr>
<td></td>
<td>• All incidents including &quot;near misses&quot; are acted upon, reported and investigated in accordance with the Trust policy.</td>
</tr>
</tbody>
</table>
- Risks are entered on to the risk register using the Datix system.

<table>
<thead>
<tr>
<th>Clinicians</th>
<th>Responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ensuring they practice within the standards of their professional bodies, any other national standards and any locally determined clinical policies and guidelines to ensure their practice is as risk free as possible.</td>
</tr>
<tr>
<td></td>
<td>• Identify by way of each Ward and Department’s risk assessment process and line management arrangements, any risks they consider exist within the service and their practice.</td>
</tr>
<tr>
<td></td>
<td>• Provide incident reports and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided</td>
</tr>
<tr>
<td></td>
<td>• Ensure they attend induction and receive mandatory training on risk management.</td>
</tr>
<tr>
<td></td>
<td>• Co-operating with Root Cause Analyses and other investigations arising out of incidents, complaints, and claims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Staff</th>
<th>Responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ensuring compliance with Trust policies, procedures, and guidelines.</td>
</tr>
<tr>
<td></td>
<td>• Assisting in the identification and reporting of all risks, unsafe practices and incidents including near misses and comply with the incident and near miss reporting procedures.</td>
</tr>
<tr>
<td></td>
<td>• Ensuring that incident reports, witness statements and any other supporting documentation requested are produced for any incident that they may be involved in or have become aware of.</td>
</tr>
<tr>
<td></td>
<td>• Attending risk management and other mandatory training and other education and training events relevant to their employment which are designed to assist in the process of risk management.</td>
</tr>
<tr>
<td>Business Unit Governance Committees</td>
<td>Responsible for:</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td>• Identification of risk which need to be included on the Risk Register.</td>
</tr>
<tr>
<td></td>
<td>• Ensuring the risk is put onto the Datix risk register module.</td>
</tr>
<tr>
<td></td>
<td>• Approving the risk on the risk register</td>
</tr>
<tr>
<td></td>
<td>• Monitoring and updating risks on the risk register within timescales indicated in this strategy and Trust policy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality &amp; Safety Committee</th>
<th>Responsible for</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Taking a strategic overview of Clinical Risk and Quality issues has delegated powers from the Trust Board to oversee, co-ordinate, review, and assess the effectiveness of risk management arrangements and activities and quality initiatives within the Trust.</td>
</tr>
<tr>
<td></td>
<td>• Continuously monitor national, regional, and local quality indicators, set in conjunction with the commissioning partners and key stakeholders, through a dashboard approach.</td>
</tr>
<tr>
<td></td>
<td>• Enabling the Trust Board to sign off self-certification of quality related to Board Statements including the Annual Governance Statement.</td>
</tr>
<tr>
<td></td>
<td>• Triangulate patient safety, quality and risk issues with operational and financial performance addressing areas of concern or deteriorating performance as required.</td>
</tr>
<tr>
<td></td>
<td>• Provide the Board with assurance regarding the effectiveness of all aspects of governance arrangements within the Trust</td>
</tr>
</tbody>
</table>

The committee is chaired by a Non-Executive with a clinical background the Quality & Safety Committee.
Committee is established to take a strategic overview.

The Quality and Safety Committee monitors Key Performance Indicators specifically identified and organised into a balanced scorecard in order to act as a gauge and give an early warning/overview of risk within the organisation and the possible impact of QEP initiatives.

<table>
<thead>
<tr>
<th>Audit Committee</th>
<th>Responsible for</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitoring the effectiveness of systems of internal control.</td>
</tr>
<tr>
<td></td>
<td>Commissioning of internal audits and reviews and the monitoring of response to any action plans arising thereof, matters of probity and financial management.</td>
</tr>
</tbody>
</table>

Independent auditors have been appointed by the Trust to act as the internal auditors to monitor assurance arrangements for aspects of Governance, Risk and Quality standards. An annual programme of review by internal audit is determined and approved by the Audit Committee. This annual audit programme includes monitoring the processes in place regarding the Trust’s Board Assurance Framework.

