NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 10.00-12.00 on Wednesday 10th January 2018
Seminar Room, Clinical Education Centre, Southport District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Time
PRELIMINARY BUSINESS			
TB001/18 (V)	**Chair's welcome & noting of apologies** To **note** the apologies for absence	**Chair**	**10.00**
TB002/18 (V)	**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**	
TB003/18 (D)	**Minutes of the Meeting held on 6th December 2017** To **approve** the minutes of the Board of Directors	**Chair**	
TB004/18 (D)	**Matters arising action Log** To **review** the Action Log and receive relevant updates	**Chair**	
STRATEGIC CONTEXT			
TB005/18 (D)	**Interim Chief Executive's Report** To **note** key issues and update from the ICEO	**Chair**	**10.10**
QUALITY & SAFETY			
TB006/18 (V)	**Alert, Assure and Advise Report including Learning from Deaths from the Mortality Assurance & Clinical Improvement Committee (MACIC) held 8 January 2018** To **receive** an assurance report and any escalated risks from the committee	**MACIC Chair**	**10.20**
PERFORMANCE			
TB007/18 (D)	**Alert, Assure and Advise Report from Finance Performance & Investment Committee (FP&I) held on 4 January 2018** To **receive** an assurance report and any escalated risks from the committee.	**FP&I Chair**	**10.30**
TB008/18 (V)	**Accident and Emergency Update** To **receive** a monthly update report	**COO**	**10.40**

Ref No.	Agenda Item	Lead	Time
GOVERNANCE / WELL LED			
TB009/18 (D)	**Charitable Funds** To **approve** a request for use of Charitable Funds	**DoF**	**10.50**
TB010/18 (D)	**Care Quality Commission Well Led Review** To **receive** an update report on the review	**DoN**	**11.00**
TB011/18 (V)	**National Guardian Office – Freedom to Speak Up Report and Action Plan** To **receive** an update on the report and action plan	**ADHR**	**11.15**
TB012/18 (D)	**Items for Approval / Ratification:** **Fit and Proper Persons' Regulation Policy**	**ICoSec**	**11.25**
TB013/18 (V)	**Questions from Members of the Public**	**Public**	**11.35**
CONCLUDING BUSINESS			
TB014/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**	**11.40** **12.00** **CLOSE**
TB015/18 (V)	**Items for the Risk Register/changes to the BAF** To **identify** any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting	**Chair**	
TB016/17 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**	
TB017/17 (V)	**Date and time of next meeting** Wednesday 7th February 2018, 10.00am Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**	

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

NHS
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Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 6th December 2017

The Boardroom, Corporate Management Office, Southport District General Hospital
(Subject to the approval of the Board on 10th January 2018)

Present

Richard Fraser, Chair
Ann Pennell, Vice Chair
Professor Carol Baxter, Non-Executive Director
Jim Birrell, Non-Executive Director
Julie Gorry, Non-Executive Director
Karen Jackson, Interim Chief Executive
Sheila Lloyd, Director of Nursing, Midwifery & Therapies *(Until Agenda Item TB252/17)*
Therese Patten, Chief Operating Officer
Jane Royds, Associate Director or HR*
Steve Shanahan, Director of Finance

In Attendance

Audley Charles, Interim Company Secretary
Rachel Flood-Jones, Temporary PA to the Company Secretary
Sue Hillyard, Interim Improvement Director (NHSI)
Carol Fowler, Assistant Director of Nursing, Workforce (*Representing Sheila Lloyd from Agenda Item TB252/17)*
Esther Steele, Specialist CQC Inspector
Michelle Kitson, Quality Matron *(Agenda Item TB254/17)*
Emily Hoban, Directorate Manager for the North West Spinal Unit *(Agenda Item TB254/17)*
Suzanne Clarke, Clinical Psychologist *(Agenda Item TB254/17)*
Cathy Taylor, Matron, North West Spinal Unit *(Agenda Item TB254/17)*

Apologies:

Ged Clarke, Non-Executive Director
Pauline Gibson, Non-Executive Director*
Professor Arpan Guha, Interim Medical Director

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
TB249/17	**CHAIRMAN'S WELCOME AND NOTE OF APOLOGIES**	
	The Chairman, Mr Fraser, opened the meeting by welcoming board members and members of the public, in particular Mr Lionel Johnson who confirmed that he had been attending Board meetings at the Trust for twenty-four years.	

	The Chair noted apologies from Non-Executive Directors, Ged Clarke and Pauline Gibson and Interim Medical Director, Professor Arpan Guha.	
TB250/17	**DECLARATION OF DIRECTORS' INTERESTS CONCERNING AGENDA ITEMS**	
	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.	
TB251/17	**MINUTES OF THE MEETING HELD ON 4th October 2017**	
	The Chair asked the Board to approve the Minutes of Meeting of 1st November subject to the following changes which were noted for amendments: **TB234/17 Guardian of Safe Working Quarterly Report:** Second bullet point to be changed to "All trainees are on compliant rotas if the rotas are fully staffed…" **TB230/17** Mrs Royd to be changed to Mrs Royds. **TB232/17 Quarterly Integrated Governance Report (Quarter One):** The required frequency in the penultimate paragraph to be changed to 'monthly'. **TB239/17 Integrated Performance Report :** • Under 'Stroke 90% Ward Stay' to be revised to "Work is being undertaken to identify appropriate places for discharge. Referrals that are coming in are being dealt with in line with national guidelines." • Under 'Referrals' statement to read electronic rota booking system or ERS in place of 'the use and book system'. • Under 'New Follow Up' 2.66% to be changed to a ratio of 2.66. • Under 'Friends and Family' the organisation of note is 'I Want Great Care'. **TB240/17 Director of Finance Report:** • Penultimate paragraph to read 'cost cutting schemes had been proposed'. • 'Clinical staffing' to be changed to Medical staffing. **TB244/17 Questions from Members of the Public:** Department of Finance to be changed to Director of Finance. **TB245/17 Any Other Business:** Minute to be changed to: Mr Birrell asked for clarity on the number and details of NHSI support roles in the Trust. Mrs Jackson to circulate a list to the members of the Board. **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the noted amendments.	
TB252/17	**MATTERS ARISING ACTION LOG**	

	The Board considered the following matters arising in turn: **TB116/17 Staff Engagement Plan:** This is an ongoing piece of work; item to remain on the log. **TB174/17 Workforce & Organisational Development:** (Status to be changed to Amber). Discussions to be concluded by Christmas 2017. A final agreement on the full contractual arrangement to be signed off and brought to the February Board. **TB179/17 Integrated Performance Report – Mandatory Training:** Item completed, to be removed from log. **TB185/17 Items for Approval, Standard Operating Procedure for the Administration of Meetings:** To be brought to the January Board for sign off. **TB199/17 Care for You:** Item completed, to be removed from log. **TB204/17 Integrated Performance Report – 7 Day Service:** This has been covered in conversations with the Clinical Commissioning Groups. The 7 days Service has been audited and has improved, the 5 day stroke service is under discussion and 5 day flow has been audited and there is to be intervention from NHS England to organise additional input from the wider health economy of a weekend. Item to be removed from the log. **TB214/17 Items for Approval – Risk Strategy:** Deferred to the January 2018 Board. **TB216/17 Any Other Business :** a) The Orientation Programme for Non-Executive Directors is to be brought to the January Board. b) Dementia Training is to be added to the Board Development Plan? c) The Board Evaluation Form is being brought to today's Board Items for Approval; item to be removed from log. **TB224/17 Interim Chief Executive's Report – National Guardian's Office:** Item completed, to be removed from log. **TB224/17 Interim Chief Executive's Report – Care For You:** Item completed, to be removed from log. **TB226/17 Highlight Report for the Quality & Safety Committee – Lock Down Policy:** The Lock Down Policy is in its final draft. A simulation exercise will follow a ward walk around and the distribution of instruction cards. A verbal update to be brought to the January 2018 Board. **TB227/17 Quality Improvement Plan & Strategy:** Both related items completed, to be removed from log. **TB228/17 CQC Improvement Plan:** Item completed, to be removed from log. **TB230/17 Workforce & Organisational Development Plan – The Capture of Staff Feedback:** The capture of feedback (in real time) is being looked at as part of 'Freedom to Speak Up'. It was agreed that a combination of methods would be required in order to support the capture of substantial levels of feedback from across the Trust. **TB230/17 Workforce & Organisational Development Plan –**	ICoSec ICoSec / DoN ICoSec / COO ICoSec / ADHR

	Organisational Development Strategy and Plan: To be brought back to the January Board. **TB323/17 Quarterly Integrated Governance Report – Content:** Mrs Jackson had spoken with Caroline Griffiths (Improvement Director, NHSI) who is working with the nursing team on the content of a new automated report. The next report would come to the January Board at which time it would be decided how regularly it was to be brought to the same. **TB232/17 Quarterly Integrated Governance Report – MRSA Case:** Mrs Lloyd to provide an update at the January Board. **TB239/17 Integrated Performance Report:** • **Average Length of Stay:** to be discussed at today's Board; to be removed from log. • **Reporting:** changes have been made to the report; to be removed from the log. • **Sickness Absence:** an update on reporting to be provided at today's Board; item to be removed from the log. **TB244/17 Questions from Members of the Public:** both items to be removed from the log.	ICoSec / DoN
TB254/17	**PATIENT STORY**	
	Michelle Kitson, Matron for Patient Experience introduced Emily Hoban, Spinal Unit Directorate Manager who introduced her colleagues, Suzanne Clarke, Clinical Psychologist and Cathy Taylor, Matron. Mrs Clarke explained that she would be presenting the patient story on behalf of a gentleman called Ryan who was not able to attend the Board due to treatment commitments. She stated that Ryan's case had been chosen over others because it was a good example of the diverse referrals that the unit received. It also provided a good illustration of the hard work that the team had put in to improve the environment (for both staff and patients) while treating an individual who would traditionally have been seen to be challenging. She recounted that the patient was 28 years old and had previously served six years in prison. At the time of the incident, he had been living in a second floor flat with his girlfriend and her children. In March 2017 he had been shot in the back and two days later was told that he would never walk again. Very limited information that had been provided with his referral; a member of the Spinal Unit Team had been out to see Ryan prior to his admission. He had a previous diagnosis of multiple personality disorder and emotional dysregulation resulting in spontaneous, unregulated behaviour.	

Mrs Taylor explained that prior to Ryan's admission the team had considered how patients with similar conditions had previously been managed within the context of the safety of the other patients. A risk assessment was undertaken and a partnership agreement discussed with Ryan incorporating a plan of behavioural coping mechanisms. The agreement was signed by both parties before Ryan was admitted so that clear parameters and expectations regarding behaviour were set. This meant that Ryan was reassured with boundaries and that staff were empowered with the tools to diffuse any difficult situations if required.

Mrs Clarke recounted that when she had asked Ryan how he understood her role he had replied, "You were there to tell me that I wouldn't walk and to tell me how I would cope with it."

She had talked with Ryan to understand how he had successfully stayed out of trouble for four years. He demonstrated great emotional intelligence and insight into himself; recognising his need for consistency, routine, his very limited concentration and matter of fact approach to others.

Ryan was motivated and determined to make personal progress, some days being better than others. He found disruption to continuity difficult, for example when a significant number of the regular staff were all on leave at the same time. Throughout his stay Ryan asked a lot of questions and stated that while he was at the unit he had 'had a personality transplant.' Ryan is currently a temporary resident at the Manchester Road Residential and Nursing Home in Southport awaiting contact from Social Services and Community Occupational Therapists.

Mrs Jackson asked what the Board could do to support Ryan's case and whether it required escalation with the Clinical Commissioning Group.

Mrs Taylor responded that Ryan's requirements would have been raised as a part of the system's standard processes.

Mrs Jackson explained that local Provider Forums were then held regularly and that it would be mutually beneficial to raise Ryan's case whilst also using it as a specific example. Mrs Jackson asked Mrs Hoban to provide specific details which she could take to the next meeting.

Mr Shanahan explained that Ryan's case should now come under the Specialist Services Commissioning Contract. Mrs Hoban said that issues with delayed discharge had been put in the Commissioning for Quality and Innovation (CQUIN). The unit was now receiving referrals from 34 Clinical Commissioning Groups (CCGs) and that each one worked differently; processes had now been put in place to reduce delayed

	discharge. If there was an issue then this could be escalated with a specialist commission. Mrs Jackson stated that the matter needed to be taken up nationally. The Chair asked what lessons had been learned and how these could be implemented to improve the service. Mrs Taylor stated that based on previous experience of issues with violent patients the unit had standard coping mechanisms which gave staff confidence in dealing with difficult situations. The Chair recommended that professional training for staff dealing with challenging patients would help them to see the real individuals behind the veneer of a condition. Mrs Clarke stated that the unit had seen an increase in the number of shootings over the last six years. She concluded that there had been a lot of positive feedback from staff on Ryan and that that was due to the hard work which had been put in by all involved to ensure that his time in the unit went well. The Chair thanked the team and asked for thanks from the Board to be passed onto Ryan. He impressed the importance of embedding lessons learned and of working collaboratively as seen in this case.	
TB253/17	**CHIEF EXECUTIVE'S REPORT**	
	Mrs Jackson presented the Chief Executive's Report highlighting the following points: • National Guardian's Office: an update on the action plan against the September 2017 report would be brought back to the Board every three months • A&E Performance & Winter Pressures: to be discussed later in the agenda. • Care for You: Discussions continue around pathways for unplanned care, Women and Children's Services, and the Frailty Pathway. • National Budget Statement: No announcement has yet been made from NHS England. **RESOLVED:** The Board **received** the Chief Executive's Report.	**ADHR**
	QUALITY & SAFETY COMMITTEE: ALERT, ADVISE & ASSURE (AAA)	

	HIGHLIGHT REPORT *(An Agenda Item number had not been allocated as it had been thought that the paper would not be prepared in time for the Board)*	
	Mrs Pennell, Chair of the Quality and Safety Committee alerted the Board to the the following items: **Estates Strategy** There had been concerns raised about the Estates Strategy; actions were to be taken to the Executive Team Meeting and reported back to the Quality and Safety Committee in early 2018. **Overdue Follow Ups** An ongoing plan of action is required for capacity, demand and impact for overdue patient follow ups (clarification is required on pathways of care going forward for referral to treatment [RTT]). Mrs Patten explained that in response to the Section 65 from the Care Quality Commission (CQC) there were now weekly calls with NHS England (NHSE) and NHS Improvement (NHSI). There remained 2,985 overdue follow up appointments which had been significantly reduced from 5,104. She further explained that the main concern remained around scoping, with little progress having been made by NHSI. Risk levels had been assessed, rated and patients prioritised accordingly. It had been agreed that all high risk patients would be seen by the end of January. If no extra resource or initiatives were to be implemented, then all other overdue patient follow ups would be completed by the end of June, however it had been agreed that external support would be secured to complete this sooner. She reported further progress with the unreported backlog of 2,397 overdue follow up appointments in radiology, then reduced to 1,297. Diabetic Eye Screening was to have been contracted out to Aintree NHS Trust but the arrangement had fallen through. The matter had been escalated to Hazel Richards, Director of Nursing. Cheshire & Merseyside, NHSE for intervention. The Chair asked when the backlog would be cleared. Mrs Patten responded that in some areas capacity could not meet demand, but that work was ongoing to scope services to meet demand, supported further by external initiatives. If there were to be changes to services, discussions would be required with the Commissioners to agree new arrangements and to prevent any contractual issues. Mrs Patten and Mrs Hillyard had met with the Clinical Commissioning Groups the previous week to discuss the provision on Respiratory, Cardiovascular and Ophthalmic Services.	

