NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 10.30 – 13.00 on Wednesday 3 October 2018
Seminar Room, Clinical Education Centre, Southport District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				
TB226/18 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**5**	**10.30**
TB227/18 (V)	**Declaration of Directors' Interests concerning agenda items** To **receive** declarations of interest relating to agenda items and/or any changes to the register of directors' declared interests	**Chair**		
TB228/18 (D)	**Minutes of the Meeting held on 5 September 2018** To **approve** the minutes of the Board of Directors	**Chair**		
TB229/18 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB230/18 (V)	**Patient Story: A Patient Journey and the Complaints Process** To **receive** the presentation and **note** lessons learnt	**Michelle Kitson**	**15**	**10.35**
STRATEGIC CONTEXT				
TB231/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**5**	**10.50**
QUALITY & SAFETY				
TB232/18 (D)	**Quality & Safety (Q&S) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of Q&S**	**5**	**10.55**
TB233/18 (D)	**Quality Improvement Plan** To **receive** the monthly report	**DoN**	**10**	**11.00**

Ref No.	Agenda Item	Lead	Duration	Time
TB234/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**IMD**	**10**	**11.10**
TB235/18 (D)	**Workforce (WFC) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of WFC**	**5**	**11.20**
TB236/18 (D)	**Monthly Safe Nurse & Midwifery Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**10**	**11.25**
TB237/18 (D)	**Guardian of Safe Working Annual Report** To **approve** the annual report	**GOSW**	**10**	**11.35**
PERFORMANCE				
TB238/18 (D)	**Finance, Performance & Investment (FP&I) Committee: Alert, Assure & Advise Report** To **receive** a highlight report including any escalated risks from the Committee	**Chair of FP&I**	**5**	**11.45**
TB239/18 (D)	**Integrated Performance Report** To **receive** a report on effective use of integrated performance management and reporting ***a. Quality Indicators*** ***b. Operational Indicators*** ***c. Financial Indicator*** ***d. Workforce Indicators***	**DoF/ Performance Manager** **DoN/MD** **ICOO** **DoF** **ADHR**	**15**	**11.50**
TB240/18 (D)	**Director of Finance Report** To **receive** the current financial position at Month 5 and progress on Internal Sustainability	**DoF**	**10**	**12.05**
TB241/18 (D)	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report** To **approve** the annual report	**DoS**	**10**	**12.15**
GOVERNANCE/WELL LED				
TB242/18 (D)	**Policy for Development and Management of Procedural Documents** To **approve** the revised policy	**CoSec**	**10**	**12.25**
TB243/18 (D/P)	**Risk Management:** **Board Assurance Framework and Risk Register & Performance Management** To **receive** the quarterly report on the BAF and	**CoSec/ DoN**	**5**	**12.35**

Ref No.	Agenda Item	Lead	Duration	Time
	the monthly Corporate Risk Register			
TB244/18 (D)	**Items for Approval / Ratification:** • **Scheme of Reservation & Delegation – Budget Adjustment** To **approve** the recommendation and the updated Scheme of Reservation & Delegation • To **ratify** the recommendation of the Remuneration Committee's **approval** of the Interview Panel's recommendation of the **appointment of the Deputy Chief Executive** • To **ratify** the Virtual Remuneration and Nominations Committee's **approval** of the **Director of Human Resources** taken on 13 September 2018	**CEO**	**5**	**12.40**
TB245/18 (V)	**Questions from Members of the Public**	**Public**	**10**	**12.45**
CONCLUDING BUSINESS				
TB246/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**	**5**	**12.55**
TB247/18 (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**		
TB248/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**		
TB249/18 (V)	**Date and time of next meetings:** **Wednesday 7 November 2018**, 10.30am Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**		**13.00 CLOSE**

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 it

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

Southport and Ormskirk Hospital NHS Trust

Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 9 September 2018

Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 3 October 2018)

Present

Richard Fraser, Chair
Jim Birrell, Non-Executive Director
Ged Clarke, Non-Executive Director
Juliette Cosgrove, Director of Nursing
Pauline Gibson, NED Designate *
Jugnu Mahajan, Interim Medical Director
Silas Nicholls, Chief Executive
Jane Royds, Associate Director of HR*
Steve Shanahan, Director of Finance
Gurpreet Singh, Non-Executive Director

In Attendance

Audley Charles, Company Secretary
Caroline Griffiths, NHS Improvement Director
Samantha Scholes, Interim PA to the Company Secretary

Apologies:

David Bricknell, Non-Executive Director
Jenny Farley, Deputy Chief Operating Officer
Julie Gorry, Non-Executive Director
Therese Patten, Director of Strategy

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB201/18	**Chairman's Welcome and Note of Apologies**	
	Mr Fraser as Chair opened the meeting by welcoming the Board members and Member of the Public. He reminded members that the Trust's Open Day and Annual General Meeting would take place on Saturday 8 September, 11am – 4pm in and around the Spinal Unit. Apologies were received from Dr Bricknell, Ms Farley (Deputy Chief Operating Officer), Mrs Gorry and Ms Patten.	

TB202/18	**Declaration of Directors' Interests Concerning Agenda Items**	
	The Chair asked that members declare interests in relation to the agenda items and asked that any changes or additions to the Register of Interests declared by the Board of Directors should be submitted to the Company Secretary. There were no changes or additions to the register .	
TB203/18	**Minutes of the Meeting Held On 3 July 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 3 July 2018. **TB189/18 Monthly Mortality Report:** *Records and Management Project Group* should read *Avoidable Mortality Group*. **TB192/18 Integrated Performance Report**: final two paragraphs to be removed. Board Attendance Register: June 2018: Mrs Gibson was present; Mr Charles had tendered his apologies. **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendments.	
TB204/18	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **TB06718 IM&T Strategy:** The paper would be delivered at the September **Private** Board **TB087/18 Monthly Safe Staffing Report:** would be updated in the monthly report **TB146/18 Emergency Care and 'First Responders':** this had been resolved **TB188/18 Quality Improvement Plan Progress Update:** the QIP, QIS and Mortality Plans to be combined	
TB205/18	**Patient /Staff Story: The Menopause Clinic,** Dr Paula Briggs and Mrs Tania Wroe	
	The Chair welcomed Dr Briggs and Mrs Wroe. Dr Briggs stated that two years ago the Menopause Clinic was set up, one of only a few clinics or teams nationally. Since then it had	

been rated highly in patient satisfaction surveys and well supported by Trust Communications and a previous Interim Chief Executive.

Menopause affects women, their families and impacted upon general practices. A booklet on the subject was produced to share with women and GPs.

The service has a multi-disciplinary team including a specialist physiotherapist and whilst the clinic was the largest in the North West its capacity was not meeting the demands of the service. The clinic focused on an HRT research approach which was a privilege to be asked to participate in.

In 2002 a report in the USA by Women's Health Initiative (WHI) reported that women taking HRT were at greater risk of breast cancer, heart disease and stroke. That led to the under-prescribing of HRT for women who would have had a better quality of life. Recently the report had been found to be inaccurate, misleading and damaging. The study group was comprised of women who started taking HRT more than 10 years after menopause and who had, as a result of lost progesterone, were of high risk of heart disease. Women with a familial or clinical high risk of the diseases would not be advised to take it, however, for those women not at risk, there was a lot to like about HRT.

The fire service, police and HMRC were all supportive of Dr Briggs Team's work, however, funding and support remained an issue

The Chair commented that he was delighted the booklet had been released and acknowledged that menopause depleted the quality of lives and the clinics such as Dr Briggs and prescribing of HRT benefited women and saved the NHS a lot of money.

Dr Briggs concurred, stating that a reduction in the treatment of heart disease in women alone benefited the NHS financially. Commissioners and providers were divided on the provision of the clinic, despite the results improving so many people's lives.

Mr Nicholls stated that that was a preventative, positive, cost-saving service and his team would pick it up with Commissioners.

Dr Briggs stated that the Trust's Communications Team had been very supportive. Her team would also be looking into providing a Diploma Course in conjunction with Edge Hill University to train the next generation.

Mrs Wroe added that the benefits of HRT were generally seen

	within three months of women starting taking it. Women have consistently commented that it had given them their lives back. Mr Singh commented that it was an excellent service and benefitted the Continence and Genito-Urinary Teams. Ms Cosgrove added that the work to date was inspiring and that she would follow up the promotion of the service operationally. The Chair thanked Dr Briggs and Mrs Wroe for their presentation. **RESOLVED:** The Board **received** the presentation.	
STRATEGIC CONTEXT		
TB206/18	**Chief Executive's Report**	
	Mr Nicholls presented the report. **Investing in Staff and Patient Services** A number of investments had recently been made including: • £136,000 for a patient discharge and transfer lounge in July. Patients move to the lounge on the day of their discharge if they were unable to go home directly – for example, where they were waiting for medicines to be dispensed. It also helped the hospital get ward beds ready for newly-admitted patients. • £300,000 to expand the Critical Care Outreach Team to a 24-hour-a-day, seven-day-a-week service. The team helps with the treatment of patients whose condition begins to deteriorate unexpectedly. • An expanded, brighter café, the *1652*, had also been opened at the entrance to Southport hospital. **Transforming Hospital Services** Following the open letter on 9 July outlining Care for Your, the Trust's plans for transforming acute hospital services locally, lively debate had taken place. Currently no decision had taken place on just what happens next. **Improvements in Car Parking** The Trust was taking steps to address difficulties some people have parking at Southport hospital earlier in the year. Mr Nicholls apologised for the inconvenience this had caused.	

	Progress had been made to create more parking for staff, patients and visitors. The first part was an agreement with King George V sixth form college across the road from Southport hospital for 50 parking spaces. These had been offered to staff to free up hospital parking for visitors. The Estates team was also working on reconfiguring the layout of the car parks to create 64 more spaces. The work was planned to be completed by the end of September. **Board Appointments** Mr Nicholls was pleased to report that Mr Steve Christian would join the organisation substantively as Chief Operating Officer in October 2018 and the role of Medical Director had been recruited to and an offer to the successful candidate was in progress. **North West NHS Leadership Academy** Mr Nicholls was delighted to accept the role of representing all NHS provider organisations in Cheshire and Merseyside on the Board of the North West NHS Leadership Academy. That would give the Trust greater insight into the work of the Academy and how it might be able to help the Trust on its own improvement journey. **RESOLVED:** The Board **received** the report	
QUALITY & SAFETY		
TB207/18	**Quality & Safety Committee - Alert, Advise and Assure (AAA) Highlight Report**	
	Mr Singh presented the report. **Alerts** • Workforce and staffing levels across all Clinical Business Units (CBUs) were low; Each CBU had their own individual action plans in response. There was, however, a mismatch between those numbers and those detailed in the FPI papers which would be investigated. • Gaps in workforce needed to be identified proactively and acted on to minimise delays. **Assurance** • It was noted that Stroke was compliant with transient ischemic attack (TIA) targets but the data was not being correctly reported, as currently patients seen in the Emergency Department were not included in the data. Dr McDonald, Assistant Medical Director (AMD) for Urgent Care, will discuss the inclusion of those patients, with the Divisional Service	

	Managers. Dr Mahajan assured the Board that patients were correctly being managed on the pathway. Mr Nicholls noted that following the National Stroke Audit, the Trust had improved on the measure to a 'B' with 90% of stroke patients provided care in stroke beds and the volume of patients attending transient ischemic attack (TIA) clinics increasing, which was encouraging and demonstrated that the Trust was heading in the right direction. Ms Cosgrove added that the recruitment and availability of 24/7 thrombolysis nurses had improved outcomes and Mrs Royds commented that there had been substantial interest in those posts. Dr Mahajan further added that the recruitment of further stroke consultants was under way and that the demographic of the local population was a significant factor in the occurrence of stroke or TIA. • Quality Improvement Plan Update – Progress was being made with 16 actions turning from 'Amber' to 'Green' • The Committee received the Research, Development and Innovation Department Annual Report 2017/18. The Committee was assured that the Department complied with all the research governance requirements and statutory obligations. They commended the report and noted the achievements and recommendations for 2018-19. **RESOLVED:** The Board **received** the report	
TB208/18	**Quality Improvement Plan Progress Update**	
	Ms Cosgrove presented the report. The Quality Improvement Action Plan was developed incorporating priorities from the Draft Quality Improvement Strategy, seen by the Board of Directors in May 2018. These include CQC 'Must Dos' and 'Should Dos' recommendations and the Trust's key quality priority themes, emerging from complaints, incidents and patient feedback. The Quality Improvement Action Plan set out the Trust's commitment to improving the quality of care for patients and would enable monitoring and measuring of progress and improvement against KPIs, metrics, audits and quality reviews. Since the last report, improvement in work streams was evident however, there had been concerns on the pace of delivery. Currently 22 Actions were identified as complete and the next report would see those become *Delivered* and *Sustained* with	

	further actions completed. Quality improvements were being supported by quality initiatives including: • Daily safety huddles with Heads of Nursing and Matrons to review all incidents reported in the previous 24 hrs. • Daily staffing meetings. • Monthly Mortality Operational Group meetings • External support with learning from deaths. • Roll out of Royal College of Physicians (RCP) Structured Judgement Review (SJR) training • Weekly Serious Incident Review Group. • Commencement of a three-month Safer Programme launch with ECIST (Emergency Care Improvement Support Team) to focus on reducing length of stay. In conjunction with Mrs Royds, a Workforce plan was being developed including Retention, Health & Wellbeing and Sickness Absence. Along with working with NHS Improvement (NHSI) and the rostering system it had resulted in a reduction of patients in corridors and clinical teams' perception of reducing the length of stay as a positive, productive outcome. Mr Birrell commended that the work which had taken place and requested that the values and behaviours be embedded across the whole organisation to ensure that the basics were right. Ms Cosgrove added that a dashboard would be developed in conjunction with Dr Mahajan and the Business Intelligence Team to demonstrate operational delivery to both committees and the Board and a meeting was scheduled for 10 September. Mr Birrell observed that a programme was required to get everything working in the right way, to which Mrs Royds responded that the SONI Way would be rolled out, once recruitment to the role was complete. Mr Nicholls stated that whilst each Executive had personal responsibility for specific areas they would work collaboratively in some instances, such as producing the dashboard. He related that earlier in the day a Consultant had spoken with him, asking how things were going and had commented to Mr Nicholls that 'things are starting to feel better' which was encouraging. The Chair added his agreement that the Trust was moving in the	

	right direction. Ms Cosgrove stated that the next scheduled CQC inspection would be in March or April 2019 which was not a lot of time and the Improvement Board would oversee the preparation progress and an update would be brought to the Board for assurance. **RESOLVED:** The Board **received** the report	
TB209/18	**Monthly Mortality Report**	
	Dr Mahajan presented the report. The roll out of the Royal College of Physicians (RCP) Structured Judgement Review and Learning from Deaths activity, were key to embedding a sustainable learning culture to improve the quality of care and to progressively reduce mortality. Reductions were seen from Quarter 2 to Quarter 3 in both Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). The main areas of concern for the month of March were Safe Staffing, In hospital deaths (the crude death rate for March was 41.39 deaths per 1,000 admissions) and A&E waiting times. In July 2018 the appointment of a Clinical Outreach Team was also approved. Dr Mahajan stated that the External Mortality Review, which was undertaken in July 2018, would be reported on at the November Private Board when the Lead of the review would be available to present. Mr Clarke asked why was there a spike in Crude Mortality in January 2018 to which Dr Mahajan responded that that was likely due to winter difficulties nationally and the flu outbreak. A comparison would establish if the Trust was an outlier on the data, however, that was unlikely. Mr Nicholls observed that the Australian winter, which tended to be an indicator of the UK winter, saw a reduction in the occurrence and impact of flu on the population. Public Health England would shortly be publicising the Winter 2018/19 flu vaccination programme. **RESOLVED:** The Board **received** the report	

TB210/18	**Bi-Annual Safer Staffing Report**	
	Ms Cosgrove presented the report. Recent reports had used data which had been insufficient and the incoming Deputy Director of Nursing - Workforce would ensure that any data provided was robust and correct and would meet weekly with the Business Intelligence Team. They would also undertake a safe staffing review of all areas from September to December 2018. Exit interviews were to be reviewed in September 2018 to define why staff were leaving and how those issues could be comprehensively addressed. Appendix 1, Nursing Expenditure April 2018 to July 2018, would be updated as new data had become available and would be circulated to the Board members. Overseas Recruitment continued, with plans in place to visit Ireland in October 2018 and March 2019. Other locations are being considered, plus the process post-arrival, including integration, in recognition of the investment made by individuals. Mr Singh observed that it was reassuring that a comprehensive process was taking place for Nurses and asked if it was possible to have a similar process to address medical and workforce needs. Dr Mahajan replied that that was already underway via the Guardian of Safe Working. Mr Nicholls added that recruitment and retention was the biggest strategic issue and challenge facing the Trust. Mrs Royds would update the Improvement Board on progress. **RESOLVED:** The Board **received** the report	**DoN** **ADHR**
TB211/18	**Guardian of Safe Working (GOSW) –Quarter 2 Report**	
	Dr Mahajan presented the report on behalf of Dr Chapman. Instances of staff staying beyond their shift to provide care had continued and were an on-going issue. **Rota Compliance and In-House Locum Arrangements** The GOSW was keen to stabilise the medical workforce by employing more substantive doctors. That means Southport & Ormskirk Hospital Trust (SOHT) would be less reliant on trainees for service provision. That would be advantageous in that SOHT did	

	not have control over the number of trainees allocated and there had often been last minute changes. It would also ensure a better working environment and educational opportunities for trainees. A SOP Covering Unfilled Trainee Doctor Shifts had been written and was with Workforce Committee for approval. **Double/Triple Bleep Carrying** Unfilled shifts in Surgery had led to Double Bleep carrying on five partial shifts. There was also a night shift when an F1 in Medicine carried the Bleeps for both Medicine and Surgery. However, on occasions the same shift had been refilled 4 times because locums had taken shifts elsewhere citing the reason as higher pay at other hospitals. The GOSW had and would continue to forward all instances of double bleep carrying to the Interim Medical Director. Mr Birrell requested that a layman's assessment as an overview be included within the report, to which the Chair concurred. The Chair questioned whether the experience of trainees had improved, to which Dr Mahajan responded that that was not yet evidenced, however, she would provide the date for the next GMC survey which would measure that. Mr Clarke asked for clarity on the recruitment of Orthopaedic Consultants, which was taking place but the data was reported as zero vacancies in seven posts. Dr Mahajan clarified that two new posts were being recruited to, so the data was incorrect and there were nine posts. Mr Nicholls commented that Orthopaedics would be the bread and butter of the Trust, given the demographic and investment would see significant benefits. Mr Singh added that currently a proportion of elective orthopaedic surgery was provided by the private sector, which needed to be addressed. **RESOLVED:** The Board **received** the report	
TB212/18	**Medical Appraisal & Revalidation Annual Report 2017-18**	
	Dr Mahajan presented the report. The total of appraisals for new doctors was 92% in the past three months. There were no late recommendations. Overall the Board	

	could be assured that the Medical Appraisal & Revalidation programme was working well and was compliant with all requirements and recommended sign off by the Board. Mr Singh congratulated the Team for their hard work and passion in achieving the result. **RESOLVED:** The Board approved the Compliance Statement which was duly signed by the Chair on behalf of the Board.	
TB213/18	**Update on Hospital Acquired Pressure Sores Audit Findings**	
	Ms Cosgrove presented the report. Concerns had been raised at a previous Board that the Hospital Pressure Sores Audit Findings had not been succinct enough. A previous presentation had been inaccurate and an accurate picture was now available. That report identified that the recognition and assessment of skin integrity in A&E was not in place and since focused awareness training and the introduction of new nursing documentation in May 2018, the number of patients being assessed as having tissue damage on admission had increased. Since the introduction of daily incident meetings in July 2018, no Hospital Acquired Pressure Ulcer (HAPU) incidents had been identified in Accident & Emergency (A&E). Having reviewed all the data available and the improved recognition assessment and reporting of patients who attend A&E, it was unlikely that the Trust now had concerns in the care given to patients which would result in a HAPU incident in A&E. That would also have a positive effect on patients admitted to the wards, as plans were already be in place for patients deemed at risk. A quality improvement plan was in place which would be monitored through the Nursing and Midwifery Board, together with the revised quality dashboard and performance framework and a quarterly assurance report from the Tissue Viability Nurse (TVN). The Chair asked if due to the local demographics, it was likely more patients would present with pressure sores, to which Ms Cosgrove responded that the Board could be assured that there was nothing unusual about the volume even in a younger population. Mr Nicholls suggest that benchmarking against the Royal Liverpool could be useful, to which Ms Cosgrove agreed. **RESOLVED:** The Board **received** the report	
TB214/18	**Quarter 1 Freedom to Speak Up and progress on National**	

	Guardian's Office recommendations/action plan.	
	Ms Cosgrove presented the report. Nine issues had been raised in Quarter 1 and all had been appropriately managed. There were no themes to note. The Board recently spent time out and completed the Freedom to Speak Up Self Review tool for NHS Trusts and Foundation Trusts, for submission by the end of July 18. An action plan to meet the issues was in place to be submitted to NHSI by 31 August 2018. The National Freedom to Speak Up Guardian (FTSU), Dr. Henrietta Hughes' visit of 20 July 2018 was very positive and she commended the Trust for its openness and candour and felt that it was becoming an exemplar organisation in this regard. The Trust had been invited to speak at the 2019 National Conference on the progress made. The Board had supported the role of FTSU Champions both at Board level and amongst staff of a variety of levels on both sites Whilst it was recognised that under reporting still occurred, there was an increase in awareness and willingness to engage. **RESOLVED:** The Board **received** the report	
PERFORMANCE		
TB215/18	**Finance, Performance & Investment Committee (FP&I): Alert, Advise and Assure (AAA) Report**	
	Mr Birrell as Chair of the Committee presented the report. **Alert** The system-wide winter plan had not been agreed by the end of July. **Assure** The Trust's 2018/19 capital programme was broadly on course for delivery so it was agreed that the latest position be presented to the Board from the perspective of the tangible service improvements that will result from the planned investment. **RESOLVED:** The Board **received** the report.	
TB216/18	**Audit Committee: Alert, Advise and Assure (AAA) Report**	
	Mr Clarke as Chair of the Committee presented the report. **Alert** • The Committee was concerned that there was not full	

	compliance with annual staff appraisals and advised that steps should be taken to ensure that that happened • In order to prevent fraud there was a need to ensure new staff were aware of the requirement to divulge any criminal convictions and that the on-going fit and proper persons' process continue at Board and senior level. **RESOLVED:** The Board **received** the report.	
TB217/18	**Integrated Performance Report (IPR)**	
	Mr Shanahan presented the report. The Chair requested that for future Boards, the agenda should define which Executive would present each section. **Medical Director** **Clostridium Difficile (C.Diff)** The Trust's 2018/19 C.diff objective as set by NHS Improvement was not to exceed 35 cases which equates to no more than 2.9 cases per month. As that figure was far above the Trust's actual of 21 cases for 2017/18, the Trust had set an internal stretch target of no more than 20 cases in 2018/19 (1.7 cases per month), hence so far this year the Trust was almost 3 cases below trajectory for the stretch target. **Falls with Harm** That was being managed with daily meetings to make improvements. Falls plus harm was not synonymous. **Emergency Caesarean-Section Rate** The rate fluctuated month by month and was considered a normal variation. **Stroke** July's performance was 54.55% admitted within 4hrs. There were delays overnight when stroke nurses were not on duty (currently stroke nurses work 7days 7:30 – 8pm). **Serious Untoward Incidents (SUIs)** The quarterly report to the Quality & Safety (Q&S) Committee detailed that there was more to be done, including analysis issues closed and lessons learned. Dr Mahajan stated that a weekly meeting was recommended for individual and organisational learning and for systems to be	**CoSec**

improved, along with emerging themes and provision of information.