<table>
<thead>
<tr>
<th>Finance, Performance and Investment Committee</th>
<th>The Finance &amp; Investment Committee analyses performance and activity levels in detail.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Risk of the robustness of the budget.</td>
</tr>
<tr>
<td></td>
<td>• Risk of budgetary control</td>
</tr>
<tr>
<td></td>
<td>• Risk assess all business plans</td>
</tr>
</tbody>
</table>

Cost Improvement Programme

A Risk rating and Quality Impact Assessment (QIA) are an integral part of the Trust’s Cost Improvement Plan Programme (CIP). A successful and sustainable savings scheme is one which delivers a financial saving and improves patient care, satisfaction and safety. The Trust has therefore implemented a new governance and accountability structure to identify, manage, and monitor the risks associated with implementing savings schemes.

A detailed Risk rating and QIA is carried out for each individual savings idea by the relevant scheme lead and included within the Savings Monitoring Tool (SMT). The Risk rating is carried out in line with the Trust’s risk register, with scheme specific risks identified and scored. The QIA considers Patient
Safety, Patient Experience, Clinical Effectiveness, Business Performance and Service Standards, Equality Impact and Staff Health and Well Being and is scored on the same basis.

These are each signed-off as an accurate assessment by the Director of Nursing and Quality and the Executive Medical Director so that the Board can make a fully informed decision as to which savings schemes to implement. Moreover, the reporting structures enable regular monitoring of savings delivery, which allows for more timely action to deal with slippage, adverse risk or quality impact. This is primarily picked up at the QEP Board Sub-Committee and Performance Management Framework (PMF) meetings. Where necessary, issues are escalated through to the QEP Board, Finance and Performance committee and ultimately onto the Trust Board.
Good Governance = Assurance and Risk escalation from Floor to Board
5. RISK MANAGEMENT POLICY STATEMENT

Within the context of this commitment the Trust will comply with all statutory and mandatory requirements creating the management arrangements and environment which recognises the management of risk as a key organisational responsibility. This requires that all managers and clinicians accept the contents of the strategy policy statement and the principles of risk management as one of their fundamental duties.

In addition, every member of staff will be encouraged to recognise their personal obligations and responsibilities for identifying and minimising risks. This requires a robust and on-going process whereby risks are not only identified but also assessed with the objective of securing improvements to service delivery and practices. The reporting of serious incidents, near misses, and errors is fundamental to this purpose.

The Trust has therefore adopted the following risk management statement and it is upon this which the Risk Management Strategy is based:

“Southport and Ormskirk Hospital NHS Trust is committed to the control of risks in a structured and organised manner to ensure that risks can be eliminated, reduced and/or controlled to an acceptable level thereby improving the experience and safety of patients, visitors and staff. This commitment is commensurate with the Trust’s aim to provide high quality clinical care which is responsive to the needs and preferences of individual patients.”

6. ASSURANCE FRAMEWORK - TRUST BOARD REVIEW PROCESS

The Board Assurance Escalation Framework is utilised by the Trust Board as a planned and systematic approach to the identification, assessment, and mitigation of the risks that could hinder the trust achieving its strategic goals. The Assurance Framework document contains information regarding internal and external assurances that the Organisational Strategic Domains are being met. Where risks to the organisation objectives and themes from the corporate risk register are identified, mitigations and subsequent action plans are mapped against them. The Assurance Framework will be used to inform the production of the Annual Governance Statement and will be interrogated by the Trust Board on a quarterly basis each year and monthly by the Audit Committee.

In addition to the Board Assurance Escalation Framework the Trust’s Risk Management Strategy provides an escalation framework throughout the tiers of assurance. The Risk Management Strategy describes the Trust’s approach to managing risk.

7. ASSESSING AND MANAGING RISKS

Identified risks are assessed using a standardised risk matrix from which a score and RAG rating is applied. Any risk identified through monitoring quality and performance is added, where appropriate, to the risk register as per the risk register process (as described within the Trust Risk Assessment and Risk Register Process Policy RM 26).
The Trust defines risk at Strategic, Organisational, Business Unit and service level.