	The Chair stated that the reduction of the overdue appointments was impressive and asked where the Trust sat in relation to the national target. Mrs Hillyard confirmed that in principle there should not be any clinical patients overdue. While some areas in the Trust were over capacity others were below; the balance of which required redressing. The service review and national intensive support team tool would support this. Mr Birrell asked how the number of people who did not want follow up appointments could be quantified. Mrs Patten said that measures had been taken to help to deal with the number of those who 'Did Not Attends' (DNAs) and those had been reviewed by specialism. Mrs Hillyard stated that a change to the system to prevent the automatic generation of follow up appointments would take out unnecessary unwanted appointments. A system that required the patient to instigate the follow up appointment would ensure that all follow up appointments that were made were required. **Elective Caesarean Section Rate** Dr Mansour reported that work had been underway to understand why the elective caesarean section rate at the Trust was higher than the national average. The matter is to be taken to the Clinical Effectiveness Committee before returning to the Quality and Safety Committee. He sought to clarify that while that was the case, the overall number of caesarean sections (elective and non-elective was lower than the national average). Mrs Pennell highlighted the following items from the 'Assure' section of the paper: **Safe Staffing Tool** That was now being used in inpatient areas across the Trust. The overall Trust position is 90% (Amber) which shows slight drop since April 2016. Real time staffing reporting has now ceased. A deep dive to be done into the use of and reporting with the Safe Care - Health Roster tool. **Paediatric Mortality Thematic Review** Dr Mansour commended the work that had gone into the Trust's Paediatric Mortality Thematic Review in response to the investigation into paediatric deaths at the Countess of Chester. The findings to date had been presented at the November Committee meeting whilst the final report would be taken to the February Committee. The Chair requested that the team be formally commended.	ICoSec

	RESOLVED: The Board **received** the report.	
	MORTALITY ASSURANCE & CLINICAL IMPROVEMENT COMMITTEE (MACIC): ALERT, ADVISE & ASSURE (AAA) HIGHLIGHT REPORT *(An Agenda Item number had not been allocated as it had been thought that the paper would not be prepared in time for the Board)*	
	Dr Mansour presented the highlight report. Professor Guha had spoken with Dr Chris Goddard about the need to develop a comprehensive picture of the work being undertaken across the Trust relating to mortality. Dr Goddard had met with Dr Mansour and Mr Birrell to discuss the leadership of the Mortality, Assurance and Clinical Improvement Committee (MACIC) and the timeframes for the seven main strands of work. Dr Mansour reported that Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI) levels were both higher than national recommended levels. The latest Advancing Quality Alliance (AQUA) report suggested however that that the Trust's SHMI should improve in the next six months, because previously high figures were due to be replaced in the rolling annual calculation. Despite this the Trust was still predicted to be outside the expected limits, support would be required from NHSE and NHSI. He explained that two Trust's clinicians had completed the 'Structured Judgement Review' training which they would roll out to their clinical colleagues; this would however be very labour intensive. He confirmed that he had also met with the coders, who were to work with individual teams to understand the complexities of coding and ensure accuracy in the recording of deaths. Mr Birrell stated that an agreement was still to be reached on the content and timescales of the proposed work streams. The intention was that the exercise should, inter alia, provide further information on the significant increase in crude deaths that impacted on the SHMI and HSMR. **RESOLVED:** The Board **received** the report.	
TB255/17	**QUARTERLY INFECTION INFECTION PREVENTION & CONTROL REPORT (QUARTER TWO)**	
	Dr Mansour presented the quarterly report highlighting the performance indicators for Clostridium Difficile (C Diff) against target. He explained that over a six month period that there should be no more than 18 cases and	

	that the Trust had only had four; two of which were to go to appeal. This was contributable in part to stringent monitoring by clinicians of the use of antibiotics. There had been a single case of MRSA in September for which a Root Cause Analysis exercise had been completed. He reported that the Infection Prevention and Control Highlight Report had been taken to both the Clinical Effectiveness Committee and to the Quality and Safety Committee. Mrs Jackson confirmed that it was a statutory requirement that the quarterly report be brought to the Board. **RESOLVED:** The Board **received** the paper.	
TB256/17	**QUALITY IMPROVEMENT STRATEGY**	
	Mrs Fowler gave a verbal update on behalf of Mrs Lloyd on the Quality Improvement Strategy, verifying that Mrs Griffiths was working with teams across the Trust to add timelines and milestones into the plan. The updated Strategy and Plan would be brought to the January Board. **RESOLVED:** The Board **received** the update.	DoN
TB257/17	**CARE QUALITY COMMISSION (CQC) IMPROVEMENT PLAN**	
	Mrs Fowler gave an update on behalf of Mrs Lloyd on the CQC Improvement Plan, confirming for the purpose of the minutes that the Trust was in the middle of a 'Well Led Visit' or inspection. She explained that there were two actions currently off track: unfilled vacancies in Accident and Emergency and the refurbishment of wards to support the delivery of dementia care. While those were behind time, activity was ongoing to ensure resolution. Mrs Jackson confirmed that the actions would be monitored through key performance indicators in order to ensure that they were embedded. **RESOLVED:** The Board **received** the update.	
TB258/17	**CARE FOR YOU**	
	Mrs Jackson gave a verbal update on 'Care For You', addressing in the first instance a request for an update on the Frailty Pathway. She confirmed that the Frailty Pathway was discussed at all 'Care For You' provider forums. She continued that while the Trust was ready to commit resources to ensure success, the commitment of other parties would only become apparent with time. At the January CEO Forum, Mrs Jackson would ask all parties for an agreement as to how the Frailty Pathway	

	would be jointly funded. Mrs Patten noted that as there was no new money in the system, funds would need to be found from within existing budgets. Mrs Gorry stated that the recruitment of Geriatricians was imperative in order for the pathway to work. Mrs Jackson said that she would be speaking with Andrew Gibson, Chair of the Sustainability and Transformation Plan for Cheshire and Merseyside and that there would be answers to these questions by Christmas. The Chair requested an update on the Frailty Pathway and a presentation from Dr Fraser at the February Board. **RESOLVED:** The Board **received** the update.	ICEO ICEO/ ICoSec
TB259/17	**WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE: ALERT, ADVISE & ASSURE (AAA) HIGHLIGHT REPORT & MINUTES OF MEETING**	
	Mrs Baxter presented the report giving an update on the following points: • Feedback had been given from the Joint Negotiating Committee (JNC) regarding back pay for doctors. The deadline for the final Trust decision would be 7th December. Mr Shanahan verified that all the payments that could be processed would be, however there remained issues with a few individual cases. • Job planning is currently being discussed with the British Medical Association. • The new apprenticeship lead Victoria Kearney will lead the Apprenticeship Levy work stream. • Work was being done to prevent issues from escalating to the formal grievance stage by encouraging grievances to be challenged as early as possible. Grievance policies were being aligned with best practice at St Helens and Knowsley NHS Trust. • The Trust target for Mandatory Training was hit in October at 85.35%. A communication was issued via Trust News to congratulate and thank staff. • Over 50% of the Trust had then enrolled for the 'ESR' HR self-service system with the launch of the E-learning component in November. Mrs Gory asked what percentage of mandatory training would be replaced by E-learning. Mrs Gibson asked how effective the changeover to E-learning	

	would be and how this would be measured. Mrs Royds responded that a means of measuring these factors could be built into the system and the results could be fed back to the Workforce Committee on a quarterly basis.	ADHR
	Mrs Baxter reported that E-Health Rostering had been identified as a risk at the meeting. Mrs Fowler explained that a significant percentage of In Patient Departments had now moved to E-Rostering and that the old systems had been switched off. The National Tool kit had been rolled out but reassurance was now being sought as to whether it was being used as required.	
	Mrs Jackson reported that there had been big issues in the rollout of the training and that a discussion was required outside of the meeting as to how to get more people trained.	ICEO/ C.Fowler
	Mr Birrell stated that safe staffing was a Workforce issue.	
	Mrs Jackson responded that if a post had already been established and staffing was required then this would be a recruitment issue. If however there was requirement for a new role to be created, this would need to be dealt with at the Executive Team Meeting and not by the Finance Investment and Performance Committee.	
	RESOLVED: The Board **received** the update.	
TB260/17	**BI-ANNUAL NURSE STAFFING ESTABLISHMENT REPORT**	
	Mrs Fowler presented the biannual report covering the period of April to September 2017 highlighting the following matters: • The Trust is compliant with the National Quality Board guidance of November 2013, working and reporting in line with the Shelford Model. • The Trust moved to an electronic system at the end of 2016 which supported staff reviews. • Mrs Fowler reported a slow rise in the number of vacancies with a move from 101.07 to 103.76 (full time equivalent) between April and September. • The Trust vacancy rate sits below the national average of 15%; additional strategies are needed to improve the vacancy and leaver rate. • Mrs Jackson stated that nurse staffing needed to remain linked to capacity and demand and that forward planning for the following year needed to be brought to the Executive Team Meeting. • It was agreed that Mrs Fowler and Mr Shanahan would meet to	

	discuss a clear way of reporting on the loss of staff due to the Community Service Transfer. • An apprenticeship opportunity for an Enhanced Care Role would be in place in early 2018. • Mrs Fowler is involved in the regional work led by the Cheshire and Merseyside Director of Nursing Forum in respect of wider recruitment campaigns. • The Trust has secured a contractual agreement with the National NHSI Workforce Team to agree the priority and phasing of work for the top three priorities: Governance, Workforce Planning and E-Rostering. • A two year programme is being delivered by the local Further Education facility with placements provided in the organisation. These are 'Acorn nursing' positions. Mr Birrell asked why there was not a similar arrangement with the local university, Edge Hill. Mrs Fowler explained that at the time of talks with Higher Education providers Cumbria University had been seeking collaboration which had not been forthcoming from other institutions; this did not mean that new partnerships could not be built going forward. **RESOLVED:** The Board **received** the report.	
TB261/17	**MONTHLY SAFE STAFFING REPORT**	
	Mrs Fowler presented the report on behalf of Mrs Lloyd to give assurance that the Trust had safe levels of staffing. • The Trust vacancy rate of Registered Nurse vacancies of Band 5 or above was at 11.55% (or 100.60 full time equivalent staff) and that the level for Healthcare Assistants stood at 9.40% (or 35.25 full time equivalent staff). • The total nurse spend is on the rise attributable to recruitment and retention levels. • The Electronic Rostering system ensures that staff are allocated to the safe care model; it's correct and optimum use is imperative to ensure the most effective allocation of staff. Support is being given to staff to ensure its correct use three times a day. • NHSI are working with the Trust (as part of the delivery plan of work priorities against the contract) to develop the Advanced Care Practitioner (ACP) role in Emergency and Urgent Care. Engagement is ongoing with from the Trust from nursing and medical colleagues at NHSI conferences during October. Mr Birrell asked what the benefit was of auto-registration for the NHSP Bank staff.	