Mr Birrell concurred that those meetings would be reviewed at the Q&S Committee for assurance to the Board.

Friends and Family Test - % That Would Recommend
An improved volume of responses had been received, which may have resulted from the opening of the new Discharge Lounge.

Accident & Emergency - 4 Hour compliance
Progress continued to be made.

Ambulance Handovers <=15 Mins
Handover times remained a challenge and work with North West Ambulance Service to test alternatives to Emergency Department had been postponed to September.

Diagnostic Waits
The Diagnostics Improvement Programme was focusing on Endoscopy and Non-Obstetric Ultrasound to address the below target performance. Phase 1 to the end of September focused on establishing current state. Phase 2 (October to March inclusive) focused on process improvements and developing a business plan. Phase 3 runs from April 2019 where larger scale improvements will be identified.

Director of Finance

Mr Shanahan detailed that all of the relevant indicators were included in the Director of Finance's report later in the Board.

Mr Birrell requested that less detail be included in the IPR, as assurance committees examine the report on behalf of the Board, whilst acknowledging the challenge the Business Intelligence Team encounter in manipulating the report. Mr Nicholls agreed that the report should be condensed to fit in with Vision 2020, with one or two indicators.

Mrs Royds commented that Anita Davenport, the Interim Performance Manager, had already begun the conversation about the content of the report.

RESOLVED
The Board **received** the report

TB218/18	Director of Finance Report	
	Mr Shanahan presented the report. **Current financial position at Month 4** The Trust's financial performance was showing a deficit of £10.725M against a deficit plan of £10.898M which was £173K better than plan. That was a reduction of £436K from Quarter 1's performance against plan. Income continued to perform to plan. A&E activity was up by 4%; Elective activity was down by 10.4%; Non-elective activity was up by 14%; Outpatient activity was down by 3.3%. Total expenditure remains within plan at month 4 Year to Date (YTD) despite an adverse Cost Improvement Plan (CIP) performance in July. Both Pay and non-pay expenditure was consistent with June's. Agency spend had increased to £616K in month which meant significant risk of achieving the NHSI cap of £5.6M as current spend was heading towards circa £6-7M. Capital expenditure was within the plan and was effectively managed through the Trust's Capital Investment Group (CIG). The Trust continues to require cash support as it was trading with a deficit each month and continues to provide a rolling 13-week cash forecast to NHSI. There were a number of risks in delivering the year end deficit of £28.8M • CIP delivery of £7.5M. • Sanctions • Ambulatory Care Unit (ACU) and Clinical Decisions Unit (CDU) tariffs • Commissioning for Quality & Innovation (CQUIN) performance If the above issues were not addressed then the Trust would not achieve the planned deficit of £28.8M.	

	RESOLVED: The Board **received** the report	
GOVERNANCE/WELL LED		
TB219/18	**Risk Management:** **Board Assurance Framework and Risk Register Mid-Year Review**	
	Mr Charles presented the report which was a full review of the year July 2017 to July 2018. Management had worked hard to give assurance to the Board that risks were being managed against a background of changes and challenges that achievement of the Trust's strategic objectives were not being impeded by the principal risks. All BAF risks were shown as Extreme or High but there has been improvement in some areas: **Risk 1**: *Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards* Had been downgraded due the work being done on Acute Sustainability, the Sefton Transformation Board, Sustainable Transformation Partnership and the appointment of a full-time substantive Director of Strategy. These steps had helped to put more controls in place and given additional assurances **Risk 6**: *Inability to provide direction and leadership* Although remaining high its score was reduced due to the Trust now having in place a more sustained senior management team with the appointment of a substantive Chief Executive, substantive Director of Nursing & Midwifery, a substantive Director of Strategy and a substantive Chief Operating Officer. Additionally, recruitment is on-going for a substantive Medical Director and there is now a full complement of Non-Executive Directors. The Director of Nursing, Company Secretary, Associate Director of Human Resources and the Interim Improvement Manager had been reviewing the way risks were escalated, managed and the method by which assurance was received by the relevant forums including the Board. One of the innovations was to link risks to the KPIs. A proposed structure showing how that would be done would be discussed at the Executive Team and along with the BAF and the High-Level Risk Register would be brought to the Board in October.	

	Mr Charles was assured by the Business Intelligence Team that the process of using Datix to link KPIs and Risks was possible but complex. Mr Birrell stated that that was enormous progress with correct assessment which was also realistic. He also welcomed linking risks to the KPIs. **RESOLVED** The Board **approved** the reports.	
TB22018	**Items for Approval/Ratification**	
	Quality Visits Schedule and Methodology Ms Cosgrove stated the planned visits would be refreshed and agreed and that a report should be brought to the Board about what happened and went well from the visits. Mr Nicholls concurred and reminded the Board that not all staff had access to email, so there was a need to have plans for staff to be informed by other mechanisms as well.	
TB196/18	**Questions From Members of the Public**	
	No questions were raised	
CONCLUDING BUSINESS		
TB197/18	**Any Other Business**	
	The Chair reminded the Board that the Open Day, including the Opening of the Garden of Remembrance and Annual General Meeting were taking place on Saturday 8 September, 11am – 4 pm in and around the Spinal Unit. Jane Devereux from the Communications Team had been integral in the organisation of the event and shared the programmes of the day. The Mayor and MPs were scheduled to attend and the event had been publicised in local media and via Facebook. Hospital radio would also be attending. The Nursing Team would be engaging the recruitment of nurses and volunteers on the day. Mr Nicholls expressed his hope that the day would be successful and that many positive messages would result, enabling a closing down of the old perceptions of the Trust.	
TB198/18	**Items for the Risk Register/Changes to the BAF**	
	There were no items or changes.	

TB199/18	**Message from the Board**	
	There was no message from the Board.	
TB200/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 3 October, 10.30 **Seminar Room, Clinical Education Centre, Southport District General Hospital**	

There being no other business, the meeting was adjourned

Board Attendance 2018/19												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser	✓	✓	✓	✓		✓						
Silas Nicholls	✓	✓	✓	✓		✓						
Jim Birrell	✓	✓	✓	✓		✓						
David Bricknell	✓	✓	✓	✓		A						
Audley Charles	✓	✓	A	✓		✓						
Steve Christian			A	A								
Ged Clarke	✓	✓	✓	A		✓						
Jenny Farley						A						
Juliette Cosgrove			✓	✓		✓						
Pauline Gibson	✓	✓	✓	A		✓						
Julie Gorry	✓	✓	✓	✓		A						
Dr Jugnu Mahajan	✓	✓	✓	✓		✓						
Therese Patten	✓	✓	✓	✓		A						
Jane Royds	✓	✓	A	✓		✓						
Steve Shanahan	✓	✓	✓	✓		✓						
Gurpreet Singh	✓	✓	✓	✓		✓						
A = Apologies, ✓ = In attendance, ***** = Non-voting Member												

Public Board Matters Arising Action Log
as at 3rd October 2018

Southport and Ormskirk Hospital NHS Trust

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**

OUTSTANDING ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG STATUS
	Jun 2017	**Human Resources Contractual Arrangement with St Helens & Knowsley (StHK)**	Board members to be apprised of the review's findings and implications	**ADHR**	Sep 2017	Sep 2018	**October 2018** On-going process - not concluded	**AMBER**
TB188/18	Jul 2018	**Quality Improvement Plan (QIP) Progress Update**	The QIP, QIS and Mortality Plans to be combined.	**DoN**	Sep 2018	Sep 2018	September 2018 Deferred to October Board. **October 2018** **On agenda**	**AMBER**

COMPLETED ACTIONS

Public Board Matters Arising Action Log as at 3rd October 2018

NHS Southport and Ormskirk Hospital NHS Trust

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**

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Completion Date	Status Outcomes	BRAG STATUS
TB067/18	Mar 2018	**Information & Management Technology (IM&T) Strategy**	The IM&T Contract to be brought to the April Board. **Note: Contract needs to be signed by October 2018**.	**DoF**	Apr 2018	Oct 2018	July 2018 Next new Contract meeting has been arranged for 1 August **September 2018:** On Public Board Agenda - complete	**BLUE**
TB087/18	Apr 2018	**Monthly Safe Staffing**	Outcome of review of hours worked by registered and non-registered staff on HealthRoster to be brought to the May Board.	**DoN**	May 2018	Sep 2018	**September 2018** Review continues to identify hours worked that are not captured centrally. DoN to update Board when full impact is identified. Included in Monthly Safe Staffing report	**BLUE**
TB146/18	Jun 2018	**Emergency Care Performance Report including 4-Hour Access Patient Flow**	COO agreed to look into 'First Responders' and Special Constables potentially undertaking some paramedic activity locally	**COO**	Jul 2018	Sep 2018	July 2018 Contact made with Robert Hussey, Community Resuscitation Manager to investigate. **October 2018** Director of Strategy has met with parties and action completed.	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item	**TB231/18**	**Report Title**	**Chief Executive's Report**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Silas Nicholls, Chief Executive		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓To Receive	

Executive Summary

- Getting ready for winter
- Making every day a "green day" for patients
- Board appointments
- Hospital open day

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
✓**SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
✓**SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
✓**SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
✓**SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
✓**SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
✓**SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*	
CQC KLOEs ✓Caring ✓ Effective ✓Responsive ✓Safe ✓Well Led	**GOVERNANCE** ☐ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change

Impact *(is there an impact arising from the report on any of the following?)*	
☐ Compliance ✓ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal ☐ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact Assessment* **must** *accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

CHIEF EXECUTIVE'S REPORT TO PUBLIC BOARD – OCTOBER 2018

Getting ready for winter

Demand for emergency services continues to rise year on year across the NHS.

Our Trust is no exception with adult attendances at A&E in the year to August already up 8.1%. In the past two months, we've also seen our two largest A&E attendance ever with more than 190 patients needing care one day in August.

These are challenging times for everyone involved in healthcare. Thanks to the hard work of staff our Trust is better prepared than ever.

The very visible elements of these preparations are the £1.25m extension and refurbishment of A&E at Southport. A Clinical Decision Unit opened in March. The final phase of work on A&E started last month and will be complete by Christmas

In the summer, we opened a discharge and transfer lounge to support patients going home and help us get beds ready for those being admitted.

The new Surgical Assessment Unit also opened last month and will provide a better experience for patients, especially those needing urgent surgery.

We have also begun replacing the CT scanner at Southport hospital. It is part of a wholescale review of the radiology estate which will see the Southport MRI scanner replaced in 2019 and the Ormskirk CT scanner in 2022.

Making every day a 'green day' for patients

Moving patients efficiently through hospital from admission to discharge is a priority for the Trust. Not only is it in the best interests of patients but ensures we have beds available to take the newly admitted.

One way we're doing this is through an initiative called Red2Green. It systematically aims to make every day a "green day" for patients with a measurable daily outcome that moves each one closer to going home.

It got off to a tremendous start on Ward 14B at Southport in July where patients' time in hospital has seen a significant decrease. It's also had the added benefit of boosting staff morale. The ward sister told us: "We're excited to get people home and to make things happen for our patients."

Other wards have begun to adopt Red2Green and we expect it to be rolled out across the Trust by the end of January.

Board appointments

Dr Terry Hankin has been appointed to the vacant post of Medical Director. He will join the Trust in December from St Helens and Knowsley Teaching Hospitals NHS Trust where he is Deputy Medical Director.

Terry, who completed some of his medical training with us, is also his current trust's Responsible Officer and Medical Director for the Lead Employer Organisation.

In these roles he has extensive experience of supporting and managing clinicians in the workplace. He has a proven record in improving patient care, and as an active critical care physician and anaesthetist has a clear understanding of the challenges of the clinical workplace.

Dr Jugnu Mahajan will continue as interim Medical Director for the time being.

We also welcome **Steve Christian** to the Board this month as Chief Operating Officer (COO). Steve was with us on secondment as interim COO over the summer from his role as Regional Director of Improvement at NHS Improvement. He lives locally and is a former Trust operational manager.

Jitka Roberts has joined the Board as Financial Turnround Director for three month to support the Trust meet its financial obligations.

Hospital open day

I was delighted by the response to our Open Day at Southport hospital on Saturday 8th September.

It was our first since 2011 and the torrential rain didn't seem to dampen the enthusiasm of what we estimate were around 300 visitors.

Among the guests were Damien Moore, MP for Southport; Bill Esterson, MP for Central Sefton; and Cllr Dave Robinson, the Mayor of Sefton.

The pride staff and volunteers clearly have for our Trust was self-evident as they showed off the services and work they do. We combined the event with our annual general meeting and the opening of a Garden of Reflection.

The garden is for use by patients, visitors and staff who wants to enjoy a quiet space. It was created with the support of the Trust's Organ and Tissue Donation Group, West Lancashire Freemasons and Dobbies Garden Centre of Southport.

Next year's event will be held at Ormskirk hospital.

News in brief this month …

- **Stroke care.** We have achieved our best performance in Sentinel Stroke National Audit Programme since its launch in 2012. On a five point scale where A is the best and E is worst performing, the Trust is now at level B. This reflects the importance we place on this important area care for our patient population. We will still have work to do but it is encouraging to see the hard work of the clinical team translate into tangible improvements for patients.

- **Advancing Quality.** The Trust participates in a regional benchmarking project measuring the care our patients undergoing hip and knee replacement surgery receive called Advancing Quality. Planned Care staff have been commended on improvement over the past 12 months with a more than 90% hit rate on two key measures.

- **Global Challenge.** Finally, my thanks to Mel Pinnington, Clinical Educator in Critical Care, for organising a Global Challenge over the summer months. Teams made up of more than 120 staff took part, clocking up virtual miles across the globe by adding up their physical activity – from half-marathons to housework. A great contribution to the health and wellbeing of everyone who took part!

Silas Nicholls Chief Executive

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE**
MEETING DATE:	**24th September 2018**
LEAD:	**MR GUPREET SINGH**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Fracture Neck of Femur Pathway - (Best Practice Tariff). The Committee are concerned that for 2016/17 the Trust did not meet the national targets, only 32.28% of patients achieved BPT; areas of concern are: patients to theatre over 36 hrs and patients having an Orth-geriatrician review in 72 hours (main concern). Investment is required to appoint Orth-geriatrician Consultant /SAS doctor and for Planned Care CBU to expand their Acute Physician establishment. A Business Case will be written and presented to a future Hospital Management Board.
- Same Sex Accommodation continues to be a concern and a challenge, particularly a single side room within the Spinal Unit.
- A Single Microbiologist with infection control lead and clinical priorities - non-collection of CQIN data and this has not been submitted for this year.

ADVISE

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

- The Committee acknowledged medical and nursing gaps in the workforce as a serious issue. Fiona Barnes, new Deputy Director of Nursing is leading on a piece of work reviewing the nursing establishment. Work has just begun on a Clinical Workforce Strategy (medical and nursing). Dr Mahajan has requested a gap analysis, taking into account the BMA's guidance around safe staffing. An action plan with objectives will be produced and feed into the Clinical Workforce Strategy.
- The E. Coli bacteraemia rate remains high and the Committee were advised that this is multifactorial. Dr Mahajan and Mr Thomas will lead on diagnostic work with infection control with a view to establishing an action plan.
- The Committee were advised that the Hospital Management Board recently approved, in principle, 8 Clinical Fellow posts and 5 new Acute Physician posts. Dr Mahajan informed members that recently 1 Gastro Consultant | 2 Geriatricians | 3 Trauma & Orthopaedic Consultants have all been appointed. There is a 3rd day of T&O interviews taking place on 28th September).
- Mortality – the aim is to achieve 100% screening of all deaths by the end of October 2018. The Structured Judgement Review (SJR) is now embedded within the Trust. The target is 10-20% of screened deaths should undergo SJR.

ASSURE

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

- Quality Improvement Groups will begin to consider the CQC concerns, looking for evidence of change and will challenging evidence if they don't feel assure around the progress.
- Serious Incident Review Group - The committee commended an informative update report. The meetings are more structured and taking place on a regular basis. The group's AAA report will be received by QSC with effect from next month

New Risk identified at the meeting	No new risks were identified.

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)

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item	**TB233/18**	**Report Title**	**Quality Improvement Plan**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality Paul Jebb, Deputy Director of Nursing		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information		☐ To Note ☐ To Receive

Executive Summary

This paper provides the Board of Directors with an update on the development of a Quality Improvement Action Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led CQC Inspections in November / December 2017 and summarises the findings of the recently published Urgent and Emergency Services unannounced responsive inspection in March 2018.

The Board of Directors are asked to receive the proposals for the development of a Quality Improvement Action Plan and note information within this report.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
✓**SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
☐ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
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✓**SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
✓**SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
✓Caring ✓Effective ✓Responsive ✓Safe ✓Well Led	✓ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change

Impact *(is there an impact arising from the report on any of the following?)*	
✓Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal ✓Quality & Safety ✓Risk ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact Assessment* **must** *accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	

Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	✓Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

QUALITY IMPROVEMENT ACTION PLAN

1. PURPOSE OF REPORT

This paper provides the Board of Directors with an update on the development of a Quality Improvement Action Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led CQC Inspections in November / December 2017 and summarises the findings of the recently published Urgent and Emergency Services unannounced responsive inspection in March 2018.

2. BACKGROUND

As reported to the Trust Board in September, a Quality Improvement Action Plan has been developed incorporating priorities from the Draft Quality Improvement Strategy, CQC Must and Should Do recommendations and the Trust's key quality priority themes emerging from complaints, incidents and patient feedback. The Quality Improvement Action Plan will enable us to monitor and measure progress and improvement against KPIs, metrics, audits and quality reviews, how this performance will be monitored is currently under discussion with the performance team and business intelligence teams and an update will be provided in next month's board report.

3. URGENT & EMERGENCY SERVICES QUALITY REPORT

The CQC visited the Trust for an unannounced responsive inspection on 7th March 2018 in response to concerns regarding patient safety and how responsive the department was to people's needs. (Report attached in appendix 1)

The CQC had previously inspected the urgent and emergency care service in November 2017, and overall rated the service as requires improvement and inadequate in relation to patient safety. During the March 2018 inspection the CQC looked at specific areas of concern including: patient safety, staffing, how services are planned, whether services met patients' individual needs and how the flow of patient through the department was managed. The CQC did not re-rate urgent and emergency care at the time of this inspection.

The CQC made a number of recommendations including 12 Must Do regulatory actions and 11 Should Do actions, a full Action Plan will be submitted to the CQC by 11 October 2018, these actions will be incorporated into the Quality Improvement Plan.