Strategic risks are risks that:

- Have the greatest impact on the achievement of its strategic objectives (reflected in the Board Assurance Framework (BAF) as appropriate)

Organisational risks are risks that:

- Threaten delivery of the Trust’s strategic objectives (reflected in the BAF as appropriate) and quality goals
- Apply to the organisation as a whole.

Business Unit/Service risks are risks that:

- Threaten delivery of the Service strategic, operational objectives and quality goals
- Are applicable to the particular Service

The Trust encourages and expects all staff to identify risk issues using a dedicated Assessment Form (via Datix) for the Risk Register.

Risks are reviewed on a monthly basis, by the identified lead and are further reviewed in Clinical Business Unit Governance Groups. A table of risks in all categories is provided with specific details for each clinical business unit summarised in the monthly quality and safety reports.

A monthly risk register report is submitted to the Quality and Safety Committee, Audit Committee and Finance, Performance and Investment and the Board, identifying all extreme level risks, extreme risks added in month, closed in month and reclassified in month. All corporate meetings have a responsibility to ensure risks, within their remit of oversight, are appropriately reviewed, mitigating actions in place and action plans in place to further reduce or close the risk.

### 8. RISK MANAGEMENT SYSTEMS AND PROCESSES

Risk Management is the process by which the Trusts risks are identified, assessed and controlled or eliminated. All identified risks within the Trust link to the Strategic Domains which are summarised below.

<table>
<thead>
<tr>
<th>SOUTHPORT &amp; ORMSKIRK HOSPITAL NHS TRUST STRATEGIC DOMAINS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Domain 1</td>
</tr>
<tr>
<td>Strategic Domain 2</td>
</tr>
<tr>
<td>Strategic Domain 3</td>
</tr>
<tr>
<td>Strategic Domain 4</td>
</tr>
<tr>
<td>Strategic Domain 5</td>
</tr>
</tbody>
</table>
Risks are then further categorised in relation to the Trust’s Organisational Imperatives:

<table>
<thead>
<tr>
<th>Comply with registration requirements</th>
<th>QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generate a Surplus</td>
<td>FINANCE</td>
</tr>
<tr>
<td>Comply with Terms of Authorisation</td>
<td>PERFORMANCE</td>
</tr>
</tbody>
</table>

**Risk Management Strategic Framework**

A whole system approach is embedded within the Trust to manage risk; the framework for the whole system approach is outlined in the figure 1. A detail of how the whole system approach to Risk Management is implemented is detailed in the following sections.
### Risk Management Framework

<table>
<thead>
<tr>
<th>RISK TYPE</th>
<th>OWNED BY</th>
<th>IDENTIFIED BY / FROM</th>
<th>HOW RECORDED</th>
<th>WHERE REPORTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGIC RISK</td>
<td>TRUST BOARD</td>
<td>Risks Score &gt; 15, Corporate Risk Themes, Horizon Scanning</td>
<td>Board Assurance Framework (BAF), Link to Trust risk register</td>
<td>Trust Board, Board Committees, Audit Committee</td>
</tr>
<tr>
<td>EXTREME RISK</td>
<td>EXECUTIVE TEAM</td>
<td>Risk &gt; 15 and/or risks that require a multi directorate / CBU approach to manage the risk. Themes from CBU Risk Registers</td>
<td>Extreme Risk Register</td>
<td>Trust Board, Board Committees, Quality &amp; Safety Committee, EMT</td>
</tr>
<tr>
<td>CBU RISK</td>
<td>CBU Management Team (ADO/HON/AMD)</td>
<td>Local Risk Registers, Operational Issues</td>
<td>CBU Risk Register</td>
<td>CBU Governance Meetings</td>
</tr>
<tr>
<td>LOCAL RISK</td>
<td>Appropriate Managers, Team Leaders, Heads of Department</td>
<td>Locally Operational Issues</td>
<td>Local Risk Registers</td>
<td>CBU Governance Meetings</td>
</tr>
</tbody>
</table>

**Definitions:**
- **Strategic Risk:** Risk to the achievement of the Trust Strategic domains.
- **Extreme Risk:** Extreme risks where it is felt an appropriate Director needs to take ownership.
- **CBU Risk:** Medium/High risk that can be managed at CBU level but requires a multi-departmental approach and ownership by a senior manager.
- **Local Risk:** Risk that can be managed locally.
Board Assurance Escalation Framework
The Assurance Escalation Framework document contains information regarding internal and external assurances that organisational strategic domains are being met. Where risks to the organisational strategic domains and themes from the corporate risk register are identified, mitigations and subsequent action plans are mapped against them. The Assurance Framework will be used to inform the production of the Annual Governance Statement and will be interrogated by the Trust Board on a quarterly basis each year and monthly by the Audit Committee.