	Mrs Fowler responded that previously staff had had to opt into the system in order to sign up for extra shifts, now they were automatically enrolled and could see what work was available on the on-line portal. Further work would be required to allow substantive staff to be able to use the system in the same way. **RESOLVED:** The Board **received** the report A break was taken between 12.30 and 12.40pm	
TB262/17	**AUDIT COMMITTEE: ALERT, ADVISE & ASSURE (AAA) HIGHLIGHT REPORT & MINUTES OF MEETING**	
	Mr Birrell updated the Board on the following issues: • The Committee sought confirmation of a date for the Merseyside Internal Audit Agency (MIAA) led Workshop on Board Assurance Framework Risks. • A Cyber Security Systems Manager is now in place. Mr Shanahan reported that there remained three outstanding issues on the NHSI Assurance Checklist. **RESOLVED:** The Board **received** the report.	ICoSec
TB263/17	**FINANCE PERFORMANCE & INVESTMENT COMMITTEE: ALERT, ADVISE & ASSURE (AAA) HIGHLIGHT REPORT & MINUTES OF MEETING**	
	Mr Birrell gave an update to the Board from the Finance Performance and Investment Committee AAA report, highlighting the following matters: • There had been little progress in the identification of new Cost Improvement Schemes and so it was almost certain that the 2017/18 target would be under achieved. • The additional financial pressure has been identified in respect of back pay to consultants who were undertaking additional sessions at the request of the Medical Director in the last financial year. • Some stroke indicators remain a concern, despite the stroke service having performed well in national clinical audit assessments. • Sickness levels remain a serious concern; this is being taken forward by Mrs Royds. • Despite ongoing discussions and planning regarding the Emergency Care Winter Plans, the extended Christmas and New Year holiday periods may create significant operational challenges	

	in early January. **RESOLVED** The Board **received** the update and the Minutes of Meeting.	
TB264/17	**EMERGENCY CARE PERFORMANCE REPORT**	
	Mrs Patten reported on Emergency Care Performance with the new monthly report to the Board which looked at trends from previous years and predicted admission levels for the Winter of 2017/18. She explained that Southport and Ormskirk Trust were repeatedly receiving more patients through Accident and Emergency than Aintree Hospital; raising the question as to whether the A&E department (including the building capacity) was fit for purpose. Steve Christian, Improvement Director from NHSI had relaunched the Monday Safety Huddles. Dr Paddy MacDonald had been put forward as the Exemplar to identify patients in the hospital who could be somewhere else. Discharge planning teams (transferred to the Community Service Providers in May) were now joining in the Monday Safety Huddle. Social Services had attended the meeting for the first time on the previous day (5th December). There remained issues of staffing within the Discharge Teams; the Trust having had to provide interim staff to Virgin Care. Mrs Patten explained that there were now two people in post but that there remained two vacancies. There was an opportunity to bid for Winter Planning monies under four programmes; Steve Christian and team were working on a proposal for funds which could be used in A&E. There has been no confirmation of support from the Clinical Commissioning Groups or Community Service Providers for ten additional Winter Pressure beds in Ormskirk. Additional nursing and medical staff would be required and without funding the plan for the ward would need to be stood down. Mr Birrell asked where the Trust sat nationally for A&E performance. Mrs Patten said that the Trust was now around the 80th or 90th out of 134; at worst it had been 133rd while at best it had been in the top 30. **RESOLVED** The Board **received** the report.	
TB265/17	**INTEGRATED PERFORMANCE REPORT (IPR)**	
	Mr Shanahan explained that work was being undertaken to the Integrated	

	Performance Report, with further changes being introduced in the new year. Mrs Jackson stated that the 'so what' was missing from the report and that the facts needed to be linked to the pertinent issues. **RESOLVED** The Board **received** the update.	
TB266/17	**DIRECTOR OF FINANCE REPORT**	
	Mr Shanahan reported that the Trust's financial position was now a deficit in excess of the original control target of £18.1m with the total at the end of month seven of £18.8m. The Trust was currently losing £2.5m a month with the end of year control total projected at £30m to £32m. Key areas remained a lack of new cost improvement plans while agency spend had gone up in October, attributable to the required spend on the Medical Bank. The Capital Investment Group would revisit the Five Year Plan at its next monthly meeting, looking in particular at the schemes and forecasts signed off by the Board in September. There was a brief discussion about the potential reallocation in the short term of monies, such as those allocated to the refurbishment of the wards. Mr Birrell advised that the funds allocated to the IT programme should be ring fenced as far as possible, as the progress in this area was slow and that delivery should not be hindered in any way. **RESOLVED** The Board **received** the report.	
TB267/17	**CHARITABLE FUNDS**	
	Mr Shanahan stated that the Financial Account for Charitable Funds was to be filed by 31st January 2018 and asked the Board to receive and approve the following items: **RESOLVED** The Board **received** the Alert, Advise, Assure Highlight Report and the Minutes of the Committee. The Board **approved** the Annual Report of Charitable Funds from KPMG. The Board **approved** the audited Annual Accounts of Charitable Funds. The Board **approved** the Management Representation Letter.	
TB268/17	**CARE QUALITY COMMISSION WELL LED REVIEW**	
	Mr Charles explained that the document presented on page 188 of the	

	Board pack was a composite report on the CQC Action Plan for the Well Led Review (based upon the detailed plan put together by Mrs Lloyd's team) for information only. Mr Birrell advised that the action plan from the last CQC visit, the Quality Improvement Plan and the actions from the new CQC Action Plan should all be presented in a single document to avoid confusion or duplication. Mrs Jackson agreed that they should all be in one place which would eventually be the Quality Improvement Plan and that actions should be taken off as they were completed. The Board **received** the report.	
TB269/17	**ITEMS FOR APPROVAL / RATIFICATION**	
	Ratification of a Resolution for Approval of an Uncommitted Revenue Support Loan taken under Emergency Powers. Mr Charles clarified that the loan had required ratification ahead of the Board due to the timing of the return. The Board **ratified** the resolution. **Standards of Business Conduct and Managing Conflict of Interest** Mr Charles reported that the policy had been through the consultation process with the Joint Negotiating Committee (JNC), the Joint Medical Staff Negotiating Committee (JNSNC), the Executive Team Meeting and Paul Bell the local Counter Fraud Specialist. There is a mention of intellectual property within the policy but there remained a need for a link to be made to the existing Policy for the Management of Intellectual Property. The Board **approved** the policy. **Freedom to Speak Up** Mrs Fowler asked the Board for any comments or feedback on the policy. Dr Mansour noted that on Page 245 it was stated that staff could raise concerns with external bodies, but it was not clear as to whether or not they would have to waive their anonymity. This needed to be detailed and incorporated into the document. Mr Charles to clarify and update the policy accordingly. The Board **approved** the policy subject to this change. **Updated Board and Committee Dates: November 2017 to December**	ICoSec

	2019 It was noted that there was still a tight turnaround between the Board and both the Quality & Safety Committee and the Workforce Committee. A revised list of dates to be brought back to the January Board. **Draft Board and Committees Evaluation Sheet.** The Board **approved** the Evaluation Sheet for the Board and for optional use at Trust Committees.	
TB270/17	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	
	There were no questions from the General Public.	
TB271/17	**ANY OTHER BUSINESS**	
	A presentation was given to Mrs Pennell whose last day with the Trust would be 21st December 2017. The Chair thanked Mrs Pennell for her hard work and dedication as Vice Chair and Non-Executive Director and wished her all the best in her role as a Non-Executive Director at another NHS Trust.	
TB272/17	**ITEMS FOR THE EXTREME RISK REGISTER / CHANGES TO THE BAF**	
	There were no items to be added to the Extreme Risk Register or Board Assurance Framework.	
TB247/17	**MESSAGE FROM THE BOARD**	
	The following messages were agreed from the Board for communication to the Trust: The direct commendation of the team responsible for the Paediatric Mortality Review.	
TB248/17	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 10th January 2018 11.00am Seminar Room, Clinical Education Centre, Southport District General Hospital	

There being no other business, the meeting was adjourned

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List
As at 10th January 2018

BRAG Status Key

Red	**Significantly delayed and/or of high risk**
Amber	**Slightly delayed and/or of low risk**
Green	**Progressing on schedule**
Blue	**Completed**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
JUNE 2017	**TB116/17** **Staff Engagement Plan**	CEO July 2017	Staff Engagement Plan to be brought to the Board on the back of the final version of the Cultural Review.	To ensure that the findings of the cultural review are fed into the WRES action plan. Final Version of Review received in late August. CEO to bring details of action to October Board. **Deferred until the Cultural review process has been completed and the Cultural Review is brought to the Board.**	**AMBER**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
SEPT 2017	**TB174/17** **Workforce & Organisational Development**	ADHR Dec 2017	Mrs Lloyd emphasised the requirement for the Trust to scrutinise the contractual requirements for the management of the Human Resources function and confirm whether any additional activity would be required to address this.	October update: formal Arrangements for scrutiny and reporting mechanism to the Board and its relevant committee to be put in place. December update: discussions are ongoing between STHK and S&O. Business Service Catalogues are in the process of being ratified and agreed. Once agreed can be shared more widely. **A further update will be brought to the February 2018 Board**	**AMBER**
SEPT 2017	**TB185/17** **Items for Approval - Standard Operating Procedure for the Administration of Meetings**	ICoSec Oct 2017	The Board and Committees' Annual Business Cycles to be brought to the October Board. Cycles for all committees are to be incorporated into a master cycle which should be published on the Trust internet site.	On the October Agenda. An update to be provided at the December Board. **This is being updated to include the Board Development Workshops and will come to the February board**	**AMBER**
OCT 2017	**TB214/17** **Items for Approval:** **The Risk Strategy**	DDoN Nov 2017	Amendments to be made and returned to the Board for approval.	To be brought to the December Board for approval. **Deferred to February Board in lieu of visit by CQC in December and Christmas period**	**AMBER**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
OCT 2017	**TB216/17** **Any Other Business**	ICoSec Dec 2017	a) The Orientation Programme for the new Non-Executive Directors had not yet been provided and is required. b) It was agreed that Dementia Training should be provided as part of a future Board Development Session. c) A Board Evaluation Form is to be brought to all future Boards.	This has been drafted and with the Chair for review and will be circulated in December. This is being built into the Board Development Session **Dementia Training to take place on 10th January 2018.** **Orientation Programme to be circulated to the Non-Executive Directors after sign off by the Chair**	**AMBER**
NOV 2017	**TB226/17** **Highlight Report for The Quality & Safety Committee – Lock Down Policy**	COO Tbc	An emergency planning simulation exercise is to be organised. An update will be provided to the Board once completed.	**An update to be brought to the Board once the exercise has been undertaken.**	**AMBER**
NOV 2017	**TB230/17** **Workforce & Organisational Development Plan**	ADHR Dec 2017	A method is required for capturing staff feedback in real time such as the use of Survey Monkey to gauge staff opinion (rather than waiting for an annual staff survey report which is out of date by the time the results are available and analysed).	Staff feedback is available in the monthly 'Friends and Family' report which captures staff opinion and comments to questions: "How likely are you to recommend Southport and Ormskirk NHS Trust as a place to work?" and "Please select the area of the Trust that you work in." **Multiple Methods have been looked into as part of Freedom to Speak Up. Item to be closed.**	**GREEN**
NOV 2017	**TB230/17** **Workforce & Organisational Development Plan**	ADHR Dec 2017	It is recognised that the 'Workforce and Organisational Development Plan' must contain an Organisational Development Strategy and Plan and a Staff Engagement Strategy and Plan. Key performance indicators, targets and timeframes to be used to measure improvement and success.	**Work is being undertaken on the incorporation of recommendations made at the November Board. The revised plan to be brought back to the February Board.**	**AMBER**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
NOV 2017	**TB232/17 Quarterly Integrated Governance Report**	DON Feb 2017	More information to be provided on lessons learned in the Quarterly Integrated Governance Report.	**To be added into the next Integrated Governance Report on Quarter 3 and in the February 2018 report.**	**AMBER**
NOV 2017	**TB232/17 Quarterly Integrated Governance Report**	DON Dec 2017	The findings of the Root Cause Analysis Report on the MRSA case of August 2017 to be brought to the Board.	**An update to be provided to the Board as soon as information is available.**	**AMBER**
DEC 2017	**TB254/17 Patient Story**	ICEO Jan 2018	ICEO to feedback to the System CEO Forum the details of the patient in question who is awaiting contact from Social Services and Community Occupational Therapy.	**Feedback to be brought to the Board following the System Meeting. Update to be brought to the Board in February 2018**	**AMBER**
DEC 2017	**Quality & Safety AAA Highlight Report**	ICEO Dec 2017	Formal commendation to be given to the team who undertook the Paediatric Mortality Review.	**ICEO to speak to Dr Chris Goddard, Chair of the review group. Update to be brought to the February Board.**	**AMBER**
DEC 2017	**Quality & Safety AAA Highlight Report**	COO/ ICEO Jan 2018	**Overdue Follow Up Appointments.** Diabetic eye screening appointments have been impacted by the failure of a service provider arrangement with Aintree Hospital.	**COO/ICEO to escalate to Hazel Richards of NHS England for intervention. Update to be given at the January 2018 Board**	**AMBER**
DEC 2017	**TB256/17 Quality Improvement Plan**	DON Jan 2018	An updated Quality Improvement Plan incorporating a timeline and milestones to be brought to the Board.	**To be added to the February agenda.**	**AMBER**
DEC 2017	**TB258/17 Care For You**	DoN Feb 2018	Dr Fraser to be invited to present an update on the Frailty Pathway to the February Board.	**To be added to the February agenda / Dr Fraser to be invited to give an update.**	**AMBER**
DEC 2017	**TB259/17 Workforce Committee AAA Highlight Report**	ADHR Spring 2018	What percentage of mandatory training has been moved to E-learning?	**Mrs Royds Department to investigate.**	**AMBER**
DEC 2017	**TB259/17 Workforce Committee AAA Highlight Report**	ADHR Spring 2018	A method of measuring how effective the new E-Learning tool is to be agreed and incorporated for quarterly reports to the Workforce Committee.	**Mrs Royds Department to investigate.**	**AMBER**
DEC 2017	**TB259/17 Workforce Committee AAA Highlight Report**	ICEO & DON Jan 2018	A discussion is required to agree how to get more staff trained on E-rostering.	**Mrs Jackson and Mrs Fowler to meet to discuss the way forward.**	**AMBER**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
DEC 2017	**TB262/17** **Audit Committee AAA Highlight Report**	ICoSec Jan 2018	Date to be confirmed for the MIAA Workshop on the Board Assurance Framework.	**The Date has now been confirmed with MIAA as the 7th March 2018 after the Board of Directors.**	**GREEN**
DEC 2017	**TB269/17** **Items for Ratification and Approval**	ICoSec Dec 2017	**Freedom to Speak Up: Raising Concerns Policy.** Clarification is required within the policy as to whether anonymity is waivered when raising concerns with externally with organisations such as NHS Improvement.	Update to be provided at January Board. **This has been clarified by the Interim Company Secretary stating that there is no need to waive anonymity as confirmed by the NGO's office. To be removed.**	**GREEN**

NHS
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TRUST PUBLIC BOARD

10 January 2018

Agenda Item	**TB005/18**	**Report Title**	**Interim Chief Executive Report**
Executive Lead	Karen Jackson, Interim Chief Executive		
Lead Officer	Karen Jackson, Interim Chief Executive		
Action Required *(Definitions below)*	✓ To Receive ☐ To Approve ☐ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

CQC Core Area Inspection Visit
Financial Position
Performance on A&E over the Winter
Local Issues – Care for You
National Issues – Focus on A&E performance

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

✓ **SO1** Agree with partners a long term acute services strategy
✓ **SO2** Improve clinical outcomes and patient safety
✓ **SO3** Provide care within agreed financial limit
✓ **SO4** Deliver high quality, well-performing services
✓ **SO5** Ensure staff feel valued in a culture of open and honest communication
✓ **SO6** Establish a stable, compassionate leadership team

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

☐ Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on BAF / HLRR Ref: ALL
☐ 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)*	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

1 Internal Issues

1.1 CQC Core Area Inspection Visit

The CQC conducted their unannounced core area inspection visit during week commencing 20th November 2017. The formal report has not yet been received and there have been no further follow up visits.

The Trust continues to work on the action plan from items raised at the visit and this will be further complemented once the report is published.