Themes from the regulatory actions are:

- Clinical Staffing levels
- Privacy and Dignity
- Access and Flow
- Medicines Management
- Staffing level
- Environment of the department
- Infection Prevention and Control
- Documentation and record keeping,
- Mandatory Training

However, it was noted within the report that staff were working extremely hard to deliver care that was caring and compassionate under very difficult circumstances and nursing and medical staff worked well together and were doing the best they could for patients.

Progress

Since the inspection the Trust has been working with stakeholders to make the required improvements, since March 18 we have invested £1.25m to fund:

- The extension and refurbishment to A&E. The final phase began this month on a bigger reception and waiting area, and a much-needed additional clinical assessment space to support the timely handover of patients arriving by ambulance
- A clinical decision unit opened in March, providing eight further beds in A&E
- A discharge and transfer lounge opened in July. The £136,000 unit provides a more comfortable experience for patients waiting to go home and helps free up ward beds for newly-admitted patients

In relation to staffing numbers since March 2018 the A&E Department has recruited additional:

- 8 WTE band 5 Registered Nurses
- Observation area 2 WTE band 5's and 1 WTE band 6
- CDU 2 WTE band 5's.
- 2.5 ED Consultants have been recruited and are due to start in October 2018

4. CQC COMPLIANCE

The quality improvement plan developed includes all Must and Should Do actions highlighted in the Trust CQC Inspection Report from March 2018, the high level update on progress is detailed in the table below.

The evidence and assurance process has been refreshed focusing on impact and sustained improvement in each area. A formal assurance statement and approval process has been developed which includes the methodology for continued compliance. This will be reviewed by a Quality Assurance Panel and reported to Quality and Safety Committee and the Board of Directors for assurance. This will enable committees to review and challenge evidence of improvement and sustainability in the long term.

The process for the sign off of completed actions has been reviewed; the Trust will adopt the assurance process described in Section 3 of this report following approval by Executive Team.

Following review and evaluation of supporting evidence, it is recommended that 21 actions should be moved to Green (subject to sign off). Therefore, of the 97 improvement actions, 74 will be rated amber (on track to deliver), 21 Green (action completed) and two blue (delivered and sustained) based on current reviews and progress. As anticipated in August 2018, progress has been moderate due to staff annual leave; the focus has been on consolidation of actions, the development of the single Quality Improvement Action Plan and establishing the quality assurance panels.

Trust overall BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	1	1	2
Action Completed	9	12	21
On track to deliver	49	25	74
No progress / Not progressing to Plan	0	0	0
TOTAL	97	97	97

BRAG rating monthly view

Rating	Baseline	June 18	July 18	August 18	September 18	Total
Delivered and Sustained	0	1	1	1	2	2
Action Completed	0	0	6	22	21	22
On track to deliver	97	96	90	74	74	73
No progress / Not progressing to Plan	0	0	0	0	0	0

5. QUALITY IMPROVEMENTS

To facilitate our improvement journey, the Quality Improvement Action Plan will be delivered through single actions or larger improvement projects. Improvement groups have been established and terms of reference and governance arrangements have been agreed.

The Trust will also retain focus on the domains and core services which the CQC found to be Inadequate or Require Improvement to ensure there is a clear trajectory for moving to good.

To support continued delivery of the action plan, the quality initiatives identified within the previous report have continued to be delivered.

6. RECOMMENDATIONS

The Board of Directors are asked to receive the proposals for the development of a Quality Improvement Action Plan and note information within this report.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item	**TB234/18**	**Report Title**	**Monthly Mortality Report**
Executive Lead	**Jugnu Mahajan,** Interim Medical Director		
Lead Officer	**Dr Chris Goddard,** Associate Medical Director of Patient Safety **Mike Lightfoot,** Head of Information **Rachel Flood-Jones,** Project Delivery Manager		
`Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The committee is asked to receive the report for assurance on the progress of the Reducing Avoidable Mortality Project, the roll out of the Structured Judgement Review, and analysis of Trust mortality data.

Contents:

Strategic Context

- The strategic context of Learning from Deaths activity.
- An update on the roll out of the Structured Judgement Review method.

Measuring Mortality

- Summary Hospital-level Mortality Indicator (SHMI) – Quarter 3 2017/18
- Hospital Standardised Mortality Ratio (HSMR) - April 2018
- Disease-Specific Mortality – April 2018
- Mortality Dashboard Highlights – July 2018

Reducing Avoidable Mortality (RAM) Project

An update is given on activity by project work stream, key risks and milestones in the project tracker.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
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☐ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
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Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
✓ Caring ✓ Effective ✓ Responsive ✓ Safe ☐ Well Led	✓ Statutory Requirement ✓ Annual Business Plan Priority ✓ Best Practice ✓ Service Change

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

☐ Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal ✓ Quality & Safety ☐ Risk ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact Assessment* **must** *accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

A quarterly update report on Learning from Deaths activity and the Reducing Avoidable Mortality Project is to be provided as requested to the July 2018 Southport Improvement Board.

Previously Presented at:

☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	✓ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

NHS
Southport and Ormskirk Hospital
NHS Trust

1.0 Executive Summary

<table>
<tr><th colspan="2">Section</th><th>Summary</th></tr>
<tr><td>1.0</td><td>Background (Strategic Context)</td><td>The national Learning from Deaths initiative is currently being implemented by the Trust and includes the roll out of the Royal College of Physician's Structured Judgement Review. The Trust is committed to delivering a reduction in mortality through quality improvement methodology with the Reducing Avoidable Mortality Project.</td></tr>
<tr><td>2.0</td><td>Structured Judgement Review</td><td>Levels of compliance in the use of the screening tool for the second month have been reported at 58%. The percentage of SJRs triggered in the first two months are significantly higher than expected; the sensitivity of the screening tool will be reviewed once compliance levels have reached 80%.</td></tr>
<tr><td>3.0</td><td>Measuring Mortality - Mortality Ratios</td><td>The data reported herein appertains to the following timeframes. We provide the most up to date information available at the time of reporting.
<table>
<tr><th>SHMI (National - 12 month rolling ratio)</th><th>HSMR (National - 12 month rolling ratio)</th><th>HSMR (Local – 12 month rolling ratios)</th><th>Mortality Dashboard (Trust Data)</th></tr>
<tr><td>Qtr. 3 2017/18</td><td>April 2018</td><td>April 2018</td><td>July 2018</td></tr>
</table>
Both the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remain high and above expected levels.</td></tr>
<tr><td>3.0</td><td>Reducing Avoidable Mortality Project</td><td>An update is given on activity by project work stream, key risks and milestones in the project tracker.</td></tr>
<tr><td colspan="3">Appendices</td></tr>
<tr><td></td><td>Appendix 1</td><td>Mortality Dashboard Highlight Report, September 2018 reporting on the month of July 2018</td></tr>
</table>

2.0 Strategic Context

Mortality is a key priority for the Trust, with improvement work driven by the 'Reducing Avoidable Mortality' (RAM) Project which has the overriding aim of reducing avoidable mortality by April 2019

The Trust is currently embedding the Royal College of Physicians Structured Judgement Review method to review in-hospital deaths, the findings from which will feed into the the Learning from Deaths processes and outputs in line with national guidance.[1]

2.1 Structured Judgement Review (SJR)

The Trust went live with the Royal College of Physician's Structured Judgement Review method on 2nd July 2018. An in-house screening tool has been developed which is to be used by junior doctors at the point that the death certificate is produced. The information input into the screening tool will trigger a request for a Structured Judgement Review where relevant. In addition, a random sample of 10% of deaths will be reviewed on an ongoing basis.

In the second month of the roll out of the SJR method, 58% of deaths were screened using the in-house tool. This is a 20% increase on the previous month with further targets of 80% compliance before the end of October and 100% by the end of January.

It was agreed at the RAM Project Communications and Promotions Subgroup that further work is required to ensure that all doctors are aware of the method and its requirements, in order to reach 100% compliance.

The RCP recommends that the expected level of deaths triggered for an SJR review should between 10% and 20%; we are currently triggering 60%. It has been agreed that the sensitivity of the tool will be reviewed once initial activity has been embedded and the level of compliance has reached 80%.

Mortality Screening Summary - 05/09/2018

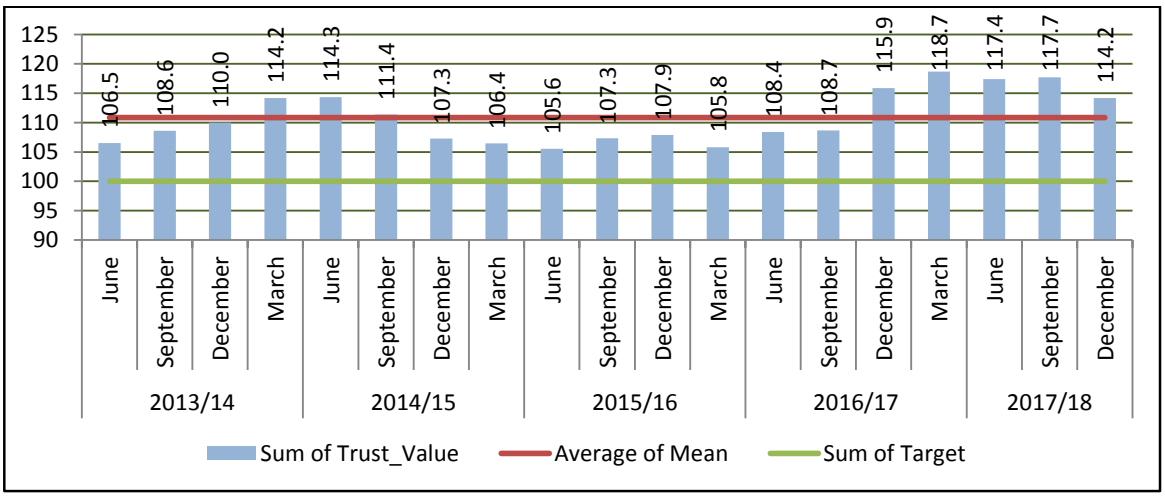
Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review
July	78	30	38.5%	18	60%
August	66	38	57.6%	25	66%

[1] In line with guidance from the Care Quality Commission's 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England' of December 2016 and the 2017 National Quality Board's 'National Guidance on Learning from Deaths (the Framework for NHS Trusts and Foundation Trusts on identifying, reporting, investigating and learning from Deaths in Care).'

3.0 Measuring Mortality

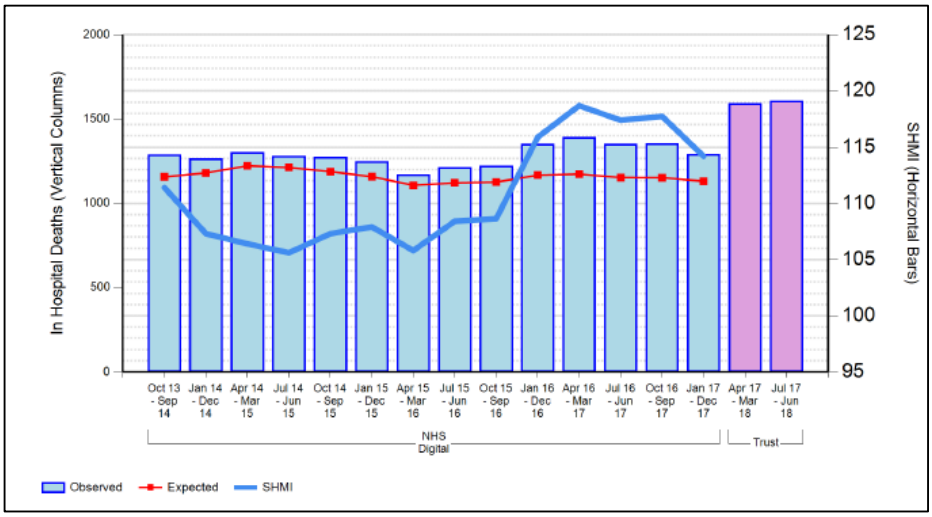
3.1 Summary Hospital-level Mortality Indicator (SHMI)[2]:

The following table reports the SHMI for rolling 12 month period for Quarter 3 is 114.2. This ratio has been calculated from a total of 1,291 actual deaths over an expected figure of 1,130. The ratio is the lowest since Quarter 2 2016/17 and is slightly lower than the ratio for the same Quarter the previous year.



SHMI

The SHMI ratios for Quarter 4 will be available in the third week of September. The graph below gives a prediction for the SHMI for the next two reportable quarters. These are based upon local data and show that there is an expected increase in the SHMI for quarter 4 2017/18 and quarter 1 2018/19. (These projections are based upon the crude mortality rates for the corresponding quarters).



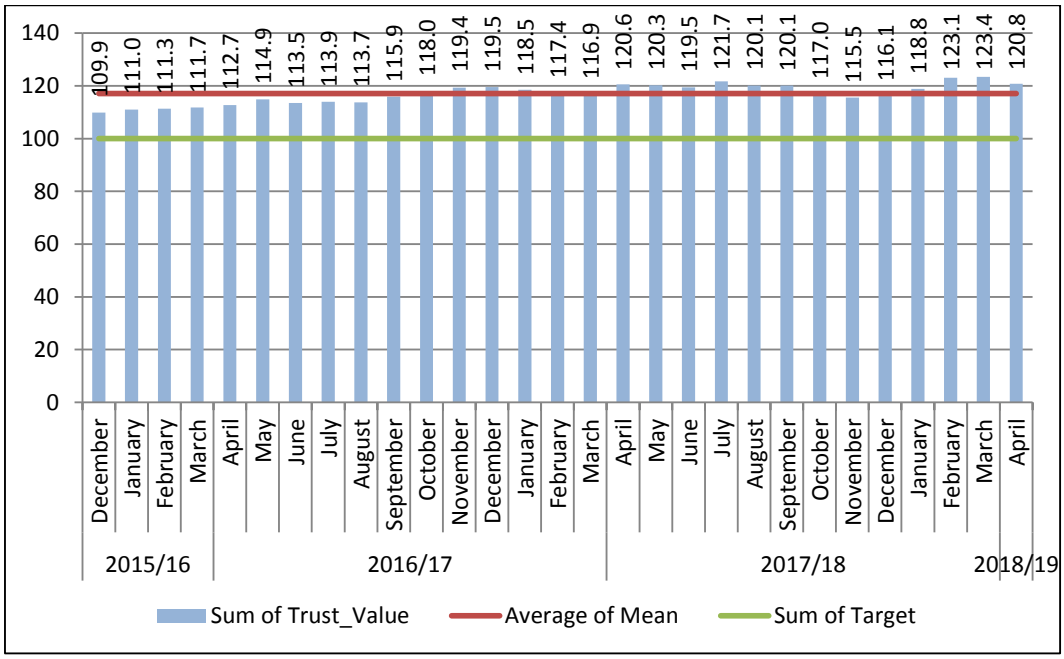
[2] The SHMI is reported quarterly and is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge.

3.2 Hospital Standardised Mortality Ratio (HSMR):

12 Month Rolling HSMR

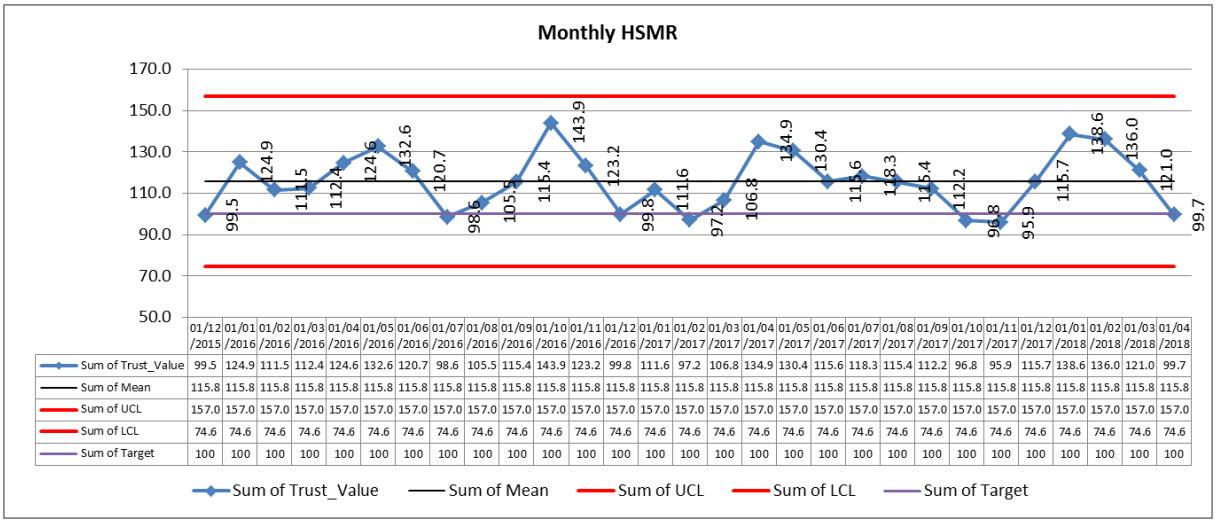
The HSMR is provided nationally by 'Dr Foster' and applies to in-hospital mortality (excluding palliative care). The 12 month rolling HSMR for April was 120.8

The HSMR for April 2018 was slightly down on the previous month, which was in line with a decline in the crude death rate (from 41.39 per 1,000 discharges in March to 30.37 in April). The diagnostic areas attributable for the decline in April were: lower respiratory tract infection, pneumonia and stroke.



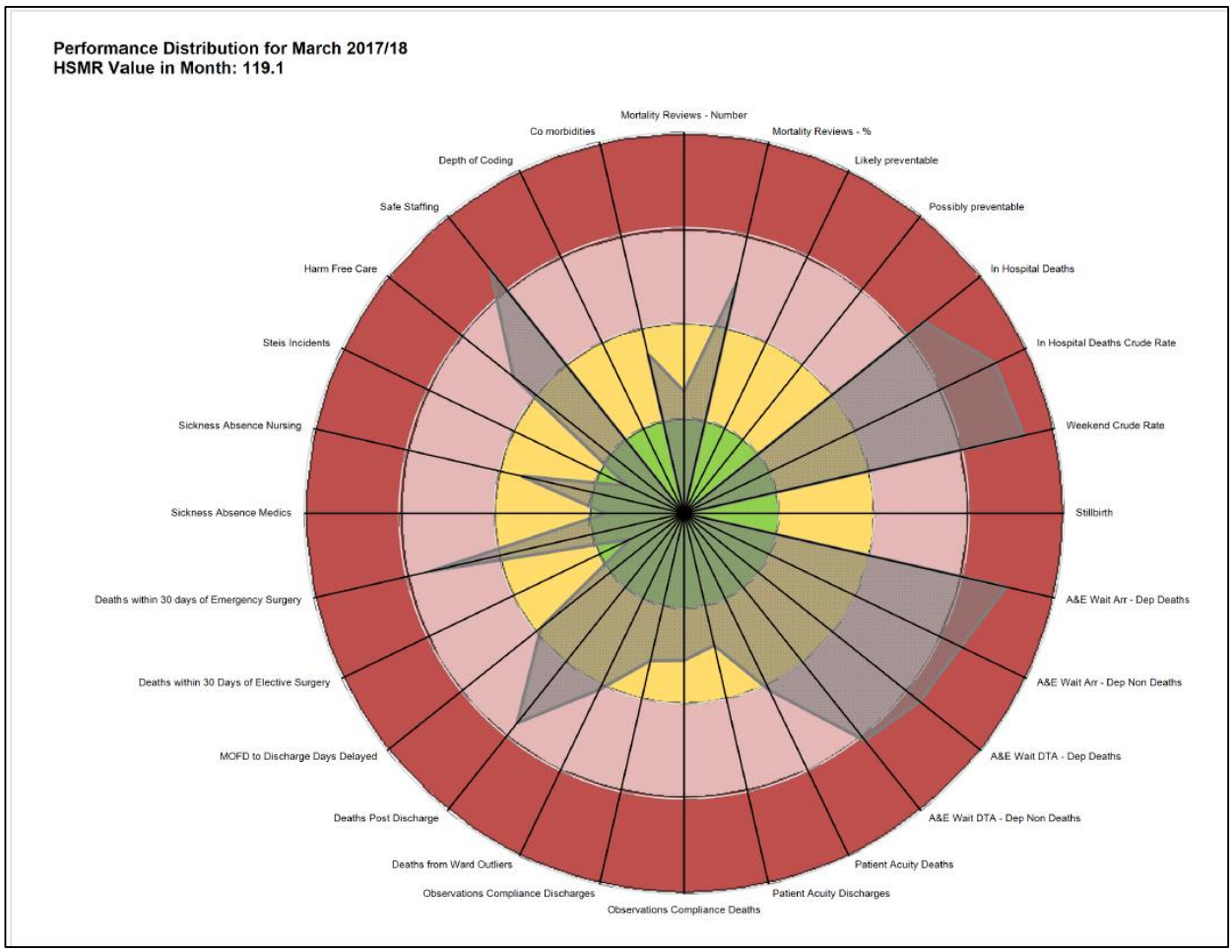
'In Month HMSR'