Strategic risk
Strategic risks are those which could impact upon the delivery of the strategic domains. Usually identified at Board Level as a result of horizon scanning, and informed by the corporate risks, they are recorded upon the Board Assurance Framework.

Corporate Risk
The Trust has developed a definition of Corporate Risk in order to assist in the identification of those risks that need to be included within the Corporate Risk Register. This is:

“Risks scoring 15 or above and/or those risks that threaten the operational delivery of the strategic domains of the Trust, that the CBU feel are out with their control, discussed and agreed as a Corporate Risk at the Trust Quality & Safety Committee, PMF Meetings and ratified by EMT.”

The Corporate Risk Register is produced monthly, detailing all of the Corporate Risks in the Trust. Its purpose is to provide the Board with a summary of the principal risks facing the organisation with a summary of actions needed and being taken to reduce those risks to an acceptable level.

With this function in mind the Committees of the Board:

- Quality & Safety Committee
- Workforce Committee
- Finance, Performance and Investment Committee
- Audit Committee

will review, as a matter of course pertinent risks that appear on the Corporate Risk Register.

The Risk Assurance Group will approve the escalation of risks from Business Unit Risk Registers to the Corporate Risk Register. These are then reviewed and agreed and ratified by EMT on a monthly basis.

The Audit Committee will oversee the Corporate Risk Register status on a bi monthly basis. Where risks to achieving organisational objectives are identified within the Corporate Risk Register, the Trust Board may elect to escalate the risk to the Board Assurance Framework as appropriate.
As corporate risks may present significant risk to the Trust in achieving its objectives, all corporate risks are linked to the Trust’s Strategic Objectives/domains and further categorised according to the Organisational Imperatives:

<table>
<thead>
<tr>
<th>Comply with registration requirements</th>
<th>QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generate a Surplus</td>
<td>FINANCE</td>
</tr>
<tr>
<td>Comply with Terms of Authorisation</td>
<td>PERFORMANCE</td>
</tr>
</tbody>
</table>

The Board Assurance Framework & Corporate Risk Register therefore complement each other, and provide the Trust Board with assurance and action plans on risk management within the Trust.

**Clinical Business Unit Risk (CBU) / Business Unit (BU)**

CBU/BU risks have an impact within several areas of the Business Unit; they generate low to high levels of risk which can be managed locally through the CBU/BU Governance processes.

**Local Risk**

Local risks are operational risks which sit within a local area i.e. ward or department but do not have an impact outside of this area. They are low to high level risks which may affect the operational day to day function of the area. They are managed at local level through the ward /department risk register and monitored through the Clinical Business Unit/Business Unit governance framework.

**Risk Assessment and Risk Register processes**

For an organisation’s Assurance Framework to be effective there must be a robust system in place for the identification, assessment, and prioritisation of risk. All risks identified must be scored using a system that enables them to be ranked in terms of their inherent severity. This normally takes account of the likelihood of a risk occurring and the impact on the organisation if it does.

The Trust policy Risk Assessment and Risk Register process policy supports the processes for managing risk across the organisation.