1.2 Financial Position

The Trust is continues to be off target to delivery is year-end financial position. Action plans have been developed to secure correction of this position by year end and these were discussed at the Finance Performance and Information committee.

NHS Improvement continues to monitor performance against updated plans and have agreed that there will be a financial turnaround director in post from January 2018 following the submission of a business case by the CEO. The individual is Steve Leivers and he will be supported by a deputy and the infrastructure of the Trust. Performance against the plans will continue to be reported to the appropriate sub-committee of the Board.

The Trust has formally raised the issue of changes to activity and income levels with its primary commissioners to determine whether the issues would lead to recovery of additional income to mitigate their impact. The commissioner response continues to be that neither commissioner is minded to accept the proposals made. Further detailed representations are being made requesting a year end settlement which will include analysis of the stranded and variable costs as a result of reductions in activity. This will be shared with NHS Improvement.

In addition the Commissioners have issued the Trust with a letter to confirm that they are required to apply the financial sanctions in full for breaches in operational and national standards for the financial year 2017/18 in line with the national contract guidance. The value of this is currently being evaluated and the letter discussed with both NHS Improvement (NHSI) and NHS England (NHSE).

Board member should note this continues to be a significant risk and is the focus of the Trust currently.

1.3 Performance on A&E over the Winter

In order to support A&E and flow performance across the system during the winter NHS Improvement have provided the services of an Improvement Director – UEC (Steve Christian) to work with the teams, to act as a critical friend and to provide access to other Trusts who have addressed similar issues. The role reports directly to the CEO and works alongside the COO and operational teams to improve quality for patients and staff. The role will work with the wider system to address some of the issues which are beyond the direct control of the Trust.

The CEO has regular weekly CEO challenge meetings continue and are highlighting issue which are being addressed by the system. In addition the Trust is now required to have weekly system wide monitoring and performance meetings with regulators to ensure all action possible is being taken to maintain patient safety and delivery of standards.

The Board will note that there is a requirement from NHSE for all non-urgent activity to be cancelled during the month of January 2018 to ensure there is the maximum number of clinical staff to deal with the increased urgent care pressure. The impact of this action on the financial plan and delivery of other performance targets is under rigorous and continual review.

It is clear that this is a national priority for the NHS and will have particular focus from the Secretary of State with there being a requirement for strong Board leadership and knowledge. As a result the Board and Finance, Performance and Information Committee will receive regular monthly reports on progress and plans to improve performance for challenge.

2 Local Issues

2.1 Care for You

The STP now has the lead role within the Care for You Programme and although NHSI and NHSE will continue to be involved their leadership task has ceased.

Both the Clinical and Operational groups are modelling the pathways and are considering all the options of site configuration. This will be reported to the Board as part of the governance process lead by the CCGs.

The Trust continues to keep close to the STP and local patch focused work to ensure solutions designed are in line with broader network delivery.

3 National Issues

3.1 Focus on A&E performance

As discussed above the national focus continues to be the management of urgent care demand during this busy period.

There is significant support within the Trust from external experts to help improve internal flow but this is also proving invaluable in challenging system input and resources.

Karen Jackson
Interim Chief Executive
3 January 2018

HIGHLIGHT REPORT

Committee/Group Meeting date:	Finance, Performance & Investment Committee 4 January 2018
Lead:	Jim Birrell, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- whilst the recovery of income has improved, the consistent but high level of expenditure coupled with a disappointing cost improvement programme, (CIP), performance has resulted in a further £2m in-month deficit, taking the accumulative overspend to almost £21m at the end of month 8
- looking ahead to the end of the financial year it is anticipated that contractual income will be adversely affected by the request to delay elective activity. Winter pressures may also result in additional staffing and consumables costs. As such it is felt that the outturn is likely to be in line with previous assessments, i.e. approximately £31.7m overspent.
- the Committee discussed a number of potential financial risks, (minaly contractual issues), that could deteriorate the projected outturn by up to £7.5m. However, the Trust has a reasonable case in each instance so they have not been included at this stage.

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 delayed timing of the Board provided an opportunity for an unscheduled FPI meeting in advance of the Board. However, because of the comparatively short notice provided to Directors, the meeting focused primarily on the Trust's in-year financial position.
- the Trust's capital programme continues to underspend, which has fortuitously helped the organisation to maintain positive cash balances.
- consideration is being given to entering into a partnership arrangement for the provision of the Trust's healthcare facilities and services. Whilst the proposal should bring financial benefits, the Committee would like to understand the service and operational impact before the matter is progressed further.

ASSURE

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

- the Trust has recently commissioned additional support to both identify CIP schemes and improve patient flow. The Committee will actively monitor progress over the next few months.

New Risk identified at the meeting	None

Review of the Risk Register
(Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)

None reviewed

NHS
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PUBLIC TRUST BOARD

10th January 2018

Agenda Item	TB010/18	Report Title	Charitable Fund Requests
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Suzanne McGrath, Deputy Financial Accountant		
Action Required *(Definitions below)*	☐ To Receive ☑ To Approve ☐ To Assure		☐ For Note ☐ For Information

Key Messages and Recommendations

The Board acting as Corporate Trustee for the charity is required to approve all charitable fund expenditure requests over £10,000.

There are three requests that meet the charitable fund objectives and there is sufficient funding available.

The Board is asked to approve the following:

1. 2x UVC disinfector units; £62,400
2. Critical care transfer trolley; £10,135
3. 6x patient couches; £19,800

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

☐ **SO1** Agree with partners a long term acute services strategy
☑ **SO2** Improve clinical outcomes and patient safety
☑ **SO3** Provide care within agreed financial limit
☑ **SO4** Deliver high quality, well-performing services
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
☐ **SO6** Establish a stable, compassionate leadership team

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) 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)*	☐ Strategy ☐ Policy ☐ Service Change

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 so that orders can be raised.

Previously Presented at:

☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

1. Introduction

1.1. As per the Trusts' Corporate Governance manual, all charitable fund requests over £10,000 require approval by the Trust Board.

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

- 2 ultra violet light disinfector units £62,400
- Critical Care transfer trolley £10,135
- 6 patient couches £19,800

2. Ultra violet disinfector units

2.1 Currently the disinfection of side/examination rooms following use by patients with multidrug resistant organisms requires a deep clean followed by disinfection using hydrogen peroxide (H2O2) vapour machines. The request is to purchase 2 UVC (ultra-violet) disinfection units.

2.2 The current machines, which will still be used, take 3 hours to disinfect whereas the UVC machines can complete this in 20 minutes. They have a similar efficacy to the hydrogen peroxide vapour machines.

2.3 The reduced time will improve the patient experience considerably for patients who require isolation as currently their transfer to a ward is delayed by 3 hours whilst the side room is disinfected.

2.4 In addition these new UVC machines can also be used in small areas such as sluices, toilets and bathrooms; the H2O2 cannot be used in these small enclosed areas.

2.5 In deciding the final supplier, the Trust utilised the National Framework Agreement for UVC Cleaning Solutions as provided by Commercial Procurement Services at Countess of Chester Hospital. These showed 4 suppliers - Preventamed, Hygiene Solutions, Gama and Amity.

2.6 The preferred supplier is Gama as it has provided a machine on free loan for the last 9 months, provided training to our domestic team and provide a discount on our current cleaning/disinfectant products. Another plus for the Gama machine as identified by our domestic staff is the ease and simplicity of use which means that the majority of our domestic staff can use it.

2.7 Note that Gama was the second cheapest supplier. The cheapest was Amity at £40,000 (plus VAT) and £2,800 maintenance for 2 years. However, the Trust has no experience with this supplier or the reliability of the product and responsiveness for support. References have been requested.

2.8 The cost of the 2 UVC machines from Gama including 2 years' free servicing is £52,000 plus VAT. Note that the VAT is not recoverable and the total cost is therefore £62,400.

This is for one brand new machine at £30,000 (plus VAT) and a reconditioned machine at £22,000. After the 2 year service contract, the Trust has the option to purchase an annual service contract at £5,000 per machine. This covers the annual replacement of 4 lamps, servicing charges and 24 hour support. If it doesn't purchase this option then the Trust will have to pay £500 per call out plus part fees eg. £800 per lamp. Warranty period is two years but doesn't cover replacement lamps.

2.9 Funding has been requested from the Southport & Ormskirk Hospital General fund; the available balance (as at 2nd January 2018) is £189,642.

3. Critical care transfer trolley

3.1 The request to purchase a critical care transfer trolley will expedite the safe transfer of critically ill patients as it is compatible with NWAS ambulances.

3.2 The design of the trolley enables equipment such as portable ventilators / monitors to be securely attached to the trolley during transit.

3.3 The total cost of the trolley is £10,135. This cost is exclusive of VAT as it is eligible for VAT relief.

3.4 Funding has been requested from the Southport & Ormskirk Hospital General fund; the available balance (as at 2nd January 2018) is £189,642.

4. Patient couches to enhance the comfort of patients admitted to the surgical assessment unit

4.1 As part of the Safe at all Times project, to improve patient flow, a new Surgical Assessment Unit has been created on ward 10b.

4.2 This new 6 bay unit provides a dedicated area for surgical admissions to wait prior to their surgery.

4.3 The request to purchase these patient couches will improve the comfort of patients whilst they wait.

4.4 The total cost of the couches is £19,800 for six. This cost is exclusive of VAT as they are eligible for VAT relief.

4.5 Funding has been requested from the Southport & Ormskirk Hospital General fund; the available balance (as at 2nd January 2018) is £189,642.

5. Conclusion

5.1 The requests meet the charitable fund objectives as they will enhance the patient experience

5.2 Sufficient funding has been identified within the charitable funds. All requests will be out of the Southport & Ormskirk General Fund. The balance remaining on this fund after approval of these 3 items will be £97,307.

5.3 The appropriate governance processes have been followed as all requests have gone through the Director of Finance, Chair or been discussed at the last Charitable Fund Committee.

6. Recommendation

6.1 It is recommended that the Trust Board, acting as the Corporate Trustee, approve the above charitable fund requests.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
10th December

Agenda Item	**TB010/17**	**Report Title**	**Care Quality Commission Improvement Plan Update**
Executive Lead	Sheila Lloyd, Director of Nursing Midwifery Therapies and Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve ✓ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

The report describes the current position and progress monitoring of the CQC improvement plan following the CQC inspection 12th – 15th April 2016. It also provides an update following the CQC unannounced visit in November 2017 and the 'Well Led' review between 5th to 7th December 2017. Any additional actions highlighted during the 2017 CQC visits will be incorporated into the revised CQC Action Plan monitored by the new 'CQC Action Plan Leadership Group', a sub-group of the Quality and Safety Committee.

The Board is asked 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 Trust strategic objectives for 2017/18)*

☐ **SO1** Agree with partners a long term acute services strategy
✓**SO2** Improve clinical outcomes and patient safety
☐ **SO3** Provide care within agreed financial limit
✓**SO4** Deliver high quality, well-performing services
✓**SO5** Ensure staff feel valued in a culture of open and honest communication
✓**SO6** Establish a stable, compassionate leadership team

Governance

✓Statutory requirement
☐ Annual Business Plan Priority

☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register: (Please give reference no.)

_____

☐ Service Change

☐ Best Practice

☐ Other List (Rationale)

_____

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)*

Previously Presented at:

☐ Audit Committee	☐ Workforce & OD Committee
☐ Finance Performance & Investment Committee	☐ Mortality Assurance & Clinical Improvement Committee
✓ Quality & Safety Committee	

CQC Update and Well-Led Review

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.

The purpose of this report is to provide an update to the Board regarding the Trust's current position in relation to the CQC Must Do and Should Do's.

2 Trust Approach to Must Do and Should Do actions

The Trust has an organisational Action Plan to deliver the CQC recommendations and is updated and led by the appropriate CBU Associate Medical Director, Head of Nursing / Midwifery and Associate Director of Operations with support from the Assistant Director of Quality.

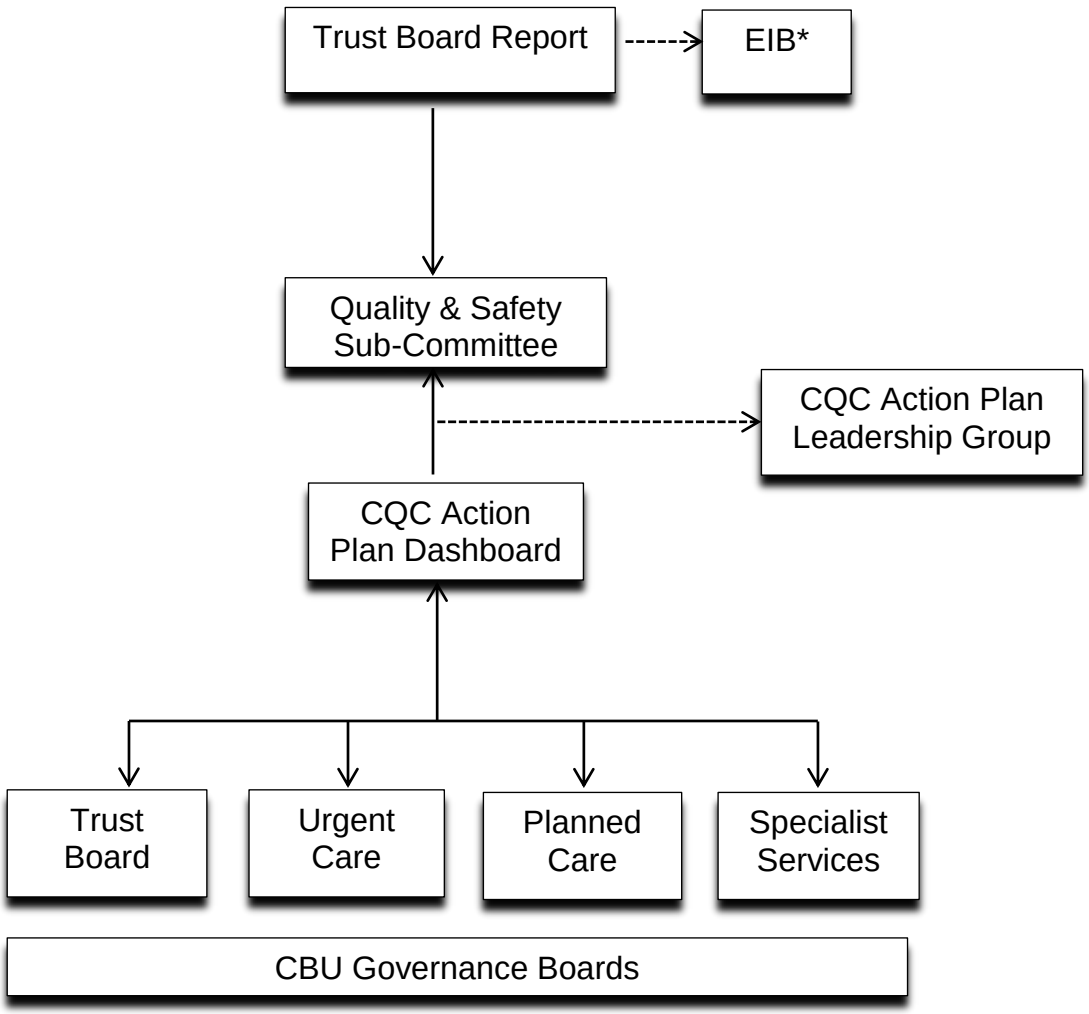
A central electronic information drive is in place to collate all the supporting evidence of completion, the Quality Standards Team are working with the CBUs to monitor, review and update evidence. In addition the Business Intelligence team have developed a matrix to monitor compliance. This matrix has indicators from three routes:

- CBU and Corporate intelligence
- 'Go and See' visits
- Audit of compliance

Action plans were being actively monitored through regular meetings led by the Deputy Director of Nursing, Midwifery and Therapies, the Assistant Director for Quality and through the CBU's Governance meetings. However, from January 2018 a new forum 'CQC Action Plan Leadership Group' has been established as a sub-group of the Quality and Safety Committee to monitor delivery against the revised CQC Action Plan. The draft Terms of Reference include:

- Monitoring delivery of the CQC Action Plan
- Establishing accountability across all operational and corporate functions
- Embed actions and improvement
- Provide assurance (evidence of ongoing compliance)
- Mitigate any risk of non-delivery

The diagram below describes the governance framework in relation to the CQC Action Plan.