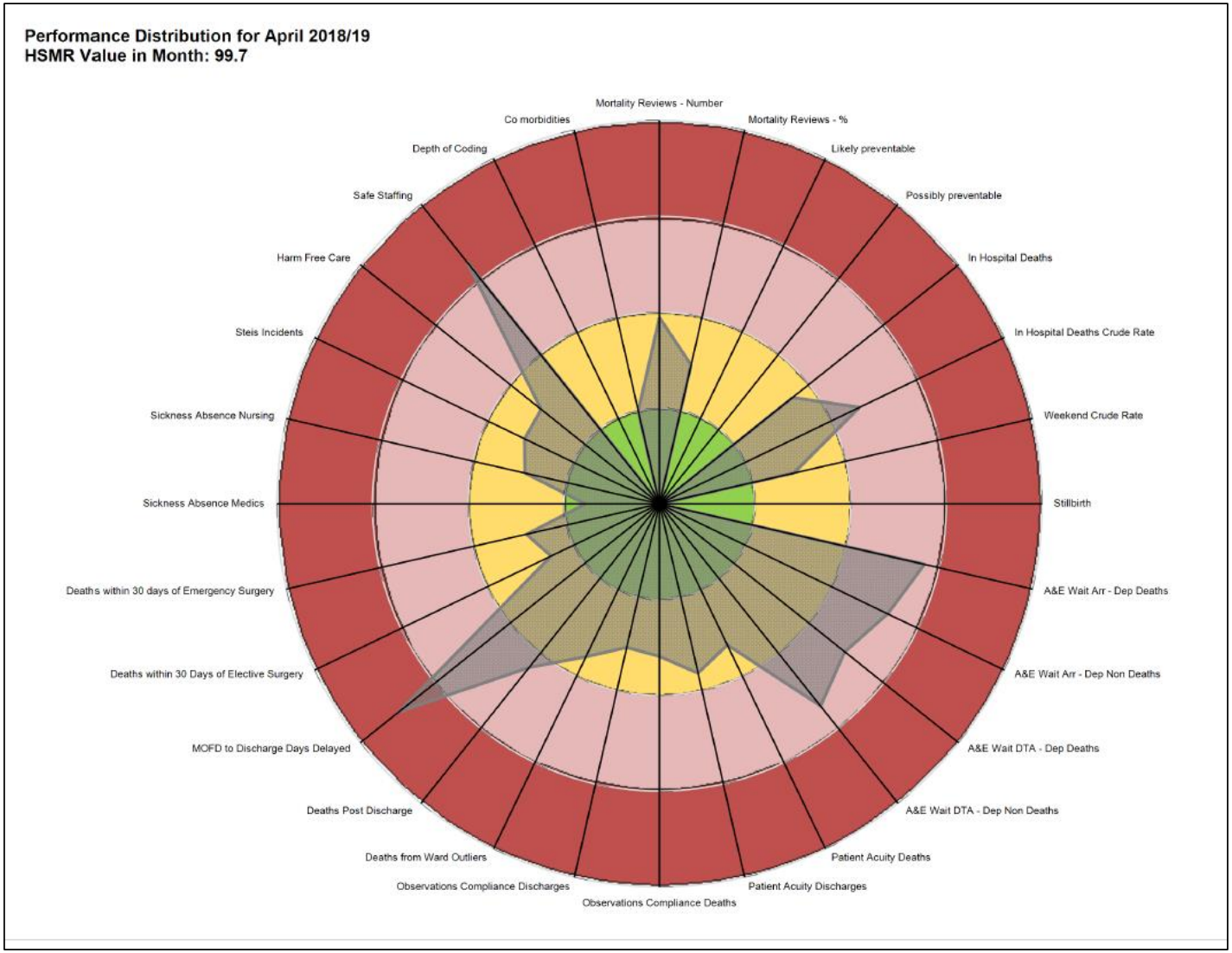
In the graph below, the 'in month' HSMR is tracked (this is the measure of in month performance only and does not take into consideration the previous 11 months). The HMSR dropped from 119.1 in March to 99.7 in April. The performance distribution chart for April (below) highlights the key indicators (in hospital deaths, crude rate, A&E waiting times and harm free care) which are attributable to the improved performance.



	01/12/2015	01/01/2016	01/02/2016	01/03/2016	01/04/2016	01/05/2016	01/06/2016	01/07/2016	01/08/2016	01/09/2016	01/10/2016	01/11/2016	01/12/2016	01/01/2017	01/02/2017	01/03/2017	01/04/2017	01/05/2017	01/06/2017	01/07/2017	01/08/2017	01/09/2017	01/10/2017	01/11/2017	01/12/2017	01/01/2018	01/02/2018	01/03/2018	01/04/2018
Sum of Trust_Value	99.5	124.9	111.5	112.4	124.6	132.6	120.7	98.6	105.5	115.4	143.9	123.2	99.8	111.6	97.2	106.8	134.9	130.4	115.6	118.3	115.4	112.2	96.8	95.9	115.7	138.6	136.0	121.0	99.7
Sum of Mean	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8	115.8
Sum of UCL	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0	157.0
Sum of LCL	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6	74.6
Sum of Target	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

The two performance distribution radar charts below show how some key indicators improve performance dramatically in month (in hospital deaths, crude rate, A&E waiting times, harm free care).




Performance Distribution for April 2018/19
HSMR Value in Month: 99.7
Mortality Reviews - Number
Mortality Reviews - %
Likely preventable
Possibly preventable
In Hospital Deaths
In Hospital Deaths Crude Rate
Weekend Crude Rate
Stillbirth
A&E Wait Arr - Dep Deaths
A&E Wait Arr - Dep Non Deaths
A&E Wait DTA - Dep Deaths
A&E Wait DTA - Dep Non Deaths
Patient Acuity Deaths
Patient Acuity Discharges
Observations Compliance Deaths
Observations Compliance Discharges
Deaths from Ward Outliers
Deaths Post Discharge
MOFD to Discharge Days Delayed
Deaths within 30 Days of Elective Surgery
Deaths within 30 days of Emergency Surgery
Sickness Absence Medics
Sickness Absence Nursing
Steis Incidents
Harm Free Care
Safe Staffing
Depth of Coding
Co morbidities

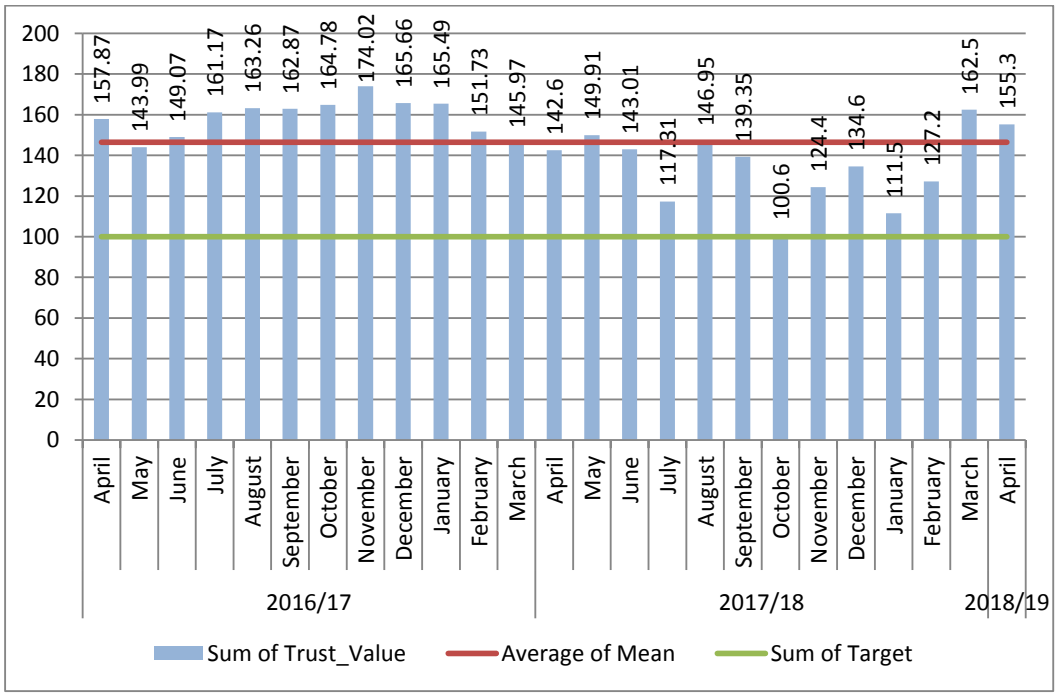
Disease-Specific Mortality – April 2018

3.2.1 Lower Respiratory Tract Infection, Acute Bronchitis & Pneumonia

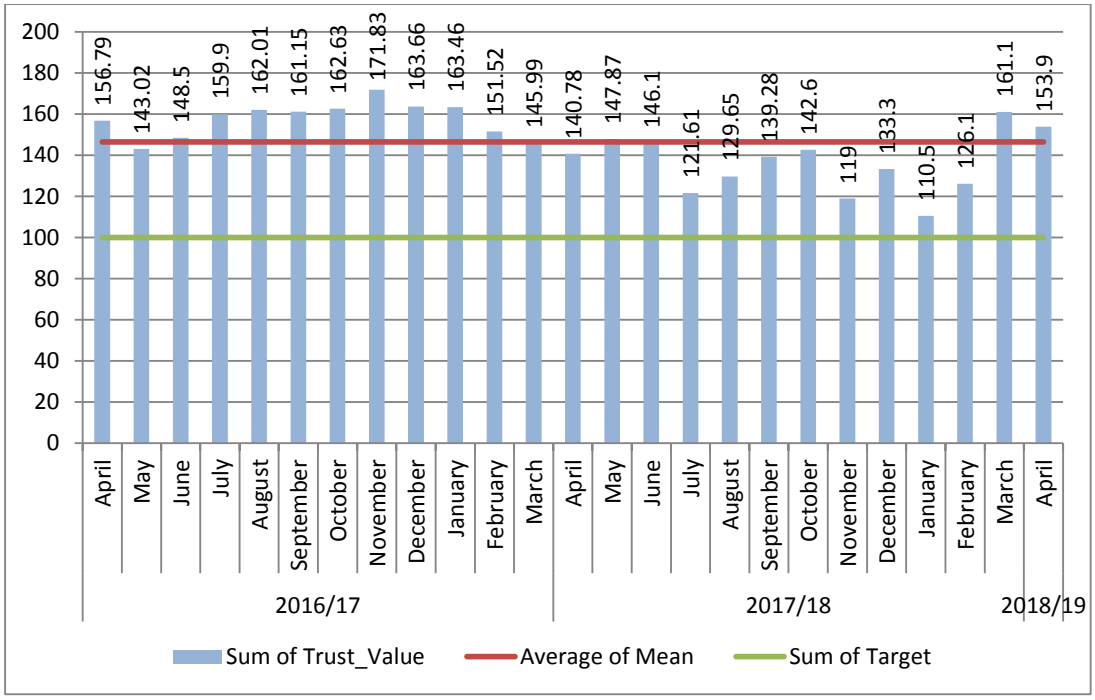
The rolling 12 month local Standardised Mortality Rate (SMR) for:

- Lower Respiratory Tract Infection (LRTI) was 155.3 for April.
- Acute Bronchitis was recorded at 153.9 for the same month.
- Pneumonia SMR was 142.4 for April, a very slight reduction on March.

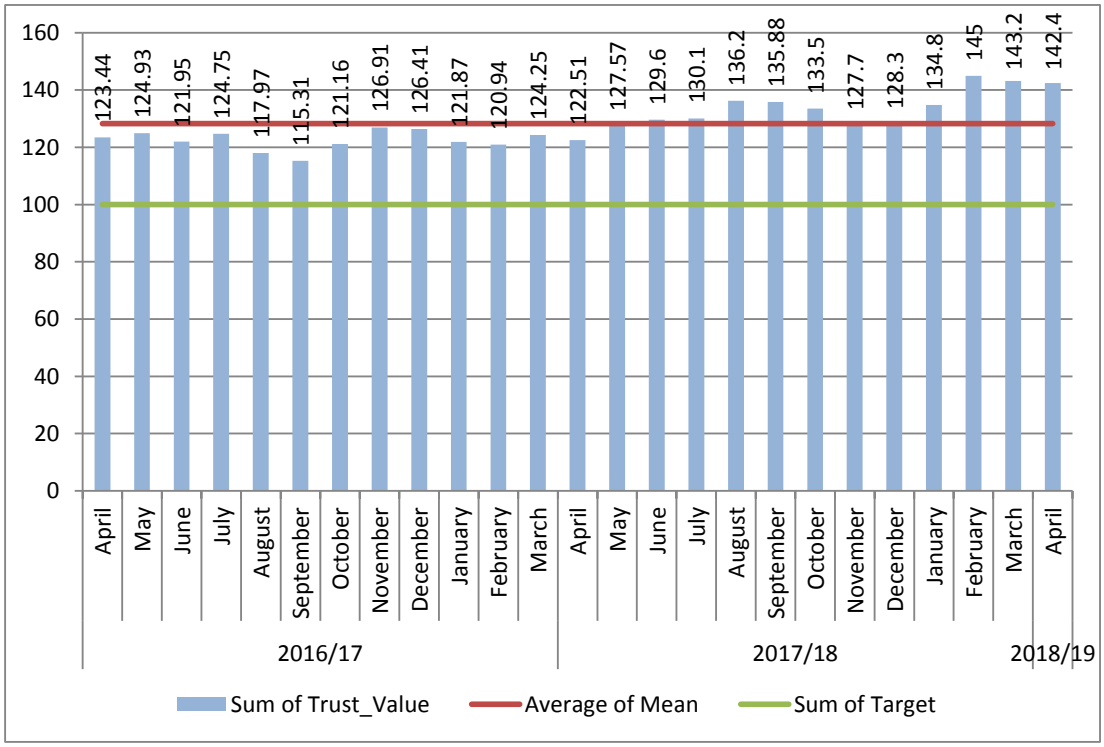
It is recognised that elderly patients with numerous comorbidities who are sedentary because of illness are particularly susceptible to lower respiratory tract infections. A revised pneumonia pathway is currently being scoped which will incorporate new processes to ensure that patients are given the most appropriate treatment as soon as pneumonia is recognised whether it is community or hospital acquired.



Lower Respiratory Tract Infection



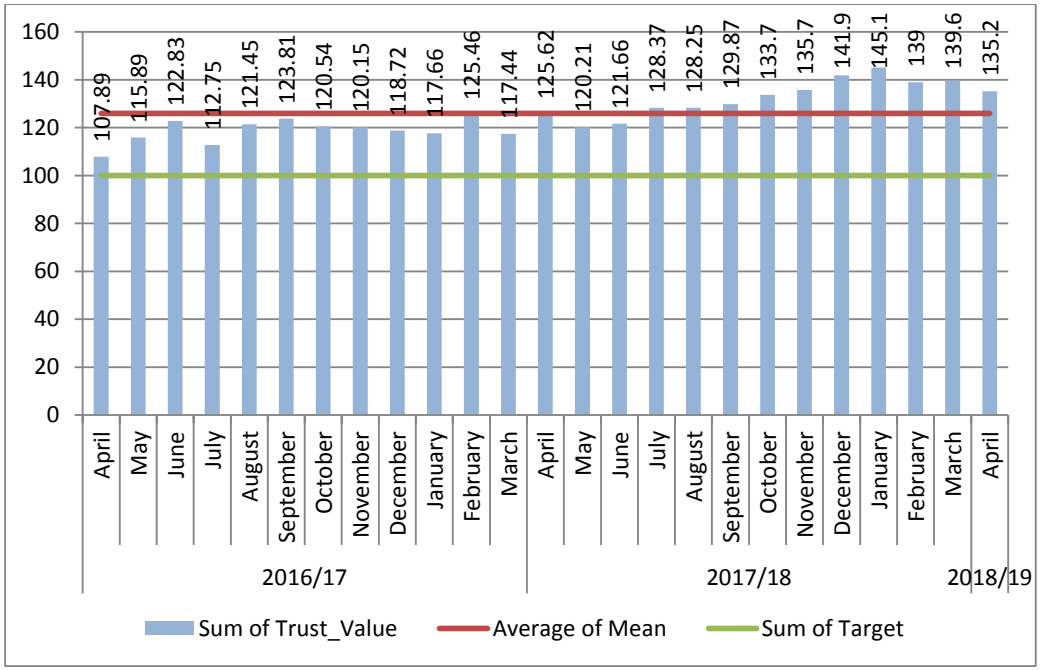
Acute Bronchitis



Pneumonia

3.2.2 Stroke

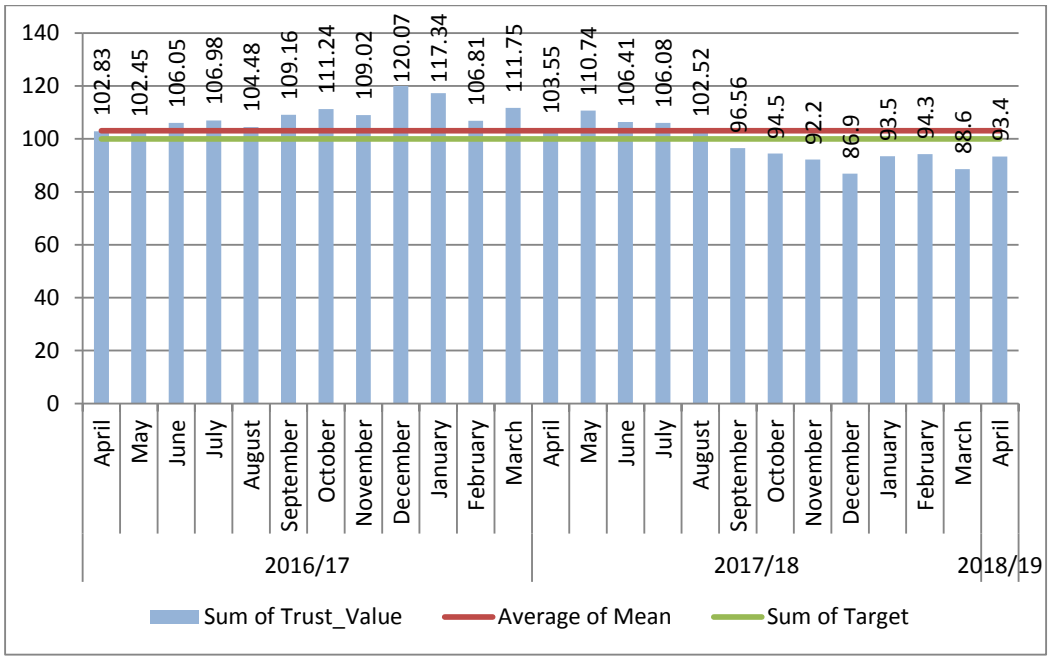
The SMR for Stroke is recorded as 135.2 for April which is the lowest ratio since November 2017.



Stroke

3.2.3 Septicemia (Except in Labour)

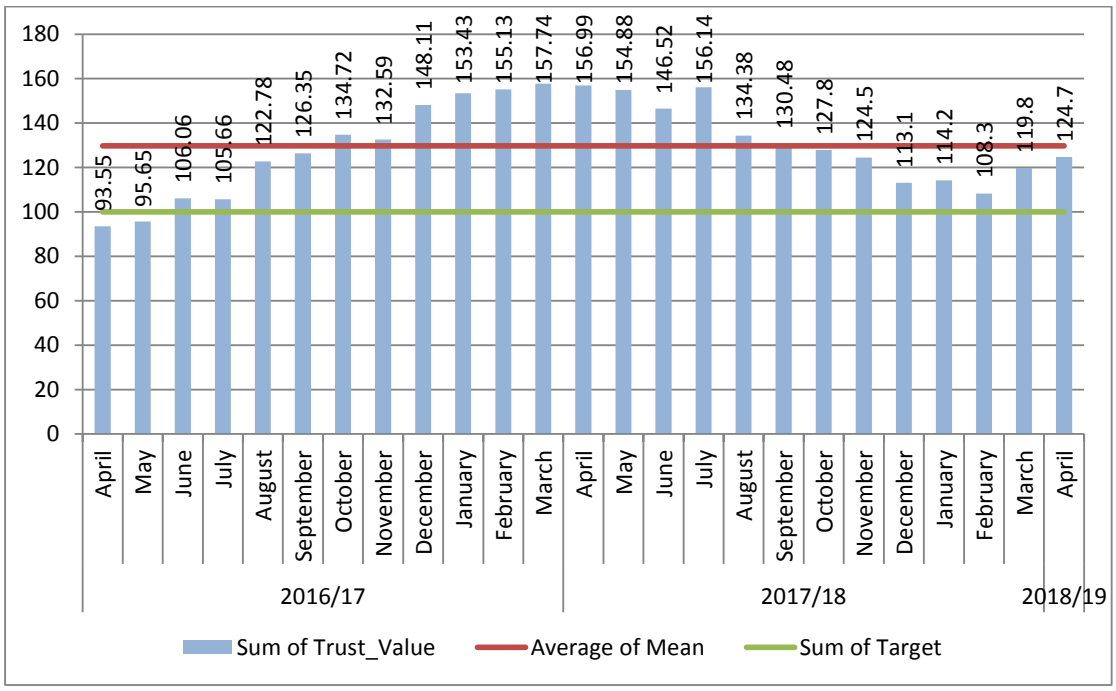
The ratio for sepsis for April remained below 100 for the eight consecutive month at 93.4.



Septicemia

3.2.4 Urinary Tract Infection

The rolling 12 month SMR for Urinary Tract Infection for April was 124.7. The recent trajectory of improvement (from August 2017 to February 2018) has been attributable to changes to improvements in coding for urinary sepsis. A deep dive however is required to understand the jump from 108.3 to 124.7 over the last three months.