**Policy to support implementation of risk management**

In order to support the risk management processes the Trust has systems in place to facilitate the management of risk in the organisation and they are described in detail in the following policy documents:

<table>
<thead>
<tr>
<th>RM 06</th>
<th>Policy for Reporting and Management of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>RM 10</td>
<td>Policy and Procedure for Handling of Clinical Negligence/Employers and Public Liability Claims</td>
</tr>
<tr>
<td>RM 19</td>
<td>Comments, Concerns, Complaints Policy and Procedure</td>
</tr>
<tr>
<td>RM 22</td>
<td>Policy for Central Alerting System (CAS)</td>
</tr>
<tr>
<td>RM 24</td>
<td>Being Open Policy</td>
</tr>
<tr>
<td>RM 26</td>
<td>Risk Assessment and Risk Register Process Policy</td>
</tr>
<tr>
<td>Corp 69</td>
<td>Whistleblowing Policy</td>
</tr>
<tr>
<td>RM 28</td>
<td>Serious Incident and never Event Policy</td>
</tr>
</tbody>
</table>
Aggregation of data
The analysis of aggregated data provides an opportunity for proactive risk management, i.e. learning from what has happened and looking ahead to see how the same things can be prevented or controlled in the future.

A quarterly Integrated Governance Report is produced and dashboards are produced monthly for the Quality and Safety Committee and Board. The report comprises a composite aggregated report of incidents, claims, and complaints, mortality with quantitative data on the numbers received combined with qualitative and narrative description and key themes of lessons to be learnt across the Trust.

Learning and Promoting Improvements in Practice
The Trust aims to support staff with their responsibilities by creating a culture of openness and willingness to admit mistakes, and is committed to being a learning organisation where lessons learnt can be embedded into practice. The sharing of these lessons can be achieved through:

- Training Courses
- Team Briefings
- Meetings
- Lessons Learnt publications sharing good practice tips and lessons learned examples

Any service improvement that has occurred as a consequence of a complaint, incident or claim will be reported in the dashboards and shared and discussed in the Directorate Governance meetings.

SECTION 8

COMMUNICATIONS AND STAKEHOLDERS

Internal
An Integrated Governance Framework has been implemented, in order to achieve a robust interface between Clinical and Non-Clinical Risks, Litigation and Complaints. The above information is aggregated into the monthly Quality and safety Business Unit reports as a single point information for the co-ordination of analysis of incidents, complaint and claims.

Robust pathways of communication are embedded in the organisation as per Figure 3 that ensures risk related issues are managed, co-ordinated and prioritised on a holistic basis.

- The Audit Committee report to the Trust Board on a bi-monthly basis.
- Joint representation at the Committees results in robust communication pathways between the sub-committees of the Trust Board.
- The Business Units Governance Committees meet monthly. To support the Business Unit’s risk management activity they are responsible for ensuring that the information provided in the monthly Quality and Safety quarterly report is
reviewed by their Governance Committees to ensure analysis at Business Unit level. This is then communicated to Quality and Safety on a quarterly basis with a monthly escalation process to the Quality and Safety Committee.

The committees who report directly to the Quality & Safety Committee are detailed in Appendix B.

The Trust will work collaboratively with other local organisations and stakeholders in relation to risk management. This will include participating in local and regional forums related to risk management, working closely with the relevant NPSA, Health & Safety Executive, and Care Quality Commission representatives and working with other local Trusts to identify risks, learn lessons and share good practice.

The Trust will also consult with local scrutiny partners e.g. Local Authority Oversight and Scrutiny Committees.

9. EDUCATION AND TRAINING

Corporate Governance provide a programme of training in the use of risk assessment techniques to nominated risk assessors in the Trust. Risk awareness training is also provided at induction and mandatory training.

10. CONSULTATION

This policy has been circulated to the EMT Members, for consultation.