**EIB – Executive Improvement Board*

The Screen Shots below provide examples of the CQC Action Plan and the CQC Dashboard

CQC Action Plan

CQC Action A&E 1			**The Service MUST ensure that Mortality is to be discussed monthly and minutes taken to evidence discussion**								
Background			Although there was a culture of reporting and learning from incidents, staff did not have a focused approach to reviewing patient deaths (mortality).								
Service definition of 'good'			Established systems and processes that review patient deaths and share learning. Staff are able to articulate the process for reviewing deaths								
Referen	**Executive Lead**	**Operational Le**	**Monitoring Commit**	**Actions**	**Timescale**	**Risk of non-completion**	**Evidence of Comp**	**Action RAG rating**	**Measure of Suc**	**Outcome RAG rating**	**Progress Update**
A&E 1.1	EMD	AMD/CD	Urgent Care Governance	All patients who die in the department who are not pre-hospital cardiac arrests to be discussed at local HARM meeting	28/01/2017	Low	HARM minutes	Complete	Capture of all ED deaths	Achieved - new	Evidence of minutes. Reconciliation report to be undertaken monthly with OSM to ensure that all
A&E 1.2											
CQC Action A&E 2			**The Service MUST Ensure mandatory training compliance reaches and consistently achieves the trust target.**								
Background			Mandatory and statutory training compliance was not meeting the Trust target of 90%. Only 63% of medical staff and 77% of nursing staff were up to date with mandatory training and only 45% of medical and nursing staff were up to date with statutory training. This gave an overall figure for training in nursing and medical staff of only 58%. Figures provided for safeguarding training showed that low numbers of staff had completed level two and three training.								
Service definition of 'good'			Staff will be compliant with mandatory training, managers will proactively manage none compliance and individuals will take individual responsibility for maintaining there own compliance								
Referen	**Executive Lead**	**Operational Le**	**Monitoring Commit**	**Actions**	**Timescale**	**Risk of non-completion**	**Evidence of Comp**	**Action RAG rating**	**Measure of Suc**	**Outcome RAG rating**	**Progress Update**
A&E 2.1	DoN	HON	Urgent Care Governance	Rolling programme to ensure all staff reach required targets. Local records to be validated against Trust records . Trajectory to be set and monitored to ensure month on month improvement evidenced	30/06/2017	Medium	improvement in compliance with mandatory training records	On track	compliance of mandatory training targets		Progress reviewed at monthly budget meetings. Clinical Educator has established mandatory training study days for A&E and obs ward nursing staff. Staff allocated to attend on a monthly basis. Discrepancies continue to be identified between local and central records. Updated timescale and unrealistic 21/2/17 due to pressures in department. Evidence of month on month
A&E 2.2	EMD	HON	Urgent Care Governance	1:1 supervision meeting will incorporate review of training compliance	01/03/2017	Low		Complete	Mandatory training compliance improves and monitoring is embedded in	Achieved - new	Supervision document amended

CQC Dashboard

NHS
Southport and Ormskirk Hospital
NHS Trust

CQC Action Plan Dashboard

Service	Must/Should Do	Indicator Name/Process of Assurance	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Trend	Achieve Target
A&E	The Service MUST ensure that Mortality is to be discussed monthly and minutes taken to evidence discussion	Weekly Harms meeting in place, new 'Learning from Deaths' guidance on place, compliant following SJR (Structured Judgement Review) training										
	The Service MUST Ensure mandatory training compliance reaches and consistently achieves the trust target.	HR - Mandatory Training - A/E	79.03%	82.4%	86.21%	84.84%	85.69%	85.18%	86.32%	84.56%		85%
	The Service MUST Ensure appropriate signage is displayed in areas where close circuit television cameras are used.	CQC Action Plan - A&E - Appropriate Signage in CCTV Areas?			Y	Y	Y	Y	Y	Y		
	The Service MUST Ensure the actions identified following our concerns about the death of a patient during our inspection are implemented in accordance with planned timescales	Number of Nursing Vacancies - A&E Safety Nurses also recruited. **Backfilled so 100%**	21	20	21	22	23	21	19	17		
		Nursing Vacancy Rate - A/E **Backfilled so 100%**	25.45%	24.16%	26.43%	27.44%	28.62%	25.82%	23.31%	22.09%		
	The Service MUST Ensure all patients receive timely (particularly initial) observations whilst in the department	Audit June 2017 Monthly point prevalence audits measure - patients with 2 or more SIRS are commenced on the Sepsis pathway | patients presenting with head injury have a head injury decision pathway commenced at triage | patients scoring a NEWS of 6 or more two hours from commencing treatment discussed with a senior and plan documented.										
	The Service MUST Ensure staff use and evidence use of the sepsis care pathway for patients suffering sepsis.	Sepsis Pathway Compliance - A&E	83.3%	100.%	91.7%	100.%	91.6%	91.6%	91.6%	100.%		95.%

The Trust CQC Action Plan includes the following information and RAG rating.

- Reference to 2016 CQC Report
- Responsible Executive / Manager
- Governance – Responsible Committee
- Description of Action
- Timescales
- Risk
- Evidence and Measure

There was a commitment to complete all MUST do actions by the end Q1 and all SHOULD do actions by end Q3.

3 Current Position and Progress Monitoring

As reported to the last Trust Board and Quality and Safety Committee, the table identifies the actions completed either MUST or SHOULD. Although these actions have been initially identified as complete, 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.

Current status of MUST and SHOULD do actions.

Action Plan	Speciality	Must Do	On track	Off track	Completed	Should Do	On track	Off Track	Completed
Trust Board	Board	8	-	-	8	1	-	-	1
All CBUs	Outpatients and Imaging	-	-	-	-	11	-	2	9
Urgent Care	Accident and Emergency	13	-	1	12	3	-	-	3
	Medicine	8	-	-	8	10	-	2	8
	Critical Care	-	-	-	-	3	-	-	3
Planned Care	Surgery	16	-	1	15	4	-	1	3
	Spinal Injuries	-	-	-	-	7	-	2	5
Women and Children	Paediatric A&E	-	-	-	-	6	-	-	6
	Children's Services	1	-	-	1	6	-	2	4
	Maternity and Gynaecology	3	-	-	3	13	-	1	12
	Sexual Health	5	-	-	5	4	-	1	3

The CBUs are currently assessing and reviewing 'should do' compliance.

Must do actions currently off track, have been escalated through executive team:

Scheme	Area	Action off track	Progress to Date
Staffing	A&E	Not all vacant posts have been filled	Active recruitment is in place – Safe Staffing is in place, supported by additional bank / agency staff, although the use of agency has drastically reduced with the majority of staff coming through NHSP. This has been due to partnership working NHSP and introducing 'auto-reg' for all new clinical and substantive staff. In October 2017 the trust commenced drafting a delivery plan of all the work included within the contract against the initial Trusts 3 priorities: • Governance • Workforce Planning • E-Rostering Within the delivery plan NHSI are commencing the governance and workforce planning elements and will continue with the rostering support. The Assistant Director for Nursing Workforce will determine detailed plan of action with NHSI, therefore the Board will be updated of plans at the meeting on 10th January 2018. A self-assessment tool will further shape this work required going forward and support the diagnostic process. A Nursing Recruitment Event took place on Tuesday 22nd November 2017, 24 candidates attended and 16 conditional offers were made.
Estates	Surgery	Refurbishment of wards to support dementia care	The Estates Team have a work programme in place to roll out ward and clinical estate refurbishment in line with the Dementia Strategy, work is estimated to be completed end of 2019. This will work alongside the 'Safe At All Times' (SAAT) ward moves programme. The Dementia Friendly decoration work commenced on Ward 14a in September 2017, this will continue to be rolled out throughout the Trust in both Southport and Ormskirk sites. Phase One of the Southport SAAT

Scheme	Area	Action off track	Progress to Date
			programme was successfully completed on Tuesday 22nd November 2017. Phase Two will include the implementation of the communications hub and the endoscopy moves, along with some outstanding estates work. This phase will rely on any funding remaining in year or new year capital funding. The project to ensure patients are Safe at all Times (SAAT) at our Ormskirk site, has 3 key objectives • Move E ward to G ward by 16th February 2018 • Move day-case unit to Ormskirk so F ward obtains all day surgery • Complete Organisational development review of nursing and medical staffing, required to enable changes at Ormskirk including all training and competency requirements by end of February 2018

Should do actions currently off track, have been escalated through executive team:

Scheme	Area	Action off track	Progress to Date
Complaints	Children's Services	Ensuring Complaints dealt with in a timely manner	Additional staff have received training in complaint handling to allow for timely investigation and responses, this will reviewed at CBU governance meetings. Seven complaints are currently outstanding in pediatric services, out of these there are three complaints over the due dates, the longest being 101 days, the expected completed date is 15th January 2018
	Surgery	Use complaints to drive service improvement	Complaints discussed at Governance and weekly Harm meetings, issues identified for sharing and lessons learnt are agreed and included in CBU news bulletins.
Estates & Environment	Children's Services	Cross departmental working to support clinics where children	Ophthalmology clinic now held in Paediatric OPD. Child friendly environmental improvements have been undertaken within Max-fax clinic. A working group has been established led by the Matron for

Scheme	Area	Action off track	Progress to Date
		attend	Paediatrics and Neonatal services to review all pediatric clinics, work is also underway engaging with patients and families to ensure theatres are more child / young person friendly at the Ormskirk site.
	Spinal	Improving facilities for management of infectious patients	Spinal manages infectious patients in line with Trust guidance. Isolations pods have been considered as an alternative to creating additional side rooms. Spinal continues to work with Estates and Infection Prevention Control to find a solution.
Workforce	Maternity & Gynae	Midwives should be up to date with their annual appraisals	Compliance monitored monthly at Governance, unfortunately compliance has fallen again in November to 74.29% against 90% target. All staff have now got dates in diaries for appraisals.
	OP and Imaging	Staffing – recruitment of medical consultants, radiologists and ultra-sonographers / sufficient cover for long-term sickness.	Substantive appointment for Sonographer made. 12 month Fixed term contract for Radiologist issued and substantive advert for appointment re-advertised. Joint working with Whiston under discussion, 2 trainee sonographers in post. Ongoing monitoring of recruitment and staffing levels via Q&S reporting
	Spinal	Improve compliance with staff training and appraisals	Improvement has been made; compliance is currently 80.23% against a 90% target. Ward managers are working with individuals to ensure they have time in diaries for appraisals and mandatory training.
Clinical	Sexual Health	Awareness of chaperone policy and patients offered chaperones	Chaperone policy has been reviewed awaiting approval and ratification (January 2018). Audit of use will be undertaken
	Medicine	All wards to have ligature points risk assessments in place.	Currently being reviewed for compliance. Mersey Care review of the ligature risk undertaken in October 2017. Ligature cutters are expected to be available on all resus trolleys by end January 2018, individualised patient risk assessment undertaken as necessary.
	Medicine	Improving seven day services to provide an equitable service throughout the week.	Urgent Care has now increased consultant presence at weekends, with an additional consultant on site between 9.00am and 9.30pm.

Scheme	Area	Action off track	Progress to Date
	OP and Imaging	Invest in e-communication system between GPs and radiology to improve referrals, appointments and reporting.	Order Communications is now in place internally through Medway. Results are also available to view by both Trust staff and GPs via the 'Review' system. Going forward systems such as ICE are being considered as an interface between primary and secondary care, in line with other Chester and Merseyside providers.

4 Planning and Preparation for CQC Visits

To ensure frontline staff are fully aware of progress made since the last CQC inspection in all areas, 'you said, we listened, we did' and 'what we have achieved in 2017' posters are displayed within clinical and public areas on both sites, these will continue to be updated as actions have been completed. The Quality Standards Team, CBU triangles and Matrons also attended clinical areas to give feedback on progress against the CQC Action Plan and face to face coaching in preparation. A 'Preparing for CQC Inspection' booklet was also developed and circulated to all staff.

5 Unannounced Core Services Visits

The CQC arrived on site on Monday 20th November for the Trust's unannounced Core Services Inspection, this initial review lasted 4 days. All core services were covered with the exception of North West Regional Spinal Injuries Centre (NWRSIC). On Monday 27th November, teams arrived again for an unannounced 4 day visit to the NWRSIC and also visited A&E to ensure the actions we agreed to take in relation to the sub-wait areas had been implemented, which they had.