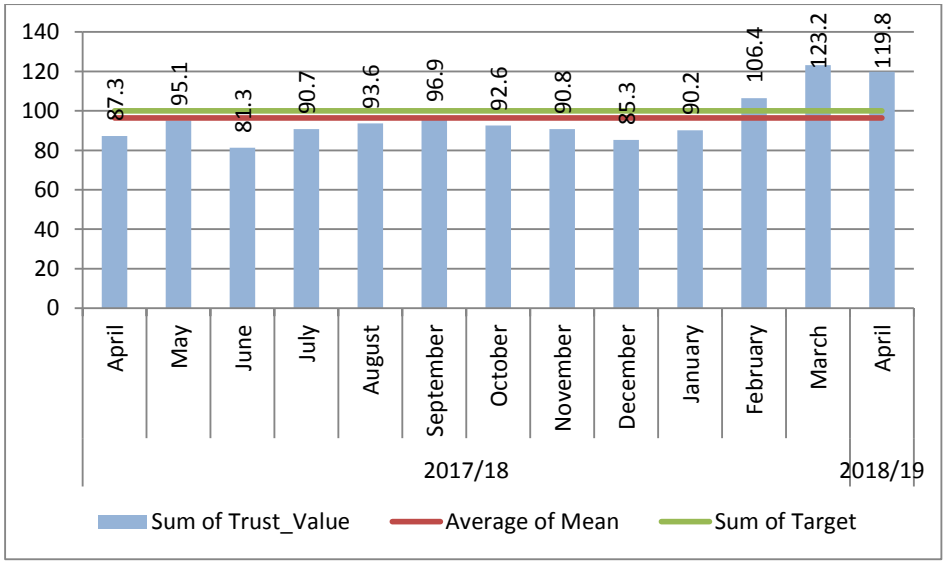


Urinary Tract Infection

3.2.5 Acute Kidney Injury

The 12 month rolling SMR for April was 119.8. The clinical pathway for Acute Kidney Injury is currently being rolled out across the Trust as part of the new Deteriorating Patient Trolleys. An AKI Steering Group has commenced in the Trust, one of the actions from which has been a patient review by pharmacy of the medications for those with AKI.

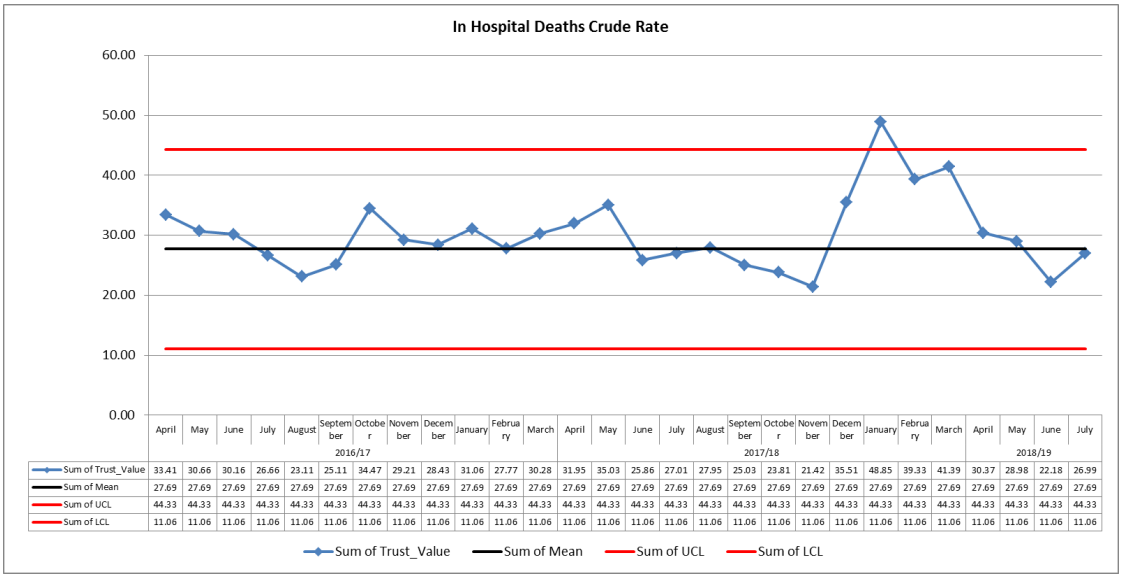
The IV Fluid Therapy Policy has also been relaunched; the new process now allows ward staff to deliver fluid bolus without it needing to be prescribed by patient thereby saving time and delivering improved patient care.



Acute Kidney Injury

3.2 Crude Mortality:

The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for July was 26.99. This has been a great improvement since January when during winter pressures, numbers peaked at 48.85.



	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July
	2016/17												2017/18												2018/19			
Sum of Trust_Value	33.41	30.66	30.16	26.66	23.11	25.11	34.47	29.21	28.43	31.06	27.77	30.28	31.95	35.03	25.86	27.01	27.95	25.03	23.81	21.42	35.51	48.85	39.33	41.39	30.37	28.98	22.18	26.99
Sum of Mean	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69	27.69
Sum of UCL	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33	44.33
Sum of LCL	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06	11.06

4.0 Mortality Dashboard Highlights – July 2018

4.1 There was one possibly preventable death in July 2018 resulting from a medical error or system issue.

4.2 96.20% of Urgent Care patients received harm free care whilst staying in the Trust in July 2018. (Harm free care is the measure of patients who have not sustained any harm in the form of hospital acquired infections, pneumonia or pressure ulcers). Clarification is being sought as to why this data is not available for Planned Care or Specialist Services.

4.3 12 patients whose deaths were recorded in July had been ward outliers during their in-patient stay in the Trust; this is reducing in line with improvements in patient flow.

4.4 There were no learning disability deaths for the month of July; the total for the year to date (from April 2018) remains at two. There are currently no national average or expected levels for learning disability deaths however reviews are being carried out under the Learning Disabilities Mortality Review (LeDeR) Programme which will provide data in the future.

4.5 There were 24 deaths within 30 days of discharge of patients who were not on the Gold Standard Framework. The cause of death is hard to review as the Trust is only notified once the HES data is produced. As part of the RAM project, the Trust will be engaging with CCG colleagues to find out the cause of death for each patient and to ascertain why they died so soon after discharge.

4.6 In July GSF patients who died within 30 days of discharge spent 129 hospital days waiting to be discharged after having been identified as being Medically Optimised for Discharge. The aim is to ensure that patients return home as soon as possible once they are MOFD. At present the discharge process does not commence until the patient is MOFD; discussions as part of the Integrated Frailty Project to change this.

4.7 The percentage of palliative care coding increased to an all-time high of 33.33%. The trajectory of improvement is expected to continue as the training and emphasis on Anticipatory Clinical Management Planning is driven through the RAM and Integrated Frailty Pathway Projects.

5.0 Reducing Avoidable Mortality Project (RAM) – August / September 2018

The Reducing Avoidable Mortality Project continues to drive six work streams with activities on track with the exception of those areas identified as risks below.

Future project reporting will change in line with the functionality of new programme software, 'Smart Sheets' over the next month. The tool will change the way that we work with the responsibility for activity updates moving directly to staff and an improved suite of project reporting for analysis and progress updates.

Project Highlight Report

Project	**REDUCING AVOIDABLE MORTALITY**
Planned Project Start Date	12th February 2018
Project End Date	1st April 2019
Project Reference	**QSI001**
Programme	Quality, Service Improvement Programme

Project Manager	Rachel Flood-Jones
Quality Portfolio Lead	Donna Lynch
Project Reports to	Mortality Operational Group & Quality & Safety Committee
Report Date	14th September for Committee on 14th September 2018
Reported to	Quality and Safety Committee

Key	
Blue	Activity is complete (100% delivered)
Green	Highly likely to deliver benefits as planned
Amber	Some risk the project will not be delivered on time / will not deliver the benefits
Red	Activity is behind schedule against plan, high risk that the benefits will not be realised

Project Objectives

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	**Comments**		**Status Update**	**Status**	**% Completion**
1. CARE PATHWAYS: To develop robust clinical processes for high risk conditions which support clinical staff to provide safe, reliable care and produce evidence to assure quality of delivery, by August 2018.	**Deteriorating Patient Trolleys**		Deteriorating Patient Trolleys containing the Sepsis and AKI Pathways are being rolled out across the Trust. End date for activity 30th Sept '18.	G	57
	Care Pathway Compliance		Compliance audits will start and will be reported through the new 'Smart Sheet' Programme Software (transfer of project information will take place throughout September and October).		0
	Pneumonia Pathway		New Respiratory Nurses are mapping a pathway which will be added to the Deteriorating Patient Trolley. Pathway will be rolled out Jan/Feb 2018 (unless governance approval can be fast tracked through the relevant committees).	G	5
	IV Fluid Therapy (NICE 174)		The new IV Fluid Therapy Drugs Chart went live on 10th September. Promotional work is currently ongoing throughout the Trust both through on-line communications (Trust News and 'The Meeting Place' on social media) and on the wards. The guidelines have been updated and added to the Trust Intranet.	B	100
	External Mortality Review: 'Developing Trust Capacity & Approach to Learning from Deaths' to review Pneumonia & Stroke deaths from May 2017 to April 2018.		The final report has been received by the Trust. The Risk Team are responding to immediately to cases where there are queries around the quality of care. A thematic action plan will be presented to the November Private Trust Board with the final report.	G	10
	VitalPac Upgrades (3.5 & 3.6)		V3.5 upgrade went live on 22nd August 2018. Testing for V3.6 (to be deployed into our UAT environment) is to start in September with completion date of v3.6 Go Live is 26/11/2018. As part of the v3.6 deployment NEWS2 / Sepsis & A&E will be included as modules which means a big deployment with a lot of change. (NEWS 2 is a module on of VitalPac 3.6 which is required by April 2019 in A&E for the purpose of Sepsis CQUINs). The AKI module is dependent on OCRR being rolled out Trust wide which is currently in progress so far we have Ormskirk Outpatients & Wards and Southport Outpatients live with OCRR. Therefore, due to the resource v3.6 will require AKI is planned in for completion in May 2019.	G	20
	Timely Emergency Surgery / Surgical Assessment Unit		The Surgical Assessment Unit (SAU) opened on Monday 10th September. The next step is to look at a process to return minor surgery patients to parent ward after surgery are on hold until after the SAU is up and running.	G	100

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	Comments		Status Update	Status	% Completion
2. EFFECTIVE ESCALATION **(IT, Safety Hub & Comms)**	**Safety Hub Go Live: Bed Meetings, Operational & Medical Handover Meetings. CCOT and Resus Team in situ.**		Teams are in place and meetings are taking place. Work is now being undertaken is to develop improved handover, smarter ways of cross team working, more efficient escalation and management of, in particular deteriorating patients. This activity has started and will continue to evolve using QI methodology throughout the life of the project.	B	90
	Safety Hub Reporting		Reporting Modes for Bed Management and Discharge Planning have been completed with a Clinical Module is in development. The IT and Information Teams are meeting on 18th September to confirm the plan to link Ward Boards to the screens in the Hub.	A	60
	Pathways for escalation to be designed and rolled out.		This will be fully developed once NEWS2 has gone live (December) / the reporting function through Ward Boards is up and running.	A	10
	Policy for the Policy for the Clinical Ownership and Review of Outlying Patients		To be returned to September Clinical Effectiveness Committee with amendments for final approval. Upload and promotional activity then required.	G	70
	Ensure **optimum use of Careflow / VitalPac** to improve patient safety.		Meetings are being coordinated with Ted Adams, the Safety Hub Team and VitalPAC Team for July and August to discuss opportunities for improvement and maximised used of the system functionality	A	0
3. LEARNING CULTURE	**Roll out of the Structured Judgement Review Method**		SJR method live in the Trust as 2nd July 2018, levels of compliance were 38% in July to 58% in August.	B	100
	Communication to embed the SJR method		Communications, posters and training have been used to promote the new method to the Trust. Ongoing communications will be required until there is full compliance. To be captured in the RAM Project Communications and Promotions Meeting monthly.	G	70
	Link Risk and Mortality Data: Formal process for triangulation of SJR method, Serious Incidents and Mortality Data		Updated draft process currently circulated for comments and reported through to relevant committees for information. Progress required, has been escalated to the RAM Communications Subgroup.	A	60
	Lessons Learned and Learning from Excellence		New approaches are being looked into for effective communication with clinicians and nursing staff. Use of IT such as Whats App groups being considered alongside research into methods used by other Trusts.	A	5
4. FUTURE CARE PLANNING: Implement care planning for those patients identified as approaching end of life (GSF) that encourages appropriate levels or intervention and enables communication with the patient and their families by April 2019	**Anticipatory Clinical Management Planning**		Dr Fraser Gordon has created a ACMP model which is in place on the Frail and Elderly Short Stay Unit (FESSU). The next stage of project is to review and implement this though an education session to help others to begin to have similar conversations with patients and their families and develop similar plans. This is to be rolled out across the health economy.	A	20
	Advance Care Planning: training and awareness is to rolled out across the Trust.		Training Sessions to be run at Queenscourt Hospice: 8th August, 13th September and 12th October. HONs, Matrons and Clinical Leads to ensure that there is representation at all sessions.	A	70
	Alternatives to admission: to be developed as part of a second stage of project: to involve Clinical Commissioning Group partners.		NWAS Community Paramedics are now attending MDT Meetings with the Specialist Palliative Care Team to identify which patients have a Anticipatory Clinical Management Plan (ACMP) and what support they may need in the event that there is an ambulance call out. 'Alternatives to admission' are also being investigated as part of the Integrated Frailty Pathway Project .	G	10
	Rapid End of Life Transfer		The objective is to address delays in appropriate transport such as a separate ambulance service for those approaching EOL which prioritises EOL transfers from the hospice back to the patient's home. This was investigated with the CCGs and with St John's Ambulance. Discussions are now taking place with NWAS Community Paramedics for options.	A	30
	Reduce time to discharge for patients Medically Fit for Discharge for patients already on the Gold Standard Framework (GSF) Registered.		This was being addressed by the Fast Track Discharge Task and Finish Group which has since been disbanded. A CHC evidence sheet can be completed by a senior clinician asa soon as the patient is stable after admission. This is to be integrated into both the hospital and discharge planning teams to embed and speed up the process. Overlapping activity is scoped under the Integrated Frailty Pathway Project which will expedite this objective.	G	10

Project Objectives					
SMART (Specific-Measurable-Attainable-Relevant-Time bound)	**Comments**		**Status Update**	**Status**	**% Completion**
5. INFORMATION: Produce one version of reporting on mortality by October 2018 that provides clear and consistent information to inform different groups of leaders and clinicians	**Understand and Communicate Mortality Data:** Mortality Reporting to QSC and Trust Board to be reviewed and updated		Mortality reporting continues to be scrutinised for effectiveness; meetings and email converstations continue with Dr Foster and AQUA to find opportunities for improvement in what we report and the way that we report it.	B	100
	Understand and Communicate SJR Mortality Data:		Once Structured Judgement Review is embedded the findings will be factored into mortality reporting (by November). It will be triangulated with existing mortality data and serious incidents in order to provide a robust apporach to learning from deaths to improve care and practice.	G	20
	Increase depth of coding		Data sharing arrangements (including intermediate work around solutions) are being sought by the Trust and the CCGs. (Next meeting 18th September). A fuller picture of the patient's medical history and comorbidities will provide the required information for increased depth of coding.	A	10
WORKFORCE: Establish the proposed workforce model to deliver agreed clinical outcomes which will include a tangible 24/7 Outreach Team by September 2018	**Establish a 24/7 Outreach Team**		The costs of the authorised business case are being reviewed by the Finance Team. Once the figures have been finalised the recruitment for new members of the Critical Care Outreach Team can commence.	R	70
	Embed Full Utilisation of Safe Staffing Tools		Improvement work to further optimise the use of safe staffing tools will recommence once the 24/7 CCOT is in place. The relevant stakeholder from nursing, HR and IT will become involved at this point.	A	30
	Increase Access to & Prioritisation of Skills Training		A strategy is required with input from Training and Development / key stakeholders to ensure managerial prioritisation and release of staff for training. Discussions to recommence once the CCOT is in place as this remains the current priority for the Workforce Project Stream.	A	10

Key Milestones

Key Milestones	Start date	End date	BRAG	Comments
Safety Hub Set Up	10th March 2018	10th March 2018	B	The Safety Hub has been set up with required IT equipment and the current Outreach Team is installed.
Safety Hub Go Live	30th June 2018	30th June 2018	B	Escalation Nursing Meetings, Medical Handover and Bed Meetings are now running in the Hub.
Safety Hub Reporting (Ward Round Reporting)	31st March 2018	31st December 2018	G	Clinical reporting will be informed by improved recording of ward rounds & use of VitalPac, all pulled through to the Safety Hub screens.
Surgical Assessment Unit Opens (SAAT Project)	14th July 2018	14th July 2018	G	Part of the Safe At All Times Project. The SAU opened on 10th September 2018.
Go Live of Structured Judgement Review Method	3rd July 2018	3rd July 2018	B	The SJR Method went live on 2nd July.
Triangulation of Serious Incident, SJR Outputs & Mortality Data	1st June 2018	30th August 2018	R	The initial processes have been written on the back of the roll out of the SJR method. This has been added to the action list for the new 'RAM Project Communications Group' to support the required activity.
Lessons Learned and Learning from Excellence	1st June 2018	29th September 2018	A	The Group is looking at alternative modes for communication to hard copy newsletters and is in contact with the North West Innovation Agency to find best practice at other Trusts. This activity has also been added to the action list for the 'RAM Project Communications Group' to support the required activity.
Joint Working of the Transform Palliative Care and Outreach Team	2nd July 2018	30th August 2018	B	This is nowbusiness as usual
Anticipatory Clinical Management Planning Training Module	1st July 2018	31st March 2019	G	The preparatory work for the training is currently underway.
Installation of a 24/7 Critical Care Outreach Team	1st March 2018	30th September 2018	G	The Business Case has been approved. The recruitment process for November start dates has commenced.

Top Risks and issues to achieving programme objectives

Risk	RAG	Mitigation Activity	RAG After Mitigation	Comments
The timely recruitment of the full 24/7 Critical Care Outreach Team	R	Recruitment to commence once work has been undertaken with the Finance Team on the business case costing. It is unlikely that new recruits will be in place until after Christmas. Joyce Jordan to then consult Carol Fowler (Workforce) and the relevant HR Manager to expedite requirements and navigate any systemic blockages encountered.	A	Issues impacting on ability to recruit to be escalated immediately as the timeframe for November (start date) is already tight.
The ability to provide robust reporting to the Safety Hub due to a deficit of information input at ward level.	A	Meetings of the 'IT / Effective Escalation' Project subgroup have identified the required activity at ward level which will overcome this risk. This is to be removed from the log as a risk.	G	Since originally raised as a risk, work has been ongoing to look at improved reporting; this along with the Hub meetings is driving a culture to use Medway. Further support will come as processes are rolled out.
The delivery of the following activity against scoped timeframes: Triangulation of Mortality Data / SJR Data / Serious Incidents & Complaints. Lessons Learned and Learning from Excellence	A	These two activities have been added to the action plan for the RAM Project Communications subgroup. The original timeframes for the required activity have been pushed back due to the actual time required to embed the new SJR screening activity however this should not be a barrier to progress.	G	A wider workstream group could be set up to deliver against an action plan. These options to be put to the workstream owners to expedite the processes and reporting requirements.
If clinical staff cannot be released for training then pathway education will not be embedded and objectives will not be achieved.	A	The key to this issue is staffing levels and doctor's rotas which are being dealt with outside of the RAM project.	G	Training funding is also an issue which is to be addressed in the same forum.