11. MONITORING AND REVIEW

In order that this strategy remains current, any of the appendices to the Risk Management Strategy can be amended and approved during the life time of the strategy, without the entire document having to return to Trust Board. The strategy will be reviewed and ratified every three years by the Trust Board or sooner if there are significant changes at a national policy level. The following table outlines the Trust’s process to monitor compliance of all organisational wide procedural documents.
<table>
<thead>
<tr>
<th>Systems</th>
<th>Monitoring and / or Audit</th>
<th>(Principles for Best Practice in Clinical Audit )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>Measurable</td>
<td>Lead Officer</td>
</tr>
<tr>
<td>The source of the risk (including, but not limited to, incident reports, risk assessments, local risk registers, and external recommendations) is as per policy</td>
<td>Risk register entries</td>
<td>Head of Risk</td>
</tr>
<tr>
<td>Description of the risk is as per policy</td>
<td>Risk register entries</td>
<td>Head of Risk</td>
</tr>
<tr>
<td>Risk score is as per policy</td>
<td>Risk register entries</td>
<td>Head of Risk</td>
</tr>
<tr>
<td>Summary risk treatment plan is as per policy</td>
<td>Risk register entries</td>
<td>Head of Risk</td>
</tr>
<tr>
<td>Date of review is as per policy</td>
<td>Risk register entries</td>
<td>Head of Risk</td>
</tr>
<tr>
<td>Topic</td>
<td>Responsibility</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Residual risk rating is as per policy</td>
<td>Risk register entries, Head of Risk, Annual, Business Governance Committees, Unit, Operational Quality and Safety Committee, Senior Executive Management Team</td>
<td></td>
</tr>
<tr>
<td>All risks are assessed as per policy</td>
<td>Risk register entries, Head of Risk, Annual, Business Governance Committees, Unit, Operational Quality and Safety Committee, Senior Executive Management Team</td>
<td></td>
</tr>
<tr>
<td>Risk assessments are conducted consistently as per policy</td>
<td>Risk register entries, Head of Risk, Annual, Business Governance Committees, Unit, Operational Quality and Safety Committee, Senior Executive Management Team</td>
<td></td>
</tr>
<tr>
<td>The authority levels for managing different levels of risk within the organisation is as per policy</td>
<td>Risk register entries, Head of Risk, Annual, Business Governance Committees, Unit, Operational Quality and Safety Committee, Senior Executive Management Team</td>
<td></td>
</tr>
<tr>
<td>Risks are escalated through the organisation as per policy</td>
<td>Risk register entries, Head of Risk, Annual, Business Governance Committees, Unit, Operational Quality and Safety Committee, Senior Executive Management Team</td>
<td></td>
</tr>
</tbody>
</table>

- A Risk Management Annual Report will be collated which will be provided to the Quality & Safety Committee.
12. **EQUALITY IMPACT ASSESSMENT**

<table>
<thead>
<tr>
<th><strong>Equality Impact Assessment</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact assessment completed by</td>
<td>Mandy Power, Assistant Director of Integrated Governance</td>
</tr>
<tr>
<td>Date Completed</td>
<td>May 2012, Reviewed December 2015</td>
</tr>
<tr>
<td>Relevance Shown</td>
<td>None</td>
</tr>
<tr>
<td>Action Plan Completed</td>
<td>N/A</td>
</tr>
<tr>
<td>Nominated lead for Managing Action Plan</td>
<td>N/A</td>
</tr>
<tr>
<td>Completed Assessments held by</td>
<td>Policy Co-ordinator</td>
</tr>
</tbody>
</table>

13. **VERSION**

<table>
<thead>
<tr>
<th><strong>Issue Date:</strong></th>
<th>May 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reviewed &amp; Amended:</strong></td>
<td>September 2016</td>
</tr>
<tr>
<td><strong>Approved By QA Committee:</strong></td>
<td>1st October 2014</td>
</tr>
<tr>
<td><strong>Ratified By Senior Executive Management Team:</strong></td>
<td>2nd October 2014</td>
</tr>
<tr>
<td><strong>Next Review:</strong></td>
<td>April 2017</td>
</tr>
<tr>
<td><strong>Author and Title:</strong></td>
<td>Mandy Power, Assistant Director of Integrated Governance</td>
</tr>
<tr>
<td><strong>Version:</strong></td>
<td>ICO version 4</td>
</tr>
</tbody>
</table>
## 14. DELIVERY PLAN