6 CQC Well Led Review

The CQC visited the Trust for the announced 'Well Led' review between 5th to 7th December 2017. In preparation, the CBUs and Corporate Teams undertook a self-assessment / review of leadership and governance using the Well Led framework. The Interim Company Secretary and Assistant Director of Quality assessed and evaluated submissions and identified gaps for review by the Executive Team, this was discussed at the CQC Well-Led Board Workshop on 1st November 2017. An action plan has been developed and will be monitored as part of the revised CQC Action Plan monitored by the 'CQC Action Plan Leadership Group'

The CQC requested three focus groups that were arranged prior to the inspection for:

- Non Consultant Doctors
- NEDs
- Consultants

In addition, at the request of the CQC, a number of Well-Led interviews were arranged with staff members. A briefing pack was developed and shared with all Non-Executive Directors, Executives and Senior Managers / Clinical Leads to assist with preparation for the Well-Led Review.

Any queries or concerns escalated during the CQC visits are included in an action plan and the status RAG rated, the action plan is regularly shared with the CQC to provide assurance regarding progress and the responsiveness of the Trust. Actions and Key issues highlighted during the CQC visits will be incorporated into the revised CQC Action Plan. A weekly meeting with the Matrons and Key Clinical Leads is in place to deliver all actions from both visits. The outcome of the meetings will populate the new 'CQC Action Plan Leadership Group', subgroup of the Quality and Safety Committee.

The CQC provided high level feedback on 7th December 2017 at the end of the visit, this included a big thank you to all staff for welcoming the CQC team and being open and honest in the interviews and focus groups.

All trust staff are fully aware that the CQC can attend any of our clinical areas at any time in the near future. It is anticipated that the Trust will receive the Inspection Report incorporating both Core Services and Well-Led in March 2018.

7 Conclusion

The Trust is currently reviewing the CQC Action Plan and focusing on embedding the changes and moving from an 'action plan' to a 'sustainable improvement plan'. Some early feedback from our recent CQC Well-Led review indicated there is still variation across the CBUs and clinical services in terms of compliance.

Therefore, the following actions are in progress:

- Review of evidence provided to date and revalidate the current position
- CBUs to undertake self-assessments of compliance against the 'Must and Should Do's' utilising the Trust's governance and committee structure.
- Review of the reporting process as part of the new (in draft) Quality Improvement Plan.
- Refresh and update the reporting documentation to Trust Board, EIB and other stakeholders
- The development of the CQC Action Plan that incorporates actions from the 2016 CQC Report, 2017 Well Led and Core Services Inspections and the, Well Led Gap Analysis.

Jo Simpson
Assistant Director of Quality
January 2018

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

NHS
Southport and Ormskirk Hospital
NHS Trust

FIT AND PROPER PERSONS' POLICY AND PROCEDURE

For Compliance with the Fit and Proper Persons' Requirements (FPRR)
CORP 118

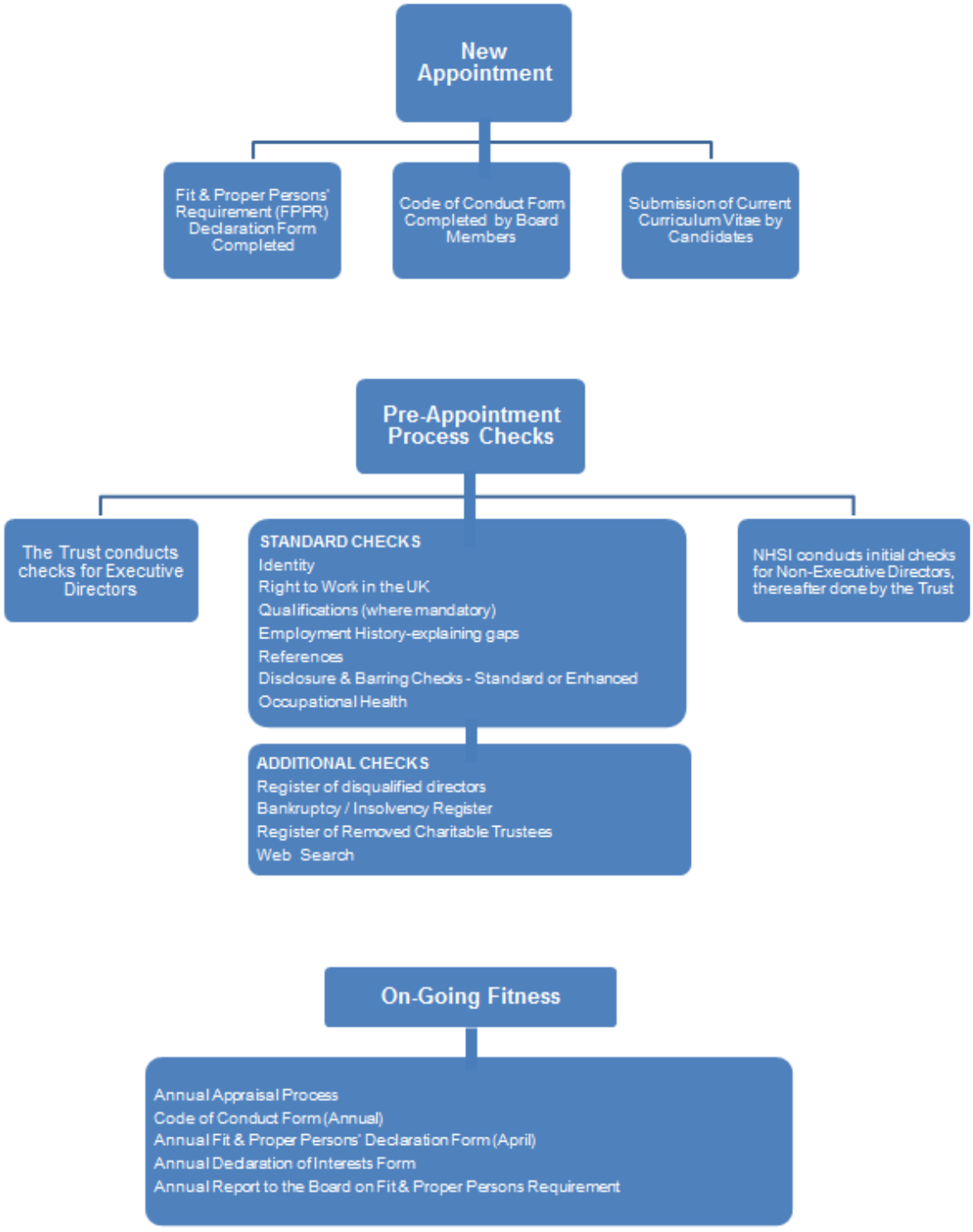
Who should read this SOP:	Planned Care CBU	Urgent Care CBU	Specialist Services CBU	Corporate
All trust Staff	✓	✓	✓	✓

CONTENTS (Ctrl + click on hyperlink to relevant section)

1. EXPLANATION OF TERMS USED IN THIS POLICY

Terminology	Explanation
Fit and Proper Persons' Regulations	A piece of regulation to ensure that people who have director level responsibility for the quality and safety of care and for meeting the fundamental standards are fit and proper to carry out this role
Fit and Proper Person's test	This is a test which aims to prevent corrupt or untrustworthy individuals serving on the boards of organisations including public sector ones.
Disclosure and Baring Service (DBS)	The DBS helps employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Record Bureau check (CRB). A search against an individual's name may be standard or enhanced depending on the individual's responsibility and contact with vulnerable groups.
Disqualified directors	The *Company Directors' Disqualification Act 1986 (section 7)* allows for a court to make a disqualification order against a director in relation to fraud or wrongful behaviour
Removed Charity Trustees	The Charity Commission for England and Wales' Register lists the names of individuals who have been removed from a Charity as a trustee and lists the reasons for such removal, usually due to undesirable behaviour
Code of Conduct	A prescribed set of rules relating to behaviour to be read and signed by directors and senior managers in organisations especially public sector ones
Nolan Principles in public life	These were defined by the Committee for Standards of Public Life chaired by Lord Nolan. These principles were published in its first report in 1995. The seven (7) principles are: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership
Bankruptcy / Insolvency Register	Registers of individuals who have been declared bankrupt or insolvent. These registers are available for public viewing.
Sequestration	The seizure of property for creditors or the state
Regulated activity	Activities which involve working with or coming in contact with vulnerable people like children, elderly or those requiring personal care.

2. FLOWCHART FOR FIT & PROPER PERSONS' POLICY



3. INTRODUCTION

Regulation 5 of the Fit and Proper Persons' Regulations has been introduced as a direct response to the failings at Winterbourne View Hospital *and the Francis Inquiry Report into Mid Staffordshire NHS Foundation Trust,* out of which it was recommended that a statutory fit and proper person's requirement be imposed on health service bodies. This policy outlines the application of this test for new appointments and existing post holders.

In addition, where the Trust engages an interim at a senior level equivalent to the posts above, the process for *Fit and Proper Persons' Requirements (FPPR)* will apply if they are employed or registered as an external worker. Where an interim is sourced by an agency the recruitment agency will be made aware of the FPPR procedure and must confirm that they have undertaken the necessary checks. Executive search companies will also be required to confirm compliance with the FPPR and provide relevant evidence for inspection by the Trust.

It is ultimately the Chair's responsibility to discharge the requirement placed on the Trust to ensure that all Directors meet the *Fit and Proper Persons' Requirements* and do not meet any of the unfit criteria.

In NHS Trusts NHS Improvement (NHSI) is responsible for the recruitment of Non-Executive Directors (NEDs), therefore, NHSI conducts the initial FPPR checks upon the appointment of Non-Executive Directors and retain this information centrally. The Trust conducts checks for Executive Directors and will ensure that both NEDs and Executive Directors remain fit and proper.

4. PURPOSE

This policy sets out how the Trust will comply with its regulatory requirements to ensure that all Directors are fit and proper persons to carry out their roles as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

5. SCOPE

This policy and procedure applies to all board appointments i.e. executive and non-executive directors and those senior managers which are formally recognised as part of the Trust's Executive Team. This includes permanent, interim and associate positions.

6. LINKS TO OTHER KEY POLICIES AND PROCEDURES

This policy and procedure should be read in conjunction with the following Trust's policies:

- Standards of Business Conduct and Managing Conflicts of Interest
- Anti-Fraud, Bribery & Corruption
- Code of Conduct for Board Members

7. MEETING THE REQUIREMENTS OF THE REGULATIONS

The introduction of the *Fit and Proper Person's Requirements (FPPR)* places the ultimate responsibility of the Chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria. Further detail is provided in the *Care Quality Commission (CQC) Guidance for NHS Bodies: Fit and Proper Persons: Directors, November, 2014*.

http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to CQC on request. Individuals who fall into the categories above must satisfy the Chair they:

- Are of good character
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed
- Are able, by reason of their physical and mental health after any required reasonable adjustments if required, capable of properly performing their work.
- Can supply relevant information as required by *Schedule 3 of the Act,* i.e. documentation to support the FPPR.
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity)

In accordance with *Schedule 4 part 1* of the act a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part v11A (debt relief orders) of the *Insolvency Act 1986.*
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the *Safeguarding Vulnerable Groups Act 2006,* or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.
- In accordance with part 2 of the Act a person will fail the good character test if they;
- Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Has been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals

8. IMPLEMENTATION OF FPRR FOR EXISTING STAFF AND ON-GOING FITNESS

8.1. Implementation

All post holders identified above are obliged to complete a FPPR declaration (**Appendix 1**).

This declaration will be retained on the individual's personal file by the Associate Director of Human Resources & Organisational Development for executive appointments and those senior managers which are formally recognised as part of the Trust Executive Group or the Chairman for non-executive appointments.

The process for assurance includes a check of personal files to ensure there is a complete employment history and where there are any gaps or omissions the post holder will be asked to provide a written explanation for this. Where the Trust has no record of mandatory qualifications or mandatory professional registration the individual will be asked to produce the original for inspection and verification.

The Chairman will be notified of any issues of non–compliance and is the responsible officer for making an informed decision regarding the course of action to be followed. Current post holders that cannot satisfy the declaration questions will not necessarily be barred from continuation of employment/office as it will depend on the relevance of the information provided in respect of the nature of the position, and the particular circumstances. The Trust will address this in the most appropriate, relevant and proportionate way on a case by case basis.

8.2. On-going fitness

The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust values and behaviour standard including the leadership behaviour expected. The CEO will be responsible for appraising the Executive Directors, whilst the Chairman will be responsible for appraising the Non-Executive Directors. The CEO will be appraised by the Chairman. The Chairman will be appraised by NHSI. A new self-declaration will be completed at each appraisal.

Every April there will be a requirement for post holders to complete a further form of declaration confirming that they continue to be a fit and proper person. Confirmation of compliance will be published in the Trust's Annual Report.

Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust using the Fit and Proper Persons Requirement Disclosure Form Existing post holders (Appendix 1).

8.3. Concerns about an individual's continued FPPR compliance status.

Where matters are raised that cause concerns relating to an individual being fit and proper to carry out their role the Chairman will address this in the most appropriate, relevant and proportionate way on a case by case basis. Where it is necessary to investigate or take action the Trust's current processes will apply using the Trust's capability process (managing performance or sickness absence), Disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'. There may be occasions where the Trust would contact NHS Improvement for advice or to discuss a case directly.

The Trust reserves the right to suspend a Director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than

necessary to protect the interests of patients of the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (GMC, NMC etc.) no longer meets the fit and proper person's requirement the Trust will inform the regulator, and also take action to ensure the position is held by a person meeting the requirements. Directors may personally be accused and found guilty by a court of serious misconduct in respect of a range of already prescribed behaviours set out in legislation. Professional regulators may remove an individual from a register for breaches of codes of conduct.