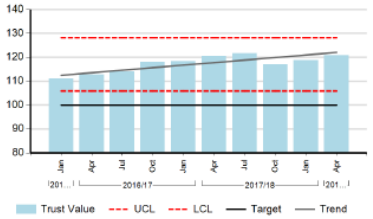
Appendix 1– Highlights from the Trust Mortality Dashboard September 2018

Southport & Ormskirk NHS Trust Mortality Dashboard September 2018

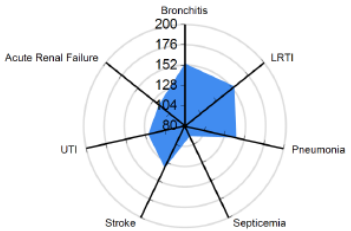
Southport & Ormskirk Hospital NHS

Dr Foster National Mortality Statistics

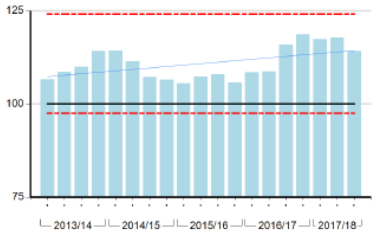
Rolling 12 Month HSMR



Local HSMR April 2018/19

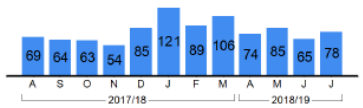


SHMI



Trust Mortality Statistics

In Hospital Deaths



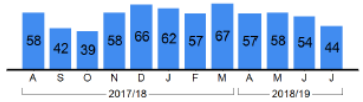
YTD Deaths of Patients with Learning Difficulties: 2

0.66% ▼

YTD Deaths of Patients with GSF Alert: 51

16.9% ▲

Deaths Post Discharge



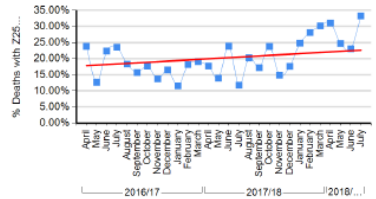
Avg Spell LOS whilst admitted: **22.8**

Avg Days to death post discharge: **13.1**

YTD Deaths of Patients with GSF Alert: 54

25.4% ▲

Palliative Care Coding %



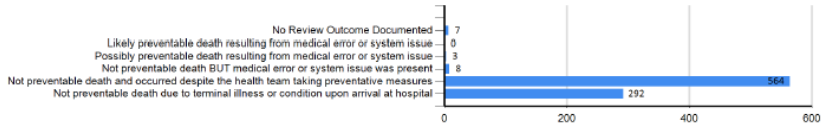
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

Primary Diagnosis Name	This Month	
Lobar pneumonia, unspecified	10	▼
Congestive heart failure	7	▲
Pneumonia, unspecified	6	▲
Pneumonitis due to food and vomit	6	▶
Sepsis, unspecified	6	▲

Mortality Reviews

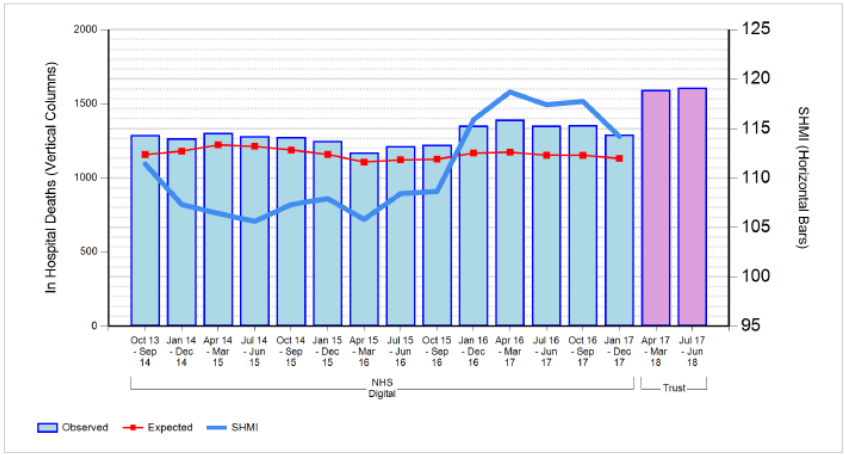
	2017/18								2018/19			
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Reviews Completed	77	71	53	64	80	126	81	109	79	75	59	
Reviews %	111.6%	110.9%	84.1%	118.5%	94.1%	104.1%	91.0%	102.8%	106.8%	88.2%	90.8%	0.0%

Mortality Review Outcomes - Last 12 Months



SHMI Breakdown

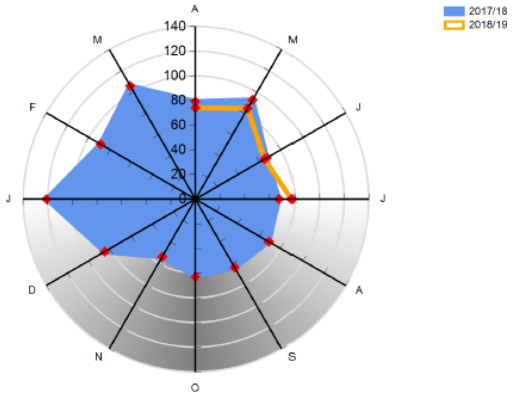
Southport & Ormskirk Hospital NHS
NHS Trust



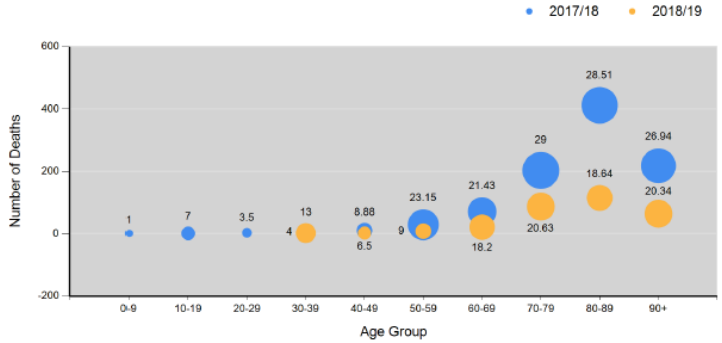
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

This should give an indication of the SHMI although the number of expected deaths for the recent periods is unknown.

In Hospital Deaths Seasonality Distribution



In Hospital Deaths - Age Group/ Avg Length of Stay Distribution



The above chart shows the distribution of in-hospital deaths by age group in 2017/18 compared to 2018/19. The relative size of the bubble represents the average length of stay of the spell.

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 20th September 2018
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Sickness Absence Policy
It was agreed 3 months ago to operate to the new policy with an expectation of sign off within 3 months, which brought us to September. Despite extensive meetings, which have included the CEO, the policy is going back to the next JNC meeting on 27/9. The WFC have agreed an expected deadline of November meeting to finalise the policy. The extension to November takes cognisance of the revised process for sign off.

Sickness Absence
This is continuing in an upward trend. HR is providing a lot of support to BU's. The challenge is finding protected management time on the floor due to resource issues. The levels of anxiety/depression are of concern and there is a well-being initiative taking place on 30/10.

Mandatory Training Decisions
At the moment clinical experts are making decisions on what training is mandatory and there is no overarching view or consideration to this decision making. This has been a previous alert and there needs to be a decision about which forum these decisions are taken to and it needs to be added to the TOR.

Medical Education
2 items from the Medical Education AAA report are raised as an alert.
Rota Gaps are impacting attendance at Induction. IT are short staffed which is impacting access to crucial systems. Trust wide risk to patient safety.

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)

Staff Survey Action Plans
We can provide some level of assurance, however this is an advise as it requires support from everyone on the Board. There is no lack of accountability, however the choice between patient safety and completing these creates a tension. That said some of the areas are making good progress.

PDR Completions
There is some progress being made, however more is required. The August figures are imminent and this is one to continue to put effort into.

Friends and Family
The completion rate of 1.3% is low. This is despite the huge efforts being made by the HR Team, who are doing walk arounds to encourage completion. As I write we are aiming for 300 completions and stand at 197. Additional questions have been added so there is a cultural pulse check, which takes the questions to 7. This requires active sponsoring by the Executive

ASSURE

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

NHS Streamlining
We continue to make good progress and in some areas we are leading with good practice.

Policy Update Work
Good progress is being made. The process has been changed and WFC will now receive the final version of policies. This should ensure that the policies are appropriately actioned.

Recruitment
It was pleasing to note that during recent recruitment (across the Trust) there has been a choice of good candidates. Whilst many might expect this, for us it is a definite move in the right direction where we are attracting high calibre talent and more able to make selection from a strong pool.

OD Strategy and Plan
This has been warmly received and positively commented on with regards to style. It is simple, straightforward and easy to understand. It has been highlighted for how different and more engaging it is. There have been suggestions to use it as a framework for future approaches to strategy and planning.

It is vital that this continues to be owned by the business and not HR and we encourage everyone to engage and execute this with their staff. It will make a huge cultural contribution to Vision 2020.

Personally, as Chair, whilst I know there are many resource constraints across the Trust I would like to commend the efforts of the HR team. I have sight of how they are going the extra mile across many strands that impact across the Trust. I am formally placing on record my thanks as they stretch to take part in pilot schemes that also focus on future benefits, whilst delivering a stretching day job.

New Risk identified at the meeting	• PDR Compliance • Mandatory Training

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)

- **Safe Staffing levels - Risk Rating has increased**
- **HENW Review – Risk can be reduced from an extreme risk**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item	**TB236/18**	**Report Title**	Monthly Safe Nurse & Midwifery Staffing Report
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Carol Fowler Assistant Director of Nursing - Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ☑ To Receive	

Executive Summary

The purpose of this report is to provide the Trust Board with the current position of nursing staffing in line with National Quality Board and National Institute of Health & Care Excellence guidance.

This report presents the safer staffing position for the month of August 2018.

The Board is advised that the current nurse staffing risk reports as High (12) via the risk register (ID 1368).

For the month of August 2018 the Trust reports safe staffing against the national average (90%) at 89.97%

Recommendation:
The Board is asked to receive the report.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

	Strategic Objective	Principal Risk
	SO1 Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
✓	**SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
	SO3 Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
	SO4 Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*

✓ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
SO6 Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
✓ Caring ✓ Effective ✓ Responsive ✓ Safe ✓ Well Led	✓ Statutory Requirement ✓ Annual Business Plan Priority ✓ Best Practice ✓ Service Change

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

✓ Compliance	☐ Legal
✓ Engagement and Communication	✓ Quality & Safety
☐ Equality	✓ Risk
✓ Finance	✓ Workforce

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

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

Executive Leads (Risk Owners should update their Risks on Datix as assurances and controls are received and ensure timely reports to Committees and the Board

Previously Presented at:

☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

1. Introduction

It is an ongoing requirement of NHS England that all NHS Trust Boards receive a monthly report relating to nurse staffing levels. This report provides an overview of the staffing levels in August 2018 and highlights the mitigation put in place to address any gaps in fill rate and addresses the rationale for gaps that have been identified.

Overall fill rate for August 2018 was 89.97% compared to 90.43% in July and 87.09% in June. (Appendix 1)

- 83.37% Registered Nurses on days
- 86.94% Registered Nurses on nights
- 97.85% Care staff on days
- 100.64% Care staff on nights

2. August Safe Staffing

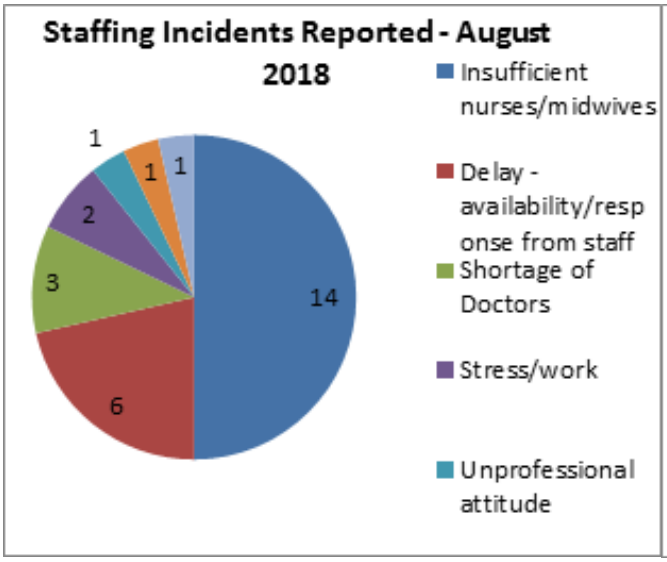
Trust whole time equivalent (wte) funded establishment versus contracted:

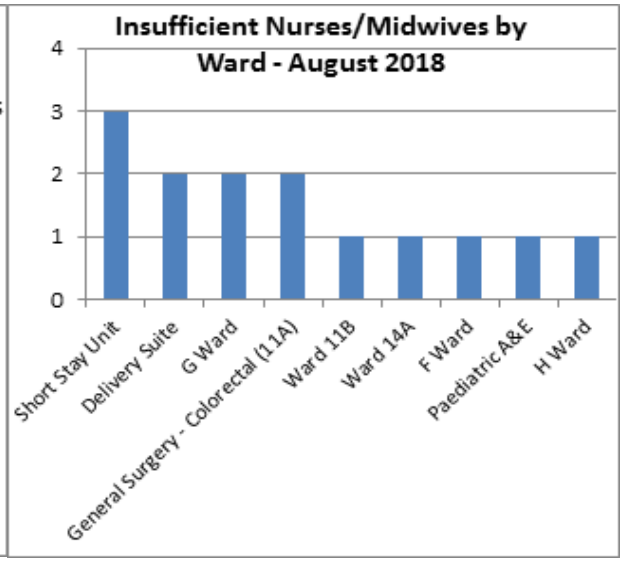
August 2018 data:

	Funded WTE	Contracted WTE
Registered	867.35	761.93
Non-registered	377.78	336.54
Total	1,245.13	1,098.47

The Clinical Business Unit (CBU) and corporate nursing and midwifery leads have in place daily safe staffing huddles to monitor, manage and ensure that the workforce is safe. The daily morning safe staffing huddle acts as a 'confirm and challenge' forum focusing on ensuring safe staffing levels whilst highlighting roster efficiency. Actions are captured to inform medium and long term plans in the delivery of efficient utilisation of Trust staffing tools and ultimately inform future workforce planning.

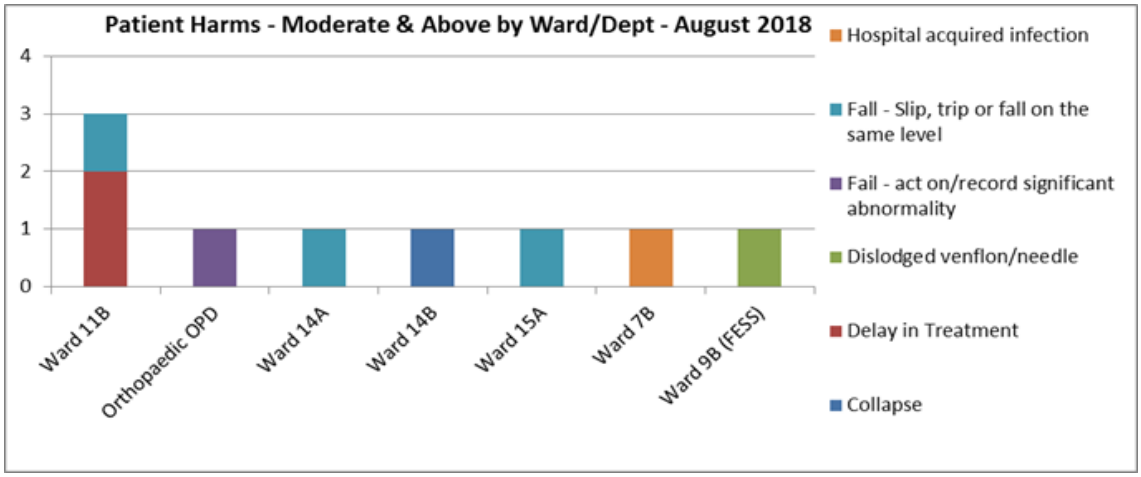
3. Staffing Related Reported Incidents





28 staffing incidents were reported in August, an increase of 2 on the previous month. 14 of these incidents highlight insufficient nurses/midwives, 1 less than the previous month. Short Stay Unit reported the highest number, with 2 reported on the same day relating to levels of patients requiring additional 1-2-1 support. Other incidents noted cancellation of shifts by flexible workers at short notice leaving the wards with insufficient staffing levels.

4. Inpatients experiencing moderate harm or above in May 2018



9 moderate or above incidents were reported in August, of which 3 were on ward 11B and 2 of which relate to potential missed/delayed medication.

5. Recommendations

The Board is asked to note the content presented in this paper.

Carol Fowler
Assistant Director of Nursing – Workforce

APPENDIX 1:

Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives / nurses	Care Staff	Overall
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
Ward 7A-SDGH	300 - GENERAL MEDICINE		1,341.50	849.08	939.00	1,356.92	1,109.50	749.50	730.00	803.00	63.3%	144.5%	67.6%	110.0%	845	1.9	2.6	4.4
A&E Observation Ward	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	757.25	714.25	371.00	509.00	719.50	623.50	366.50	417.00	94.3%	137.2%	86.7%	113.8%	247	5.4	3.7	9.2
E A U	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	1,703.00	1,449.75	1,070.50	1,176.75	1,095.00	880.00	729.50	669.50	85.1%	109.9%	80.4%	91.8%	499	4.7	3.7	8.4
FESS Ward	300 - GENERAL MEDICINE		1,541.67	1,058.58	1,347.67	1,214.17	1,113.00	717.50	732.00	873.50	68.7%	90.1%	64.5%	119.3%	847	2.1	2.5	4.6
Ward 11B-SDGH	300 - GENERAL MEDICINE		1,344.00	1,107.65	1,098.50	1,459.73	1,113.50	730.00	733.50	972.00	82.4%	132.9%	65.6%	132.5%	810	2.3	3.0	5.3
Ward 14B-SDGH	300 - GENERAL MEDICINE		1,610.50	1,422.00	1,406.50	1,407.08	1,100.50	1,054.00	735.00	673.00	88.3%	100.0%	95.8%	91.6%	884	2.8	2.4	5.2
Short Stay Unit	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	1,494.50	1,079.25	1,069.50	1,528.75	740.00	723.00	739.00	978.00	72.2%	142.9%	97.7%	132.3%	828	2.2	3.0	5.2
Ward 15A General Med	300 - GENERAL MEDICINE	410 - RHEUMATOLOGY	1,093.25	1,151.50	845.50	1,416.50	1,107.00	880.00	740.50	1,205.50	105.3%	167.5%	79.5%	162.8%	717	2.8	3.7	6.5
Stroke Ward	300 - GENERAL MEDICINE		1,339.48	1,228.73	956.67	1,294.58	1,106.75	881.08	738.50	676.50	91.7%	135.3%	79.6%	91.6%	562	3.8	3.5	7.3
Rehab & Discharge Lounge	314 - REHABILITATION		800.08	1,126.33	876.75	1,330.75	734.00	662.00	759.50	723.50	140.8%	151.8%	90.2%	95.3%	745	2.4	2.8	5.2
Ward 14A	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	1,337.25	1,137.00	2,157.20	1,819.25	743.50	735.00	736.75	891.75	85.0%	84.3%	98.9%	121.0%	892	2.1	3.0	5.1
Short Stay Surgical Unit	100 - GENERAL SURGERY		1,896.25	1,209.50	1,733.50	1,176.75	735.00	627.00	368.00	473.00	63.8%	67.9%	85.3%	128.5%	470	3.9	3.5	7.4
Ward H	110 - TRAUMA & ORTHOPAEDICS		743.50	572.50	737.25	212.75	742.00	466.00	369.00	189.00	77.0%	28.9%	62.8%	51.2%	143	7.3	2.8	10.1
Surgical Ward	100 - GENERAL SURGERY		1,333.25	922.25	1,113.00	1,224.50	742.50	670.50	733.50	661.00	69.2%	110.0%	90.3%	90.1%	538	3.0	3.5	6.5
Spinal Injuries Unit	400 - NEUROLOGY		3,930.98	3,072.48	3,691.00	3,298.08	2,830.00	2,459.00	1,487.98	1,433.00	78.2%	89.4%	86.9%	96.3%	1193	4.6	4.0	8.6
Ward G	101 - UROLOGY	502 - GYNAECOLOGY	1,413.50	827.83	740.00	356.00	743.00	599.50	359.50	347.50	58.6%	48.1%	80.7%	96.7%	244	5.8	2.9	8.7
ITU/CCU	192 - CRITICAL CARE MEDICINE		4,717.00	3,792.00	1,105.50	721.25	4,079.00	3,505.50	1,104.00	821.00	80.4%	65.2%	85.9%	74.4%	361	20.2	4.3	24.5
Delivery Suite	501 - OBSTETRICS		1,678.25	1,793.42	372.00	378.00	1,511.00	1,473.67	372.00	373.00	106.9%	101.6%	97.5%	100.3%	71	46.0	10.6	56.6
Maternity Ward	501 - OBSTETRICS		1,185.50	1,106.25	737.67	713.17	802.00	766.00	365.50	341.00	93.3%	96.7%	95.5%	93.3%	294	6.4	3.6	10.0
MAU	501 - OBSTETRICS		1,193.75	1,208.00	344.00	437.00	741.50	738.00	366.00	342.50	101.2%	127.0%	99.5%	93.6%	85	22.9	9.2	32.1
Neonatal Ward - ODGH	420 - PAEDIATRICS		1,116.75	1,092.50	318.00	270.00	1,116.00	1,117.00	24.00	24.00	97.8%	84.9%	100.1%	100.0%	195	11.3	1.5	12.8
Paediatric Unit	420 - PAEDIATRICS		3,536.30	3,220.18	1,106.50	1,078.25	1,858.50	1,851.50	743.00	443.00	91.1%	97.4%	99.6%	59.6%	219	23.2	6.9	30.1

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item (Ref):	**TB237/18**	**Report Title:**	**Guardian of Safe Working Annual Report to Board 01/08/17-31/07/18**
Executive Lead	Acting Medical Director, Dr Jugnu Mahajan		
Lead Officer	Guardian of Safe Working, Dr Ruth Chapman		
Action Required	☐ **Note** √ **Approve** ☐ **Assure**		

Key Messages of this Report & Recommendations:

Need for Clinical Fellows in Medicine to provide stable ward based workforce

Implementation of New F2/CT Rota in Surgery and T & O to significantly reduce unfilled shifts

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
XSO3 Provide care within agreed financial limit
XSO4 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 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 ✓ Equality	✓ 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

NHS
Southport and Ormskirk Hospital
NHS Trust

THE GUARDIAN OF SAFE WORKING ANNUAL REPORT TO TRUST BOARD 1st August 2017- 31ST July 2018

Introduction

Under the terms of the 2016 contracts all Trusts with trainees are obliged to have a Guardian of Safe Working (GoSW).