### YEAR 1 - 2 2016 - 2018

<table>
<thead>
<tr>
<th>Delivery Objectives</th>
<th>Delivered by</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop a risk aware culture throughout the Trust</td>
<td>• Assess the Trusts risk maturity level against an approved model and developing an appropriate action plan to increase the level of maturity accordingly.</td>
</tr>
<tr>
<td>• ensure that the concepts and ideas of risk assessment and risk management are</td>
<td>• Ensure all strategic and business plans consider risk management;</td>
</tr>
<tr>
<td>embedded into day-to-day working practices.</td>
<td>• Include risk registers as standard agenda item in all Board Committee meetings, Business Unit committees and Executive Management Team meeting;</td>
</tr>
<tr>
<td>• ensure that appropriate systems are in place for identifying, assessing and</td>
<td>• Ensure staff understand the risk management procedures through mandatory risk management training is available for all staff.</td>
</tr>
<tr>
<td>controlling key risks.</td>
<td>• Ensure that managers are informed and appropriate action is taken when staff fail to attend mandatory training.</td>
</tr>
<tr>
<td></td>
<td>• Implementing an incident management system and organisational risk registers across all areas of the Trust</td>
</tr>
<tr>
<td></td>
<td>• Reinforce the need for staff to consider and assess risk in all daily activities;</td>
</tr>
<tr>
<td></td>
<td>• Ensure that lessons learned from incidents, complaints and claims are shared across the organisation and with the wider health economy to</td>
</tr>
<tr>
<td></td>
<td>prevent recurrence;</td>
</tr>
<tr>
<td></td>
<td>• Quarterly review of key risk systems (e.g. Extreme risk register, incident reporting) to ensure that they are meeting the changing needs of the</td>
</tr>
<tr>
<td></td>
<td>organisation.</td>
</tr>
</tbody>
</table>
| To maintain effective organisational structures for risk management so that a consistent approach is taken across the Trust that reflects best practice | • Ensure that the risk management strategy is reviewed to take into account national guidance and best practice;  
• Ensure that the structures and responsibilities set out in the policy are effective in practice;  
• Ensure that the Trust Board reviews the effectiveness of the structures and responsibilities to identify any useful improvements;  
• Implementing findings from review of risk management systems;  
• Ensure that up to date policies are available to staff and key stakeholders on the intranet, internet and in paper form |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 3 2018-2019</strong></td>
<td></td>
</tr>
</tbody>
</table>
| To ensure good and progress in the implementation of effective risk management across the Trust | • Taking corrective actions in light of audit and review processes;  
• Take part in national benchmarking studies to identify not only how well the Trust is doing but also what steps it can take to improve further. |
### Figure 1 Quality and safety Committee structure

<table>
<thead>
<tr>
<th>Committees</th>
<th>Infection prevention and Control</th>
<th>Safeguarding Board</th>
<th>Clinical Effectiveness</th>
<th>Drugs and therapeutics</th>
<th>Health and Safety</th>
<th>Patient carer and families, engagement, involvement and experience</th>
<th>Workforce</th>
<th>Workforce Leadership Executive Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBU Quality and safety group</td>
<td>Planned care</td>
<td>Urgent Care</td>
<td>Women's and Children's</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------</td>
<td>---------------</td>
<td>---------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal Committee of the Trust Board Accountable to the Trust Board</td>
<td>Harm Meetings</td>
<td>Serious Incident review Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board Sub Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Committee/Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operational Reporting Forum Accountable to the CEO (via a Director)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting Group/Working Group Accountable to a SubCommittee/Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix B
SUMMARY OF RISK MANAGEMENT PROCESS

IDENTIFY RISK
- Strategy and key objectives.
- Business Plan
- National & Local Standards and priorities
- Known / new hazards

ASSESS RISK
- Identify & grade likelihood and severity
- Identify and grade controls in place
- Identify further controls

COMMUNICATE RISKS TO STAKEHOLDERS
- Internal – Committees, Staff
- External – Regulators, Public, CCGs, Professional Bodies,

ACTION PLANNING
- Validate proposed controls
- Assign lead. Set implementation and review dates.
- Escalate uncontrolled risks. Identify resources.

SUBMIT TO RISK REGISTER
- Risk agreed by Manager.
- Need for further control agreed by Manager

REVIEW COMPLETED ACTIONS
- Reassess & regrade residual risk. Accept residual risk. Escalate uncontrolled risks. Set

MONITOR USING KEY INDICATORS
- Feedback from Staff, Incidents, Complaints, Claims, Integrated Performance reports