9. PROCESS FOR NEW APPOINTMENTS

The Trust's comprehensive pre-employment checking processes are determined by the NHS employment standards and include the following:

1. Proof of identity
2. DBS check where relevant to the post (the Trust considers all Executive/Non-Executive Directors and those Senior Managers which are formally recognised as part of the Trust Executive Group.
3. Occupational Health Clearance as relevant to the role
4. Evidence of the right to work in the UK
5. A check of employment history and two references one of whom must be the most recent employer. Specifically, this includes validating a minimum of three years continuous employment including details of any gaps in service. The number of references may differ for each applicant, depending on how many episodes of employment they may have had in the last three years prior to making their application.
6. Qualifications/registration applicable to role

In addition the following registers will be checked:

- *Disqualified directors*
- *Bankruptcy and insolvency*
- *Removed Charity Trustees*
- *A web search of the individual*

The FPPR requirements introduce the requirement to complete a FPPR Declaration form for new employees, (**Appendix 3).** This form and summary

guidance (**Appendix 4**) will be included with the application pack and form part of the application process for the position.

While the Trust will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent' there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

The Chair of the appointments panel will be responsible for ensuring compliance supported by the relevant recruitment support. A detailed checklist will be completed and will be retained on the post holder's personal file for the purposes of audit.

NHSI is responsible for the appointment and removal of the Chairman and the Non-Executive Directors, drawing on the recommendations of the Board of Directors' Remuneration & Nominations Committee and the Chair respectively. In respect of Executive Directors, this responsibility will be discharged by the Board of Directors' Remuneration & Nominations Committee which is responsible for the appointment and removal of the Executive Directors.

Any executive or non-executive appointment will take into account the Trust's obligations under the Regulations. Where the Trust makes a decision on the suitability of an individual, the reasons will be recorded by the Trust's Director of HR or equivalent.

Where the Trust deems that the individual who is to be appointed is suitable, despite not meeting the characteristics outlined in *Schedule 4, Part 2 of the Regulations (Good Character),* the reasons will be recorded by the Trust's Company Secretary in the minutes of the relevant meeting: i.e. the Board of Directors' Remuneration and Nominations Committee (in the case of Executive Directors) or NHS Improvement (in the case of the NEDs) (the 'Relevant Meeting') and the information about the decision will be made available. The appointment process will include an evaluation against the Trust's values and any relevant external guidance. External advice will be sought as necessary.

Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator.

The Trust will carry out employment checks (so far as reasonably practicable) on a candidate's qualifications and employment records. The recruitment process will necessarily include a qualitative assessment and values based assessment.

Where the Trust considers that an individual can be appointed to a role based on their qualification, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timescale any such discussions or recommendations will be recorded by the Company Secretary in the minutes of the Relevant Meeting. Any discussion, recommendation or decision must also be recorded in the minutes.

If the Director has a physical or mental health disability wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. Any prospective candidate will need to complete the '*Fit and Proper Person' Declaration*. In the event the prospective candidate identifies any physical or mental health concerns (and subject to further information being obtained from the candidate, if necessary) their appointment will be subject to clearance by Occupational Health as part of the pre-appointment process. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded by the Trust's Company Secretary in the minutes of the Relevant Meeting.

10. BOARD ASSURANCE

The Board of Director's Remuneration and Nominations Committee will receive a report to confirm implementation of the FPPR for existing post holders. The Trust's statutory and assurance committees will also receive reports regarding new appointments and the annual FPPR checking process. The Chairman is the responsible officer for ensuring compliance for new starters. A summary of compliance will appear in the Trust's *Annual Report*.

11. REFERENCES

The following documents are helpful in providing a greater understanding of the policy

- Committee for Standards of Public Life (Nolan Principles)
- The Insolvency Act
- The Bankruptcy Act
- The NHS and Social Care Act 2006 (as amended 2012)
- The Data Protection Act 1998
- The Freedom of Information Act 2000

12. ROLES AND RESPONSIBILITIES FOR THIS POLICY

Title	Role	Responsibilities
Trust Chairman		Overall responsibility to ensure that there is compliance with the policy including appointment of the Chief Executive and other Executive Directors
Chief Executive		To ensure that the policy is applied with regards to executive directors
Associate Director of Human Resources		To support the Chairman by ensuring all the Regulation 3 checks are undertaken prior to appointees commencing their role
Company Secretary		To support the Chairman by undertaking searches of relevant registers to ascertain a potential board member's fit and proper status and to ensure that all directors (NEDs and Executives) are annually declared fit and proper
Executive Directors		To support the Chairman by ensuring that direct reports engaging in regulated activities are fit and proper by undertaking the relevant checks

13. TRAINING

Which aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure NHS Improvement that staff have had this training
Checks and searches	Human Resources	No	On a face to face session	By the Company Secretary	Annually	The Company Secretary

14. EQUALITY ANALYSIS ASSESSMENT

Southport & Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Governance Team.

15. DATA PROTECTION AND FREEDOM OF INFORMATION

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff members have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

16. MONITORING HOW THIS POLICY IS WORKING IN PRACTICE

Monitoring this policy is working in practice? (measurable policy objectives)	Ensure process for new appointments are robustly undertaken	Undertake checks of existing staff	Ensure that relevant staff maintain on-going fitness and proper persons' requirements
Where described in the policy?	Section 7	Section 6	Section 6
How will they be monitored? (method & sample size)	Undertake random checks of personal files	Undertake checks of all personal files for relevant staff	Undertake checks of all personal files for relevant Fit & Proper Persons' Declaration Form to be completed and signed along with Directors' Code of Conduct
Who will monitor?	Internal Audit and Company Secretary	Company Secretary	Company Secretary
How Frequently?	Annually	Annually	Annually or more frequently if required
Group/Committee that will receive and review results	Audit Committee/Board	Audit Committee/Board	Audit Committee/Board
Group/Committee to ensure actions are completed	Audit Committee/ Board	Audit Committee/ Board	Audit Committee/ Board
Evidence this has happened	Report of findings in personal files of designated staff: * identity *DBS check	As above	Completed and signed FPPT Form Completed Code of Conduct Form

	*Occupational Health clearance *Evidence of right to work in UK *Employment history *Qualification & Registration checks *Disqualified directors check *Bankruptcy and insolvency check *Removed Charity Trustee Check *Web search of individual		

17. APPENDICES

Appendices for the Fit and Proper Persons Policy and Procedure	
Appendix 1	Fit and Proper Persons Requirement Personal Disclosure Form for an Existing Post Holder (Implementation, Annual Review or Ad-hoc Declaration).
Appendix 2	Recruitment and Selection Processes to meet Fit and Proper Persons Regulations (FPPR) for a New Appointment.
Appendix 3	Fit and Proper Persons Requirement Personal Disclosure Form for Applicants.
Appendix 4	Fit and Proper Persons Requirement, Important information for Applicants.
Appendix 5	Fit and Proper Persons Requirement, New Applicants' Employment Checklist.
Appendix 6	Supplementary information to support reference request, Fit and Proper Persons Requirement.

17.1. Appendix 1 Fit and Proper Persons Requirement Personal Disclosure Form for an Existing Post Holder

NHS
Southport and Ormskirk Hospital
NHS Trust

Fit and Proper Persons Requirement Personal Disclosure Form For an Existing Post Holder

(Implementation, Annual Review or Ad-hoc Declaration)

STRICTLY CONFIDENTIAL

First Names	
Surname	
If you are known under any other name please state	

Position Held	

Please respond to the following questions. You can type your responses and the box will expand if necessary. You can add an 'X' in the relevant answer box or delete the one that does not apply. If you choose to complete by hand please continue on a separate sheet if there is insufficient space detailing the number of the relevant question/s. A hard copy of the signed form will be required.

1. Are you currently or have you been the subject of action by the police? Action includes, but is not restricted to: investigation, summons, arrest, bound over, caution, reprimand, warning, driving offences, charge conviction or imprisonment which are not deemed 'protected' under the amendment to the Exceptions order 1975*, issued by a Court or Court-Martial in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include here details of the order binding you over and/or the nature of the office, the penalty, sentence of order of the Court, and the date and place of the Court hearing: You are not required to tell us about parking offences or spent driving offences

Please note that you do not need to tell us about convictions, cautions, warnings or reprimands which are deemed 'protected' under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 as amended by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013. You can read guidance and the criteria for the filtering of these convictions and cautions from the Disclosure and Barring Service website at:
https://www.gov.uk/government/organisations/disclosure-and-barring-service

2. Have you been charged with any offence in the United Kingdom or in any other country that has not yet been disposed of?

NO ☐
YES ☐

If **YES**, please include here details of the nature of the offence with which you are charged, date on which you were charged, and details of any on-going proceedings by a prosecuting body:

You are reminded that you have a continued responsibility to inform us immediately if you are charged with any new offence, criminal conviction or fitness to practise proceedings in the United Kingdom or in any other country.

You do not need to tell us if you are charged with a parking offence.

3. Are you aware of any current NHS Counter Fraud and Security Management Service (CFSMS) investigation following allegations made against you?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the NHS CFSMS.

4. Have you been investigated by the Police, NHS CFSMS or any other Investigatory Body resulting in a current or past conviction or dismissal from your employment or volunteering position?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the Investigatory Body:

Investigatory bodies include: Local Authorities, Customs and Excise, Immigration, Passport Agency, Inland Revenue, Department of Trade and Industry, Department of Work and

Pensions, Security Agencies, Financial Service Authority. This list is not exhaustive and you must declare any investigation conducted by an Investigatory Body.

5. Have you ever been dismissed by reason of misconduct from any employment, volunteering, office or other position previously held by you?

NO ☐
YES ☐

If **YES**, please include details of the employment, office or position held, the date that you were dismissed and the nature of allegations of misconduct made against you:

6. Have you ever been disqualified from the practice of a profession, or required to practice subject to specified limitations following fitness to practice proceedings, by a regulatory or licensing body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the nature of the disqualification, limitation or restriction, the date, and the name and address of the licensing or regulatory body concerned:

7. Are you currently or have you ever been the subject of any investigation or fitness to practice proceedings by any licensing or regulatory body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the reason given for the investigation and/or proceedings undertaken, the date, details of any limitation or restriction to which you are currently subject, and
the name and address of the licensing or regulatory body concerned:

8. Are you subject to any other prohibition, limitation, or restriction?

NO ☐
YES ☐

If **YES**, please include details:

9. Have you been responsible for, been privy to, or contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity?

NO ☐
YES ☐

If **YES**, please include details:

10. Do you consider that there is any reason why you are not able to carry out your role by reason of health (physical or mental health)? (See note below).

NO ☐
YES ☐

Note: It is important to stress that the FPPR requirements regarding ability to properly perform tasks intrinsic to the office or post does not mean that people who have a long-term condition, a disability or mental illness cannot be in such a position. It would be required of the Trust to, wherever possible, make reasonable adjustments to enable an individual to carry out the role. If you wish to discuss any aspect of your response, in confidence with an Occupational Health Physician, we can make arrangements for you to do so.

If **YES**, please include details:

11. Are there any other matters that may be relevant to your position which might cause your reliability or suitability to be called into question?

NO ☐
YES ☐

If **YES**, please include details:

Declaration

Important: The Data Protection Act 1998 requires us to advise you that we will be processing your personal data. Processing includes: holding, obtaining, recording, using, sharing and deleting information. The Data Protection Act 1998 defines 'sensitive personal data' as racial or ethnic origin, political opinions, religious or other beliefs, trade union

membership, physical or mental health, sexual life, criminal offences, criminal convictions, criminal proceedings, disposal or sentence.

The information that you provide in this Declaration Form will be processed in accordance with the Data Protection Act 1998. It will be used for the purpose of determining your suitability for the senior position you hold. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud.

This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the Trust who are authorised to view it as a necessary part of their work.

In signing the declaration on this form, you are explicitly consenting for the data you provide to be processed in the manner described above.

I consent to the information provided in this declaration form being used by the Trust for the purpose of checking that I satisfy the requirements of the FPPR for the position I hold.

I confirm that the information I have provided in this declaration form is correct and complete. In addition to completing an annual FPPR questionnaire I also understand that it is a requirement that I make the Trust aware as soon as practicable of any incident or circumstances which may impact on my position and provide details of the issue to the Chair or Associate Director of Human Resources so that this can be considered by the Trust.

I understand and accept that if I knowingly withhold information, or provide false or misleading information, this may result in an investigation in accordance with relevant Trust processes and could lead to the termination of the appointment.

Signature	
Full Name	
Date	

PLEASE COMPLETE, SIGN AND FORWARD A HARD COPY OF THE DECLARATION FORM IN AN ENVELOPE MARKED 'CONFIDENTIAL' FOR THE ATTENTION OF THE CHAIRMAN OR COMPANY SECRETARY.

17.2. Appendix 2 Recruitment and Selection Processes to meet Fit and Proper Persons Regulations (FPPR) for a New Appointment

NHS
Southport and Ormskirk Hospital
NHS Trust

Recruitment and Selection Processes to meet Fit and Proper Persons Regulations (FPPR) for a New Appointment

The aim of the FPPR is to ensure that all board level appointments of NHS institutions carrying on a regulated activity are responsible for the overall quality and safety of that care and for making sure that care meets the existing regulations and effective requirement of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. FPPR Regulation 5 is about ensuring that those individuals in senior appointments are fit and proper to carry out this important role.

FPPR Declaration requirements

The Trust will ensure that full compliance with the FPPR. Candidates will be required to complete a FPPR Declaration form along with a supporting up to date CV for the position. A copy of the guidance notes for candidates and the Declaration form is attached at Appendix (to be amended as relevant for each process).

If an agency or executive search organisation is supporting the Trust with the appointment, the agency/executive search company will be required to ensure that the Declaration form is completed by all candidates.

If the shortlisting panel considers a candidate that has declared a matter that appears to be in breach of the FPPR is a strong candidate worthy of further consideration it will be responsibility of the Chair of the shortlisting panel to discuss with the Chairman and the Director of Human Resources and Organisational Development before making a final shortlist decision. The Chairman and Director of Human Resources & Organisational Development will consider the matter and there may be occasions where it is considered necessary to consult with Monitor before deciding to exclude or include a candidate to the next stage of the process.

FPPR pre-appointment processes

The following checks are undertaken for all appointments to the Trust:

- Identity check.

- Right to work in the UK.
- Qualification checks (where essential/mandatory).
- Comprehensive employment history with any gaps in employment explained in writing.
- Reference checks to include confirmation of period of employment with the referee organisation, reasons for leaving their post.
- DBS checks (standard or enhanced appropriate to role).
- Occupational Health Declaration form.