The GoSW is a senior person, independent of the management structure within the organisation, for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed. The GoSW is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training. The GoSW will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the trust board or equivalent body that doctors' working hours are safe.

The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of doctors and dentists in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured.

As Guardian of Safe Working I am responsible for collating information with regard to safe working for trainee doctors. This information is produced from Exception reports generated by trainees. I also review incidents (Datix) submitted by and relating to trainees. I disseminate an anonymised overview to the Executive Medical Director, Assistant Medical Directors, Clinical Directors, trainees and Directorate Managers and trainees on a monthly basis.

Detailed quarterly reports have been presented at Trust Board Meetings in November, February, May and September and this is an overview of the year.

1. EXCEPTION REPORT OVERVIEW (1st August 2017– 31st July 2018)

	01/08/17-31/10/17	01/11/17 31/01/18	01/02/18-30/04/18	01/05/18-31/07/18	01/08/17-31/07/18
Exception Reports ERs	**19**	**121**	**52**	**14**	**206**
Completed ERs	**17/19**	**80/121**	**31/52**	**3/14**	**131/206**
Not Exception Reports*	**0/19**	**3/121**	**0/52**	**2/14**	**5/206**
Trainees	**9**	**15**	**14**	**7**	**25**
Episodes	**27**	**135**	**72**	**17**	**251**
Review Interview Held	**19/19**	**120/121**	**44/52**	**9/14**	**192/206**
A&E	**0**	**0**	**0**	**0**	**0/206**
Medicine	**15**	**111**	**46**	**11**	**183/206**
Surgery	**2**	**2**	**1**	**1**	**6/206**
Orthopaedics	**2**	**4**	**0**	**0**	**6/206**
Anaesthetics	**0**	**0**	**0**	**0**	**0/206**
Ophthalmology	**0**	**0**	**0**	**0**	**0/206**
Paediatrics	**0**	**4**	**5**	**0**	**9/206**
Obs & Gynae	**0**	**0**	**0**	**0**	**0/206**
GP	**0**	**0**	**0**	**2**	**2/206**

The majority of Exception Reports generated were due to excess work load in medicine resulting in additional hours worked, missed educational opportunities and lack of senior support. The fluctuation throughout the year reflected clinical pressures experienced across the hospital. It is not possible to determine if any real improvement has occurred.

The high number of Exception Reports generated demonstrates a positive culture of Exception Reporting in the Trust.

There are significant numbers of Exception Reports not signed off as completed by the trainees. I consider the important element of the process is the Review Meeting and agreed outcome between the trainee and supervisor. This has occurred for the majority of Exception Reports. Changes involving rostering, monitoring and payment should improve trainee completion rate.

Grade	Exception Reports	Review Meeting Held	Not ER
F1	95	90/95	1/95
F2	26	23/26	0/26
CT1/2	80	74/80	2/80
ST1/2	0	0	0
>ST3	5	5/5	2/5
Total	206	192/206	5

The majority of exception reports are submitted by trainees in their first 4 years of training. More experienced trainees have submitted reports when there is a concern about safety due to unfilled shifts.

Upon review 5 episodes were not deemed to be suitable for Exception Reporting; 4 related to leave requests and 1 relating to the clocks changing.

2. PAYMENT AND FINES

There have been no GOSW fines levied in the last year.

Payment for TOIL generated from Exception Reports from 1st August 2017 to 31st July 2018 is £1,723.80.

3. IMPROVEMENTS

A) Double Bleep Carrying

This has reduced.
The Executive Medical Director is now aware of all episodes of Double Bleep carrying reported.
Recent episodes of Double Bleep carrying have related to last minute locum cancellation or sickness.

B) Paediatric Trainee Support

Improved support for Paediatric trainees was recognised by HENW. Trainees have also reported improved levels of satisfaction.

C)) Improved Bank Holiday Staffing

Trainee Bank holiday staffing is now the same as week end staffing which has reduced trainee workload and improved patient safety over weekends and bank holidays..

D) Payment System for Exception Reports

A Payment system for Exception Report Additional hours is now in place and functioning.

E) MIAA Report

The Mersey Internal Audit Agency Report on Junior Doctors Contracts was positively rated as Significant Assurance.

F) Southport Mess

Trainee dissatisfaction with the Mess facilities dates back many years. Work to enlarge and upgrade the Mess facilities at Southport has been agreed and is due to start in September.

4. AREAS OF CONCERN

A) Medicine Staffing

Although 5 SAS doctors have been appointed, none have a starting date as yet and the Executive Team have still not approved the Business Case for Clinical Fellows. Unless these staffing changes are implemented before December 2018 I would not expect any reduction in the Exception Reported events during Winter 2018/19. There were 19 exceptions reported in December, 73 in January and 21 in February across Medicine last winter.
The increase in staffing was a key factor in reducing concern during the HENW inspection.

B) Information Provided by Deanery and Lead Employer

Information about trainees who will be starting each rotation is frequently supplied late and does not detail trainees working part-time, off on maternity or sick leave. This prevents rostering of appropriate work schedules and meeting of the required 6 week notice period prior to trainee start date.

C) Rota Gaps in Surgery

Surgery and Trauma and Orthopaedics have experienced unfilled posts at F2/CT over the last year resulting in a significant number of unfilled shifts. Many of the episodes of Double Bleep carrying have arisen from these unfilled shifts. A new combined Surgery and Trauma and Orthopaedic rota, starting on 5th December, should help mitigate this problem.

D) Trainee Doctors' Forum Attendance

HENW assessed trainee engagement through Exception Reporting and direct contact with the Guardian of Safe Working as high, however attendance at Trainee Doctors' Forum remains low. Although Trainee Doctors' Forum time is protected there is no one else to do the trainees' work whilst they are away from their clinical duties. From August a change of day is being trialled to see if this improves attendance.

Ruth Chapman
Guardian of Safe Working

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 24 September 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)

- the Trust is overspent by £13.5m at month 5, which is in excess of its planned deficit. In addition, the Cost Improvement Programme is behind its target level of savings.

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)

- a revised accountability framework has been developed to strengthen governance arrangements within the organisation
- there is a major focus on improving productivity within both the elective and out patient programmes
- work on the Acute Sustainability Financial Model has progressed and the initial output is being tested against a range of possible scenarios
- the Trust's internal winter plan has been drawn up but discussions are continuing regarding out-of-hospital care.

ASSURE

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

- the format of the Integrated Performance Report has been amended with the aim of making it easier to understand and facilitating more consistent reporting across the Trust
- the recent initiatives to improve waiting times at the Southport A&E department have resulted in a significant improvement in August
- the Trust has adopted an action plan to address issues raised in the ICO's Audit Report which was received in August..

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

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PUBLIC TRUST BOARD

3 October 2018

Agenda Item	TB239/18	Report Title	Integrated Performance Report
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Anita Davenport, Interim Performance Manager		
Action Required *(Definitions below)*	☐ To Approve ☒ To Assure ☐ For Information		☐ To Note ☐ To Receive

Executive Summary

The report highlights the indicators that require discussion by Trust Board. Some of these indicators require corrective action to be taken. A brief narrative has been provided in order to provide assurance that corrective measures are in place.
Indicators within the Integrated Performance Report form part of the Trust's new performance management framework and are discussed with the relevant teams in monthly performance forum meetings.
The Board is asked to discuss the report and highlight any further assurance necessary in relation to areas of poor performance.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
☒ **SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
☒ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
☒ **SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
☒ Caring	☒ Statutory Requirement
☒ Effective	☐ Annual Business Plan Priority
☒ Responsive	☐ Best Practice
☒ Safe	☐ Service Change
☒ Well Led	

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

☐ Compliance	☐ Legal
☐ Engagement and Communication	☐ Quality & Safety
☐ Equality	☐ Risk
☐ Finance	☐ Workforce

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

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

Previously Presented at:

☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

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Board Report - August 2018

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
C.Diff - Variance from plan	0	-29	-29	N/A			
Never Events	1	0	1	0			
VTE Prophylaxis Assessments	95%	97%		130			
Harm Free (Safety Thermometer)	95%	94.4%	96.2%	21			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
SHMI (Summary Hospital-level Mortality Indicator)	100.1	114.2		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100.1	120.8	120.8	N/A			
Stroke - 90% Stay	80%	77.3%	61.3%	5			
Sepsis Screening & Antibiotic Administration	85%	94.7%	81.5%	4			

Caring	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	1	4	48	4			
Written Complaints	44	22	117	22			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	89.1%		74			

CQC Action Plan Performance

Note: These charts only relate to the CQC Action Plan and not the surrounding indicators.

REGULATORY	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
CQC Registration	-						
Monitor Governance Rating	Green	-	-			-	-

Responsive	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Accident & Emergency - 4 Hour compliance	95%	88.9%	91%	1078			
Accident & Emergency - 12+ Hour trolley waits	1	0	6	0			
Ambulance Handovers <=15 Mins	99%	46.4%	39.1%	799			
Diagnostic waits	1%	3.2%		90			
14 day GP referral to Outpatients	93%	94.6%	94.4%	47			
31 day treatment	96%	98.4%	98.4%	1			
31 day treatment (Surgery)	94%	100%	94.1%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day GP referral to treatment	85%	74.2%	80.7%	11.5			
62 day pathway Analysis	85%	62.4%	77.7%	19			
Referral to treatment: on-going	92%	95.5%	95.5%	445			

Reporting Frequency is monthly except for SHMI which is quarterly.

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Distance from Agency Spend Cap	0%	-8.1%	-5.6%	N/A			
Staff Turnover	1%	0.7%	1%	N/A			
Vacancy Rate - Medical		12.5%	12.5%	N/A			
Vacancy Rate - Nursing		11.8%	11.8%	N/A			
Sickness Rate	4%	5.6%	5.5%	N/A			
Personal Development Review	85%	65.2%	65.2%	N/A			
Mandatory Training	85%	83.5%	83.5%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	7.9		N/A			
Duty of Candour - Evidence of Discussion	100%	55.6%	70.5%	4			
Duty of Candour - Evidence of Letter	100%	55.6%	84.1%	4			

Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DTOC - Number of Beds lost per month		4		4.35			
Post MOFD (Medically Optimised for Discharge) - Number of Beds lost per month		20		20			
Length Of Stay		7.1		N/A			
Bed Occupancy	85%	69.6%		N/A			
New:Follow Up	2.64	2.4	2.4	N/A			
DNA (Did Not Attend) rate	8%	7.5%	7.4%	1622			
Cancelled Ops	1%	0.3%	0.3%	7			

Board Report August 2018

Safe

KPI	Update	Remedial Action (If Red)
Never Events	There have been two Never Events in the last 12 months. However, there were none reported in the month of August	No action required – met target in August
Harm Free (Safety Thermometer)	The Trust has consistently met the 95% target over the previous 11 months for harm free care but performed slightly below the 95% target in August at 94.4% - Catheter UTI's are a major contributor - Since May 18 there has been an increase in Catheter UTI's from 6 in May 18 to 17 in August 18. VTE and Falls have seen more modest increases (0 in May 18 to 6 in Aug 18 for Falls, 0 in Apr 18 to 4 in Aug 18). Hospital Acquired Pressure Ulcers have increased from 0 in May 18 to 3 in Aug 18. It should be noted that there is a significant number of community acquired pressure ulcers (14 in Aug 18) which reflects on our external harm free care performance.	Review UTIs to understand Root Causes and formulate action plans
C.Diff - Variance from plan	The Trust remains under trajectory for C diff with only 2 cases in August	
VTE Prophylaxis Assessments	The Trust continues to meet the required compliance of 95%, and has met the target in the last 12 months.	

Effective

KPI	Update	Remedial Action (If Red)
HSMR	Rolling 12 Months (Hospital Standardised Mortality Ratio) for April 2018 was slightly down on the previous month	• Revised and updated AKI, sepsis and pneumonia pathways. Best practice pathway for GI Bleed and revised, well publicised drugs charts • The use and development of the Safety Hub. Effective new processes to improve team working and management of the deteriorating patient. Business Case submission for Critical Care 24/7 Outreach Team • Advance Care Planning, Anticipatory Clinical Management Planning, Alternatives to Admission, Rapid End of Life Transfer, Reduce time to discharge for patients Medically Fit for Discharge • Roll out and embedding of the Structured Judgement Review • Continuous assessment for opportunities for improvement. Collaborative Working with AQUA and Dr Foster.
SHMI (Summary Hospital-level Mortality Indicator)	The ratio is the lowest since quarter 2 2016/17 and is a minor improvement on the same quarter the previous year	As for HSMR
Stroke - 90% Stay	The trust does not meet the 90% target but has still received a B rating. The positive result has been achieved in part due to the admission of stroke patients directly to the stroke unit within 4 hours. The data for this KPI is currently being validated	Awaiting vacancy approval for an additional stroke nurse to enable the provision of 7 day 24 hour cover.
Sepsis Screening & Antibiotic Administration	Sepsis compliance continues to improve month by month. The pathway will be monitored through the reducing avoidable mortality group	Not required

Caring

KPI	Update	Remedial Action (If Red)
DSSA (Delivering Same Sex Accommodation)	The majority of breaches are on critical care and are as a result of patients awaiting transfer to acute beds within the hospital	Ongoing patient flow management
Friends and Family Test - % That Would Recommend - Trust Overall	Performance is lower than the previous months data but within normal variation.	Pledge group work within the patient experience strategy is ongoing
Written Complaints	There were 23 written complaints in August	

Responsive

KPI	Update	Remedial Action (If Red)
Accident & Emergency - 4 Hour compliance	August saw some improvement against the 4-hour standard but remains below the 95% target. However there was a significant increase in attendances across the month compared to the same period in 2017 (10.5% - 499 additional patients)	• CDU continues to see over 30 patients a day, and the Discharge Lounge is available during the week to support earlier release of inpatient beds once discharges have been confirmed. • The Surgical Assessment Unit was delayed in opening, however opened on 10/9/18 to enable streaming of appropriate surgical patients from ED. • Exec agreement has been given for ACU to be ring fenced to prevent its use as an escalation area and a business case is being presented to HMB in September to increase Acute medicine staffing to expand and develop ambulatory care to support streaming of medical patients. • ED estate works commence 12/9/18 to create a larger triage area, a dedicated ambulance area, 4 protected cubicle spaces for ambulance patients, and 2 additional consulting rooms including an enhanced care room
Ambulance Handovers <=15 Mins	August ambulance handover performance saw the best performance time for the last 12 months, however remains significantly below the target. the 10% increase in attendances in August 18 compared to August 17 were predominantly majors category, although the number of patients arriving by ambulance did not have a dramatic change. The continued pressures on inpatient flow, coupled with surges in activity and restricted clinical assessment space, have heavily impacted on ambulance handover times. The Phase 3 estate works with a dedicated ambulance triage and 4 assessment cubicles will greatly support timely ambulance handovers, whilst ensuring that patients have privacy and dignity	• Plans agreed with clinical teams. Building works commence 12/9/18 and due to complete 23/11/18. • Rapid improvement event held. New way of working in place. Significant reduction in extended ambulance waits in ED
Diagnostic waits	Diagnostic waits improved in August from 4.16% to 3.19% - The Trust has failed to meet the threshold of 1% in the last 12 months. The Diagnostics Improvement Programme is focusing on Endoscopy and Non-Obstetric Ultrasound to address this. Phase 1 to the end of September focuses on establishing current state. Phase 2 (October to March inclusive)focuses on process improvements and developing a business plan. Phase 3 runs from April 2019 where larger scale improvements are identified	• Opening of additional room in endoscopy, once nurse training has been completed. Agreement to be reached over safe staffing levels • For all scopes there are WLIs On Saturdays. • Demand and capacity work underway - completion end September
62 day GP referral to treatment	Performance is not compliant against the 62 day standard	• A substantial piece of work is being undertaken to address the ongoing concerns around 62 day performance. This involves the adoption of a 7 day rule for each stage of every suspected cancer pathway.
62 day pathway Analysis	Slight improvement in post-reallocation performance	
Accident & Emergency - 12+ Hour trolley waits	The Trust met the target for 12 hour+ trolley waits in August. Whilst the Trust has met the target, there remains ongoing management to avoid breaches	• Meeting held. Re-circulation of comms for escalation of 12 hour breach • IP&C attend daily bed escalation meetings. Support given to wards and ED ensuring appropriate use of side rooms. Continued liaison with community IP&C to ensure awareness of community issues that may affect side room demand
14 day GP referral to Outpatients	Performance remains on target	
31 day treatment	Performance remains on target	
31 day treatment (Anti-cancer drugs)	Performance remains on target	
31 day treatment (Surgery)	Performance remains on target	
Referral to treatment: on-going	Performance remains on target	

Well-Led

KPI	Update	Remedial Action (If Red)
Duty of Candour - Evidence of Discussion	The Trust is not compliant for the month of August. Duty of Candour discussion is documented using the Datix system. The non compliance for August matches the non compliance of the evidence of a Duty of Candour letters. Delays may occur in the system of identifying moderate or above harm due to the CBU harm process and the introduction of the SIRG processes.	• Review at SIRG DOC process • Weekly status reports are sent to the Clinical Business units to ensure the Duty of \Candour compliance is achieved for all reported moderate or above harm incidents. • Monitored through Performance Review Boards
Duty of Candour - Evidence of Letter	As for Duty of Candour – evidence of letter	• As for Duty of Candour – evidence of letter
Sickness Rate	Sickness absence has increased again in month and remains high above the average. Urgent Care significantly reduced their sickness absence in month from 5.40% in June to 4.61% in July. Estates and facilities has the highest sicknessabsence rate at 7.24% in July, followed by Planned Care at 6.34% in month. Performance in being monitored on a monthly basis and targeted support and focus is being provided to the CBU's.	• Review of sickness absence policy – revised policy to go to Workforce Committee in September • Integration of Health and Wellbeing, Sickness absence and self assessment action plans – draft plan submitted to NHSi • Health and Wellbeing Task and Finish group to be set up following NHSi feedback • Launch of Health and Wellbeing Brand, 'For You, With You' 5th October 2018
Personal Development Review	PDR compliance has slightly improved for the fourth consecutive month. - All CBU's have been provided with detailed focused reports in order to drastically improve their compliance. The outcome of this intensive work should be realised in September's figures. Additionally an options appraisal is going to September's Hospital Management Board, to approve an appraisal window cycle and also further streamlined documentation.	• Target date for completion of PDRs set • Workforce dashboards to be provided monthly focusing on progress
Mandatory Training	Mandatory training is 1.48% below target - Mandatory training remains below target, although it has seen a slight increase of 0.62% in month, falling 1.48% short of the Trust's 85% target. Balancing patient safety/safe staffing levels versus staff attending training has the greatest impact on the Trust's ability to achieve its 85% target and above.	• Consultant/SAS Doctors' mandatory training days have been re-instated, first date Oct 2018 with further dates in 2019, to improve compliance. • eLearning is available 24/7 for most subjects where there is no requirement for a practical element. • A Clinical Competency Working Group will be re-scheduled to Sept 2018
Care Hours Per Patient Day (CHPPD)	Performance remains above target	
Distance from Agency Spend Cap	At Month 5 the trust is above the NHSI agency cap. Agency spend has risen in the last two months	
Staff Turnover	Staff turnover has reduced in month and performance is on target for August	

Efficient

KPI	Update	Remedial Action (If Red)
Bed Occupancy	Improvements are noted since June but this may be seasonal; awaiting further data to assess if trend is continuing	
New:Follow Up	Performance is on target	
DNA (Did Not Attend) rate	Performance remains consistently above target	
Cancelled Ops	Performance remains consistently above target	

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PUBLIC TRUST BOARD
3 October 2018

Agenda Item	TB240/18	Report Title	Director of Finance Report - August 2018
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ☑ To Receive	

Executive Summary

- At month 5 the Trust's financial performance is a deficit of £13.516M against a deficit plan of £13.279M which is £237K worse than plan.
- Agency spend is rising, particularly in nursing
- CIP delivery is the main cause of the adverse performance in August.
- There are a number of other risks which, if not addressed, will lead to the Trust not achieving the planned deficit of £28.8M
- The main risks are CIP and agency spend.
- Based on the current run rate the outturn will be in the region of £30-32M deficit.
- There is no plan at this stage to amend the forecast outturn from £28.8M deficit.

The Board is asked to receive the month 5 Director of Finance report.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
☐ **SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
☑ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*

☐ **SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
☐ Caring	☑ Statutory Requirement
☐ Effective	☐ Annual Business Plan Priority
☐ Responsive	☐ Best Practice
☐ Safe	☐ Service Change
☑ Well Led	

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

☐ Compliance	☐ Legal
☐ Engagement and Communication	☐ Quality & Safety
☐ Equality	☐ Risk
☑ Finance	☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact Assessment* **must** *accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

Add actions with milestones and Leads here

Previously Presented at:

☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☑ Finance, Performance & Investment committee	☐ Workforce Committee

1. Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 5 (the financial period ending 31st August 2018).