Additionally for posts that require the FPPR test the following must be in place:

- Fit & Proper Person's Declaration form assessed as meeting the requirements.
- Checks on the 'barred' list, by using the register of disqualified directors, the bankruptcy/ insolvency register and the register of removed charities trustees' sites.
- The Trust will also carry out a web search of the individual.

17.3. Appendix 3 Fit and Proper Persons Requirement Personal Disclosure Form For Applicants

NHS
Southport and Ormskirk Hospital
NHS Trust

Fit and Proper Persons Requirement Personal Disclosure Form For Applicants

(This form will form part of the application process for all posts that are considered to meet the FPPR)

STRICTLY CONFIDENTIAL

First Names	
Surname	
If you are known under any other name please state	

Position Applied for	

Please respond to the following questions. You can type your responses and the box will expand if necessary. You can add an 'X' in the relevant answer box or delete the one that does not apply. If you choose to complete by hand please continue on a separate sheet if there is insufficient space detailing the number of the relevant question/s. A hard copy of the signed form will be required.

1. Are you currently or have you been the subject of action by the police?? Action includes, but is not restricted to: investigation, summons, arrest, bound over, caution, reprimand, warning, driving offences, charge conviction or imprisonment which are not deemed 'protected' under the amendment to the Exceptions order 1975*, issued by a Court or Court-Martial in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include here details of the order binding you over and/or the nature of the

office, the penalty, sentence of order of the Court, and the date and place of the Court hearing:

You are not required to tell us about parking offences or spent driving offences.

*Please note that you do not need to tell us about convictions, cautions, warnings or reprimands which are deemed 'protected' under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 as amended by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013. You can read guidance and the criteria for the filtering of these convictions and cautions from the Disclosure and Barring Service website at:
https://www.gov.uk/government/organisations/disclosure-and-barring-service

2. Have you been charged with any offence in the United Kingdom or in any other country that has not yet been disposed of?

NO ☐
YES ☐

If **YES**, please include here details of the nature of the offence with which you are charged, date on which you were charged, and details of any on-going proceedings by a prosecuting body: You are reminded that you have a continued responsibility to inform us immediately if you are charged with any new offence, criminal conviction or fitness to practise proceedings in the United Kingdom or in any other country.

You do not need to tell us if you are charged with a parking offence.

3. Are you aware of any current NHS Counter Fraud and Security Management Service (CFSMS) investigation following allegations made against you?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the NHS CFSMS.

4. Have you been investigated by the Police, NHS CFSMS or any other Investigatory Body resulting in a current or past conviction or dismissal from your employment or volunteering position?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the Investigatory Body:

Investigatory bodies include: Local Authorities, Customs and Excise, Immigration, Passport Agency, Inland Revenue, Department of Trade and Industry, Department of Work and Pensions,
Security Agencies, Financial Service Authority. This list is not exhaustive and you must declare any investigation conducted by an Investigatory Body.

5. Have you ever been dismissed by reason of misconduct from any employment, volunteering, office or other position previously held by you?

NO ☐
YES ☐

If **YES**, please include details of the employment, office or position held, the date that you were dismissed and the nature of allegations of misconduct made against you:

6. Have you ever been disqualified from the practice of a profession, or required to practice subject to specified limitations following fitness to practice proceedings, by a regulatory or licensing body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the nature of the disqualification, limitation or restriction, the date, and the name and address of the licensing or regulatory body concerned:

7. Are you currently or have you ever been the subject of any investigation or fitness to practice proceedings by any licensing or regulatory body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the reason given for the investigation and/or proceedings undertaken, the date, details of any limitation or restriction to which you are currently subject, and the name and address of the licensing or regulatory body concerned:

8. Are you subject to any other prohibition, limitation, or restriction?

NO ☐
YES ☐

If **YES**, please include details:

9. Have you been responsible for, been privy to, or contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity?

NO ☐
YES ☐

If **YES**, please include details:

10. Are there any other matters that may be relevant to your position which might cause your reliability or suitability to be called into question?
NO ☐
YES ☐

If **YES**, please include details:

Declaration

Important: The Data Protection Act 1998 requires us to advise you that we will be processing your personal data. Processing includes: holding, obtaining, recording, using, sharing and deleting information. The Data Protection Act 1998 defines 'sensitive personal data' as racial or ethnic origin, political opinions, religious or other beliefs, trade union membership, physical or mental health, sexual life, criminal offences, criminal convictions, criminal proceedings, disposal or sentence.

The information that you provide in this Declaration Form will be processed in accordance with the Data Protection Act 1998. It will be used for the purpose of determining your

suitability for the senior position you hold. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud.

This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the Trust who are authorised to view it as a necessary part of their work.

In signing the declaration on this form, you are explicitly consenting for the data you provide to be processed in the manner described above.

I consent to the information provided in this declaration form being used by the Trust for the purpose of checking that I satisfy the requirements of the FPPR for the position applied for.

I understand and accept that if I knowingly withhold information, or provide false or misleading information, this may result in an investigation in accordance with relevant
Trust processes and could lead to the termination of the appointment.

Signature	
Full Name	
Date	

17.4. Appendix 4 Fit and Proper Persons Requirement Important information for Applicants

NHS
Southport and Ormskirk Hospital
NHS Trust

Fit and Proper Persons Requirement Important information for Applicants

1. Background to Regulation 5: Fit and Proper Persons, Directors

The aim of this regulation is to ensure that all board level appointments of NHS foundation trusts and special health authorities carrying on a regulated activity are responsible for the overall quality and safety of that care, and for making sure that care meets the existing regulations and effective requirement of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 5 is about ensuring that those individuals in senior appointments are fit and proper to carry out this important role

The regulation was introduced as a direct response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory fit and proper person's requirement be imposed on health service bodies.

2. Applying the FPPR

Where the Trust engages an interim at a senior level equivalent to the posts above the same process will apply where they are employed or registered as associates with the Trust's Bank. Where an interim is sourced by an agency the recruiting agency will be made aware of the FPPR process and must confirm that they have undertaken the necessary checks.

3. Applicants Requirement to Complete a FPPR Declaration Form

The position for which you are applying is considered as a post that requires the FPPR test to be applied. At the application stage applicants are required to complete the Fit and Proper Persons Requirement (FPPR) Procedure (new applicants) self-declaration form and attach this to their application for the position.

This is required to ensure the Trust is able to properly discharge its requirement that all those in post holders detailed in paragraph 2 above meet the fitness test and that a post holder does not meet the 'unfit' criteria as outlined below:

The regulations require that post holders must:

- Be of good character.
- Have the qualifications, competence, skills, and experience necessary for the relevant office for the position of work for which they are employed be able by reason of their health, after reasonable adjustments are made, of properly.
- Be able to perform tasks which are intrinsic to the office or position to which they are appointed or to the work for which they are employed.
- Not be prohibited from holding office (e.g. directors' disqualification order).
- Not have 'been responsible for or privy to, contributed to or facilitated any serious.
- Misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

A person is deemed unfit to hold senior office if they:

- Are an un-discharged bankrupt.
- Are subject to bankruptcy restrictions.
- Are prohibited from holding an office or position under relevant legislation (for example the Companies Act or Charities Act).

In assessing character the matters to be considered include whether the person:

- Has been convicted of any offence.
- Has been erased, removed, struck off a register of professionals maintained by a regulator of health care or social work professionals.
- Is on any 'barred' list, by using the register of disqualified directors, the bankruptcy /insolvency register and the register of removed charities trustees.

More detailed information about the fitness requirements to help you respond to the questions can be found on CQC Guidance for NHS Bodies (Nov. 14).
http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

4. Trust pre-appointment processes

The following checks are undertaken for all appointments to the Trust:

- Identity check.
- Right to work in the UK.
- Qualification checks (where essential/mandatory).
- Comprehensive employment history with any gaps in employment explained in writing.
- Reference checks to include confirmation of period of employment with the referee organisation, reasons for leaving their post.
- DBS checks (standard or enhanced appropriate to role).

Additionally for posts that require the FPPR test the following must be in place:

- Occupational health clearance.

- Fit & Proper Person's Declaration form assessed as meeting the requirements.
- Checks against the register of disqualified directors, the bankruptcy /insolvency register and the register of removed charities trustees.
- A web search of the individual.

An appointment cannot commence until full compliance with the checks detailed above, and is conditional upon the same.

17.5. Appendix 5 Fit and Proper Persons Requirement New Applicants' Employment Checklist

Southport and Ormskirk Hospital NHS Trust

Fit and Proper Persons Requirement New Applicants' Employment Checklist

(This checklist must be completed for all applicants for the positions included in the Trust's FPPR Policy and Procedure)

If an executive search company is engaged, it is standard practice to accept CVs at the initial stages. Where the Trust engages an interim at a senior level (equivalent to ED or Director status) the Trust, or if relevant, the agency recruiting the interim must be made aware of the requirement and standards that have to be met and will need to provide documentary evidence of compliance.

Name
……..

Position
……..

Date..……..

Identification Checks	Yes	No	Comments
Verification of ID as per the right to work checklist NHS employment standards Confirmation of any restrictions on right to work in UK – if applicable Verification of Identification and Right to Work Checklist Confirm documents seen and that copies have been taken and verified			

Employment History			
Confirmation of a full employment history			
Any gaps in employment or study have been clearly documented and written explanations provided Detail any further information below			
Qualification Checks			
Original certificates verified for mandatory qualifications Confirm copies taken and verified			
Criminal Record Checks			
Standard DBS Disclosure received prior to employee commencing work Confirm e-DBS undertaken and date received			
Enhanced DBS in place for those staff working in a 'regulated activity' with children or vulnerable adults. This will also include the children and adults barred list Confirm e-DBS undertaken and date received			
Professional Registration			
Evidence of Professional registration checked at initial appointment *(e.g. nursing midwifery, medical)* State the professional body and details of registration			

References			
Reference from current employer and a further relevant reference.			
Occupational Health Checks			
Completed Health Declaration Form received			
OH referral completed if appropriate			
Immunisation/Infection Screening Questionnaire in place for all those in clinical roles			
Fit and Proper Persons Checks			
Declaration form received and confirmation of no cause for concern. If there is any cause for concern confirm outcome after discussion with the Chairman and/or the Director of Human Resources & Organisational Development. Confirm check against the 'barred' list by using the register of disqualified directors, the bankruptcy / insolvency register and the register of removed charities trustees: o Disqualified directors http://wck2.companieshouse.gov.uk//dirsec o Bankruptcy and insolvency https://www.insolvencydirect.bis.gov.uk/eiir/ o Removed Charity Trustees http://apps.charitycommission.gov.uk Confirm any relevant web search results			

	Date	Tick to Confirm	Name and Signature
Recruitment Adviser confirmation all the above is in place **Final Approval by Chair of Panel** **All pre-employment checks completed and proceed to final offer of employment** **Chairman's Report to the appropriate Remuneration & Nominations Committee**			

Chairman's Signature	
Full Name	
Date	

17.6. Appendix 6 Supplementary Information to Support Reference Requests for the Fit and Proper Persons Requirement

NHS
Southport and Ormskirk Hospital
NHS Trust

Supplementary Information to Support Reference Requests for the Fit and Proper Persons Requirement

The *Health and Social Care Act 2008* (Regulated Activities), Regulations 14 sets out fundamental standards of care. Regulation 5 introduces specific criteria against which the applicant for this post must be assessed.

- Is of good character.
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed.
- Is able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work.
- Can supply relevant information as required by schedule 3 of the Act.
- Not have been responsible for or privy to, contributed to, or facilitated any serious
- Misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

In accordance with schedule 4 part 1 of the act a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy.
- Restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

In accordance with part 2 of the Act a person will fail the good character test if they;

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

Considering the above requirements do you have any concerns relating to individuals suitability for Employment.

YES/NO

Based on your knowledge of the individual do you believe that they are compliant with the Fit and Proper Person Requirements as outlined above.

YES/NO

If you have answered yes to either question please specify detail.

Signature	
Full Name	
Date	

18. POLICY IMPLEMENTATION PLAN

Policy Title	Fit and Proper Persons' Regulation Policy
Is this New or revision of an existing policy	Revision
Name and role of Policy Lead	Audley Charles, Interim Company Secretary
Give a Brief Overview of the Policy	
The policy sets out the requirements needed to ensure that relevant staff undergo the relevant checks as set out in Regulation 3 of the Fit and Proper Persons' Regulation. It sets out the process for checks for new appointments, checks for existing staff and activities to ensure continued fitness. The policy also sets out the training and monitoring process.	
What are the main changes in practice that should be seen from the policy?	
More robust checks of Regulation 3 requirements and reporting of same during the year	
Who is affected directly or indirectly by this policy?	
The Board of Directors, the Trust's senior management Team and all staff involved in regulated activities.	
Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training?	
Explain the issues?	**Explain how this has been resolved**
Human Resources staff and Board of Directors	Annual training by the Company Secretary
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation?	
Explain the issues?	**Explain how this has been resolved**
NO	N/A
Have the financial impacts of any changes been established?	
Explain the issues?	**Explain how this has been resolved**

N/A	N/A
Any other considerations	
Explain the issues?	**Explain how this has been resolved**
NO	N/A

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under **Signature: Audley Charles** **Date Approved January 2018**.

19. POLICY DETAILS

Title of Policy	Fit and Proper Persons' Regulation
Unique Identifier for this policy is	
State if policy is **New** or **Revised**	New
Previous Policy Title where applicable	N/A
Policy Category Clinical, HR, H&S, Infection Control, Finance etc.	Corporate
Executive Director	Company Secretary
Policy Lead/Author	Company Secretary
Committee/Group responsible for the approval of this policy	Board of Directors
Month/year consultation process completed	December 2017
Month/year policy approved	January 2018
Month/year policy ratified and issued	January 2018
Next review date	January 2021
Implementation Plan completed	Yes
Equality Impact Assessment completed	Yes
Previous version(s) archived	Yes
Disclosure status	Full
Key words for this policy	Fit and Proper Persons, Disclosure Baring Service, Regulated activities

For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Integrated Governance.

Review and Amendment History

Version	Date	Details of Change
1.0.0	December 2017	Policy made more robust by adding more details of Regulation 3 requirements, added sections of requirements for new appointments, on-going fitness and annual checks and declarations. The policy has been strengthened by adding a number of templates in the appendices for good practice. Training of key staff and monitoring of the policy has also been added. A flow diagram illustrating the process has also been added