2. Executive Summary

2.1. The Trust control total for 2018/19 was £6.9M, £13.681M excluding Provider Transformation Funding (PSF).

2.2. The Trust could not sign up to its control total and set a deficit plan of £28.8M.

2.3. At month 5 the Trust's financial performance is a deficit of £13.516M against a deficit plan of £13.279M which is £237K worse than plan.

2.4. This is a reduction of £409K from month 4's performance against plan.

2.5. Income continues to perform to plan for activity although a provision of £333k has been made in income for CQUIN underperformance.

2.6. A&E activity is up by 4%; resulting in a financial impact of £214k

2.7. Elective activity is down by 10%; resulting in a financial impact of -£475k

2.8. Non elective activity is up by 14%; resulting in a financial impact of £1.761M although this has been reduced for ACU and CDU until an agreement has been reached.

2.9. Due to the high level of non elective performance the Trust has provided for a reduced level of non elective income to take account of the marginal rate (70%) for activity above the agreed baseline.

2.10. The Trust continues to make provision for ACU and CDU activity while tariff discussions continue with CCG's. The deadline for completion under the terms of the Expert is 30 September. MIAA are expected to report by 26 September 2018.

2.11. Any agreement reached regarding the Trust's tariff proposals for ACU and CDU would have a positive impact on the current financial position.

2.12. Outpatient activity is down by 4%; resulting in an adverse financial impact of £42k.

2.13. Total expenditure now exceeds plan at month 5 YTD, mainly driven by CIP underperformance against a high monthly profile.

2.14. Pay expenditure includes back pay for the Agenda for change pay award; underlying expenditure is slightly up on previous months reflecting the increased nurse agency usage in August.

2.15. Non pay spend is consistent with July.

2.16. Agency spend has increased again this month to £688K in month which leads to a YTD spend of £3M; this means there is a significant risk of not achieving the NHSI cap of £5.6M as current spend is heading towards circa £7M.

2.17. The table below is the I&E statement for August:

I&E (including R&D)	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
Commissioning Income	148,902	61,834	61,761	(73)	12,334	12,195	(139)
PP, Overseas & RTA	1,384	576	496	(81)	116	68	(48)
Other Income	14,243	5,893	6,078	185	1,663	1,725	62
Total Income	**164,529**	**68,303**	**68,335**	**32**	**14,113**	**13,988**	**(125)**
Operating Expenditure							
Pay	(129,036)	(54,652)	(54,684)	(32)	(11,097)	(11,377)	(280)
Non-Pay	(53,129)	(22,284)	(22,426)	(142)	(4,470)	(4,463)	7
Total Expenditure	**(182,165)**	**(76,936)**	**(77,110)**	**(174)**	**(15,567)**	**(15,840)**	**(273)**
EBITDA	**(17,636)**	**(8,633)**	**(8,775)**	**(142)**	**(1,454)**	**(1,852)**	**(398)**
Non-Operating Expenditure	(11,217)	(4,673)	(4,678)	(5)	(933)	(932)	1
Retained Surplus/(Deficit)	**(28,853)**	**(13,306)**	**(13,453)**	**(147)**	**(2,387)**	**(2,784)**	**(397)**
Technical Adjustments	63	27	(63)	(90)	6	(6)	(12)
Break Even Surplus/(Deficit)	**(28,790)**	**(13,279)**	**(13,516)**	**(237)**	**(2,381)**	**(2,790)**	**(409)**

2.18. Capital expenditure is within the plan and is effectively managed through the Trust's Capital Investment Group (CIG).

2.19. The Trust continues to require cash support as it is trading with a deficit each month and continues to provide a rolling 13 week cash forecast to NHSI.

2.20. There are a number of risks in delivering the year end deficit of £28.8M

2.20..1. CIP delivery of £7.5M.

2.20..2. Agency costs are rising.

2.20..3. There is no provision for contract sanctions; current understanding is that CCG's will not apply.

2.20..4. Current non-elective activity and price is likely to lead to contract challenges from the commissioners.

2.20..5. Potential further business cases or pressures not covered by reserves; full analysis to be completed as part of the forecast outturn.

2.21. If the above issues are not addressed then the Trust will not achieve the planned deficit of £28.8M and, based on the current run rate, will be in the region of £30-32M deficit.

2.22. There is no plan at this stage to amend the forecast outturn from £28.8M deficit.

3. Income Performance

3.1. The Commissioning income budget has underperformed in month due to CQUIN performance.

CQUIN income has now been reduced by £333,000 (5/12 of £800k) reflecting the "red" RAG rated scheme.

3.2. Non elective activity continued to overperform even after stripping out both ACU and CDU activity until agreement has been reached. The marginal rate reduction (70%) is being applied for activity exceeding the baseline.

3.3. Elective activity continues to underperform although the income shortfall has reduced from 8% to 6% resulting in a similar adverse variance (compared to month 4 YTD) in monetary terms. There are plans to reduce the elective shortfall back to plan and, therefore, it is likely that overall activity levels will generate a significant overperformance on CCG contracts.

3.4. The issue regarding the tariffs for Ambulatory Care Unit (ACU) has still not been agreed. MIAA visited the Trust in August to form a view on the tariff being proposed. MIAA are scheduled for a further meeting at the Trust in the week commencing 17 September with the Urgent Care team to further review pathways. It is expected that a recommendation will be made by the end of September 2018. The commissioning income position currently reflects the tariffs applied by the Expert in 2017/18.

3.5. The Clinical Decision Unit (CDU) was opened at the end of April. This resulted in a rise in non elective activity and, as such, income was reduced until the pathway and tariffs have been agreed with commissioners. As in 3.4 above the Trust awaits MIAA's recommendation; no additional income has been accrued for this activity in the month 5 position.

3.6. In summary, non elective activity is generating a favourable variance against plan of £685k after deductions for ACU, CDU and marginal rate.

3.7. Outpatient activity remains below plan but continues to generate a YTD favourable variance.

3.8. The Trust may be subject to sanctions in 2018/19 for non compliance with performance standards. The YTD income position does not include any reduction for sanctions.

4. Expenditure

4.1. Underlying expenditure levels for pay remain consistent compared to last year although agency expenditure is beginning to increase. The summer holidays may have exacerbated this issue so September's results should indicate if this non recurrent.

4.2. The pay award for Agenda for Change staff was applied in July. The payment for April, May and June has been made in August.

4.3. Pay expenditure in July is consistent with previous month's performance apart from nurse agency (£250K in month of which £122K relates to Thornbury).

4.4. The Trust received £164K from the DoH (for July) for the element of the pay award not in tariff. A further £656K has been received in August (for April, May, June and August). The DoH will then pay a monthly amount of £164K for the remainder of the year.

4.5. Annual budgets for income and pay expenditure have been increased and profiled in line with the amounts in 4.4.

4.6. The Trust's financial plan has not been adversely impacted by the central calculation for additional DoH funding.

4.7. All pay budgets are underspent in month except for non-consultant medical staff and nursing. Both staff groups rely heavily on premium agency staff to fill vacancies and other staff absences.

4.8. Nurse bank is higher in August which reflects the higher bank rates back dated to 1 April 2018 in line with the pay award.

4.9. Non pay spend overall 0.6% overspent with meetings scheduled for September and October with all budget holders to bring back into balance.

5. Agency spend

5.1. The Trust has spent £688K on agency staff in July (6.3% of the substantive payroll) which is above the planned spend submitted to NHSI. The monthly profile of the plan reduced considerably in July, however spend has increased with more Thornbury agency nurses being used to cover the increasing nurse vacancies and holidays.

5.2. Based on the current level of agency spend there is a significant risk of not achieving the £5.67M NHSI agency cap.

5.3. Agency spend is across all staff groups in medical staff, nursing and other staff such as key senior manager and A&C posts.

5.4. Executive Directors have been tasked with developing plans to replace/stop agency spend within senior manager/A&C posts. The Turnaround Director is addressing this issue after compiling a full list of all temporary posts.

5.5. Nurse agency spend is £250k in August which continues on an upward trend as reported at last month's Board.

5.6. As in July high agency levels are experienced in A&E but there has been a large increase in agency within both ITU and Spinal injuries this month.

5.7. Bank fill remains high and August's spend was 34% up on July; the focus continues to be recruiting to substantive posts.

5.8. Increasing vacancy levels of 11.8% are preventing any further material improvements on nurse bank and agency spend.

5.9. The cost of providing cover for nurse sickness in August was £132k (bank £116k; agency £16k) based on the information provided by NHSP.

5.10. Thornbury nurse agency spend has increased over the last three months: June £24K; July £45K; August £122K.

5.11. With regard to medical staff the Trust is coming under intense pressure to breach its own bank rates when shifts require filling at short notice and there are quality/safety concerns.

5.12. A revised escalation procedure has been discussed at the Executive Team Meeting. This procedure plans to speed up decision making but also take into consideration the required executive authorisation (as per NHSI rules) before shifts are booked. This has been partially implemented in September with the remaining elements of the policy due to be introduced in October following the commencement of the COO.

5.13. Plans are being developed to appoint substantively or secure fixed term contracts on reduced rates.

5.14. The cost of providing cover for medical sickness in August was £5k bank only based on the information provided by TempRE.

6. Cost Improvement Plan (CIP)

6.1. The Trust's I&E plan assumes a £7M CIP is delivered in 2018/19 from both increased income and reduced expenditure.

6.2. This figure rises to £7.5M to take account of the balance to FYE of 2017/18 schemes. These schemes have already been delivered in 2017/18 but are included to be consistent with monthly reporting to NHSI.

6.3. The performance to date is shown in the table below:

	Annual	YTD			In Month		
	Plan £000	Plan £000	Actual £000	Var £000	Plan £000	Actual £000	Var £000
18/19 Plan	7,006	1,953	1,275	(678)	673	428	(245)
17/18/ balance to FYE	535	224	224	0	45	45	0
Total	7,541	2,177	1,499	(678)	718	473	(245)

6.4. The CIP profile increased in July and continues at a high level for the remainder of the financial year. Once again the CIP has underachieved and is contributing materially to the adverse budget performance in month.

6.5. The Turnaround Director reviewed the CIP plans last month and revised the CIP forecast down to £4.494M (£3.959M of the £7M "in year" plan). Additional schemes have been identified and these are currently being worked through. The financial impact of these schemes will be reported at next month's FPI committee and Board.

7. Cash

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

7.2. A rolling 13 week cash forecast is updated monthly and sent to NHSI, usually in the second working week of the month; this forms the basis of any cash draw downs in the future month (August's cash flow was sent on 11th July).

7.3. It is anticipated that the cash required to resolve 2017/18 contract issues following the results of the Expert Determination will be required in October 2018. The borrowing for October is forecast to be in the region of £5m.

7.4. The Trust borrowed £2.573m in August which was the below the maximum available. Note that as the Trust has not agreed its control total with NHS Improvement, there is a punitive interest rate charge of 3.5% (normally 1.5%).

7.5. Performance against the cash target in August was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	1,446	Brought forward balance
Cash inflows	17,067	18,003	DHSC AfC funding (£164k) not in plan, Health Education income higher than planned (£200k). VAT Recovery £130k higher than planned. Progress on Virgin Care debt (£100k) and other debt (£262k)
Cash outflows	-17,066	-17,340	Weekly payroll £155k higher than planned, offset by lower than planned payroll statutory payovers £93k
Closing balance	**1,001**	**2,109**	

7.6. Cash is monitored daily and plans are adjusted to reflect any changes in month to ensure that the Trust does not breach the loan condition of having £1m bank balance at the end of the month.

7.7. September's loan request of £2.142m was approved at the Private Board on 5th September.

8. Capital

8.1. A more detailed capital plan is now shown which includes commitments. This provides a better model for decision-making purposes particularly as the medical equipment line is managed on a contingency basis.

8.2. Overall spend was £257k in month with a cumulative position of £1,595k (planned year to date £2,850k).

9. Commissioning for Quality and Innovation payments (CQUINS)

9.1. The full 2.5% CQUIN income of £3.2M has been included in the 2018/19 Financial Plan. Most of the CQUIN targets are "national" targets and are a continuation of 2017/18.

9.2. There is a risk of losing £181K for Quarter 1 with a potential full year risk of £812K of schemes rated Red. Therefore, the Trust has recognised this risk in August's position and reduced CCG income by £333k (5/12 of £800k). Work is underway to restrict the loss of CQUIN income to a figure below £800k.

9.3. This is an area of focus for the Turnaround Director.

10. Risks

10.1. Following an assessment by the Turnaround Director there is a significant risk of delivering the CIP of £7.5M (£7M 'in year').

10.2. No provision for contract sanctions has been accrued into August's financial position.

10.3. Current activity projection is that our two main CCG contracts will overperform.

10.4. Future business cases or pressures are not covered by reserves.

11. Forecast Outturn 2018/19

11.1. The Trust continues to work with NHSI regional finance team to forecast the year end position.

11.2. The finance team, in association with the Turnaround Director, will now use the month 5 financial position to forecast the year-end with an associated monthly profile. This will be reported to October's FPI Committee and November's Board.

11.3. There is no plan at this stage to amend the current forecast outturn from £28.8M deficit.

12. Recommendations

12.1. The Board is asked to receive the month 5 Director of Finance report.

Southport and Ormskirk Hospital NHS Trust

Statement of Comprehensive Income (Income & Expenditure Account)

I&E (including R&D)	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
Commissioning Income	148,902	61,834	61,761	(73)	12,334	12,195	(139)
PP, Overseas & RTA	1,384	576	496	(81)	116	68	(48)
Other Income	14,243	5,893	6,078	185	1,663	1,725	62
Total Income	**164,529**	**68,303**	**68,335**	**32**	**14,113**	**13,988**	**(125)**
Operating Expenditure							
Pay	(129,036)	(54,652)	(54,684)	(32)	(11,097)	(11,377)	(280)
Non-Pay	(53,129)	(22,284)	(22,426)	(142)	(4,470)	(4,463)	7
Total Expenditure	**(182,165)**	**(76,936)**	**(77,110)**	**(174)**	**(15,567)**	**(15,840)**	**(273)**
EBITDA	**(17,636)**	**(8,633)**	**(8,775)**	**(142)**	**(1,454)**	**(1,852)**	**(398)**
Non-Operating Expenditure	(11,217)	(4,673)	(4,678)	(5)	(933)	(932)	1
Retained Surplus/(Deficit)	**(28,853)**	**(13,306)**	**(13,453)**	**(147)**	**(2,387)**	**(2,784)**	**(397)**
Technical Adjustments	63	27	(63)	(90)	6	(6)	(12)
Break Even Surplus/(Deficit)	**(28,790)**	**(13,279)**	**(13,516)**	**(237)**	**(2,381)**	**(2,790)**	**(409)**

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	31/08/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	125,769	(1,021)	(267)
Other assets	1,382	1,526	144	(162)
TOTAL NON CURRENT ASSETS	**128,172**	**127,295**	**(877)**	**(429)**
CURRENT ASSETS				
Inventories	2,454	2,567	113	39
Trade and other receivables	9,591	7,554	(2,037)	(543)
Cash and cash equivalents	1,079	2,109	1,030	663
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**13,124**	**12,230**	**(894)**	**159**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(24,655)	576	(21)
Provisions	(131)	(158)	(27)	0
PFI/Finance lease liabilities	(1,746)	(1,746)	0	0
DH revenue loans	(4,220)	(4,220)	0	0
DH Capital loan	(400)	(400)	0	0
Other liabilities	(471)	(188)	283	8
TOTAL CURRENT LIABILITIES	**(32,199)**	**(31,367)**	**832**	**(13)**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(19,137)	(62)	**146**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**108,158**	**(939)**	**(283)**
NON CURRENT LIABILITIES				
Provisions	(278)	(266)	12	0
DH revenue loans	(66,615)	(79,302)	(12,687)	(2,718)
PFI/Finance lease liabilities	(13,807)	(13,845)	(38)	71
DH Capital loan	(1,400)	(1,200)	200	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(94,613)**	**(12,513)**	**(2,503)**
TOTAL ASSETS EMPLOYED	**26,997**	**13,545**	**(13,452)**	**(2,786)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	97,241	0	0
Retained earnings	(83,484)	(96,936)	(13,452)	(2,786)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**13,545**	**(13,452)**	**(2,786)**

In month material movements are as follows:

No significant in month variances to highlight. The Trust received a loan of £2,573k which was entirely used to fund the deficit.

Reduction in propery, plant & equipment is due to low in month spend on capital.

Retained earnings decreased by £2,786k in line with the in month deficit excluding technical adjustments.

Source of information from Financial se\controlxxYY\balance sheets

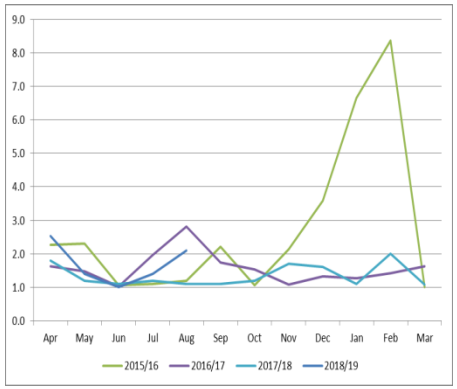
Statement of cash flows

Southport and Ormskirk Hospital NHS Trust

	Actual Apr-18	Actual May-18	Actual Jun-18	Actual Jul-18	Actual Aug-18	Plan Sep-18	Plan Oct-18	Plan Nov-18	Plan Dec-18	Plan Jan-19	Plan Feb-19	Plan Mar-19	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,217)	(2,330)	(2,192)	(2,274)	(2,376)	(1,968)	(1,896)	(1,991)	(1,988)	(1,345)	(1,569)	(1,739)	(23,885)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)	(20)		(15)				(10)		(150)
Depreciation and Amortisation	523	524	523	524	523	517	517	517	517	517	516	516	6,234
Impairments and Reversals	0	0	0	0	0								0
(Increase) in Inventories	(50)	59	(83)	0	(39)						39	74	0
(Increase) in Trade and Other Receivables	976	153	(468)	558	818						(818)	(1,219)	0
Increase in Trade and Other Payables	135	(859)	261	(514)	(371)	1,707	(3,204)	(193)	191	(651)	450	1,249	(1,799)
Increase in Provisions	(3)	(3)	(61)	82	0			(30)	(27)		(28)	10	(60)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(2,050)	(1,642)	(1,465)	256	(4,598)	(1,697)	(1,307)	(1,479)	(1,420)	(1,109)	(19,660)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	2	3	2	2	3	2	2	28
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(31)	(44)	(50)	(44)	(57)	(56)	(47)	(39)	(546)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(198)	(1,007)	(513)	(502)	(454)	(506)	(492)	(437)	(5,630)
Receipts from disposal of fixed assets	0	0	1	2	0								3
Receipt of cash donations to purchase capital assets	5	52	30	18	20		15				10		150
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(207)	(1,049)	(545)	(544)	(509)	(559)	(527)	(474)	(5,995)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	127							127
Public dividend capital repaid	0	0	0	0	0								0
Loans received from DH	2,739	2,178	2,479	2,718	2,573	1,942	5,628	2,318	2,356	2,356	2,356	2,357	32,000
Loans repaid to DH	(200)	0	0	0	0		(200)						(400)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(537)		(114)			(203)		(894)
Capital element of PFI, LIFT	(14)	(14)	(161)	(14)	(14)	(161)	(14)	(14)	(161)	(14)	(14)	(161)	(756)
Interest Paid	(99)	(103)	(148)	(104)	(136)	(484)	(144)	(150)	(193)	(153)	(184)	(1,058)	(2,956)
Interest element of finance lease	0	0	0	0	0		(314)	(5)			(205)		(524)
Interest element of PFI, LIFT	(80)	(80)	(196)	(80)	(80)	(60)	(43)	(43)	(79)	(43)	(44)	(76)	(904)
PDC dividend (paid)/refunded	0	0	0	0	0		(81)					(36)	(117)
Net Cash Inflow/(Outflow) from Financing Activities	2,338	1,973	1,966	2,512	2,335	827	4,832	1,992	1,923	2,146	1,706	1,026	25,576
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**663**	**34**	**(311)**	**(249)**	**107**	**108**	**(241)**	**(557)**	**(79)**
Cash - Beginning of the Period	1,079	2,531	1,380	1,018	1,446	2,109	2,143	1,832	1,583	1,690	1,798	1,557	1,079
Cash - End of the Period	**2,531**	**1,380**	**1,018**	**1,446**	**2,109**	**2,143**	**1,832**	**1,583**	**1,690**	**1,798**	**1,557**	**1,000**	**1,000**

The Trust held enough cash to cover 4.05 days of operating expenditure at the end of July 2018 (July = 2.78 days).

Month end cash balances held in the last 3 years



NHS Southport and Ormskirk Hospital NHS Trust

CATEGORY	CAPITAL SCHEME DESCRIPTIONS	SCHEME CODES	2018/19 £'000	YTD £'000			Orders not yet received	Verbally agreed / letter of intent	Remaining Budget to Yend £'000		
			Plan	Plan	Actual	Variance	Actual	Actual	Plan	Actual	Variance
MEDICAL DEVICES	Medical Equipment fund	G0072	735	200	172	28	93	39	735	304	431
	Beds / Trolleys	G0060	50	50	51	(1)			50	51	(1)
	Sub total MEDICAL DEVICES		**785**	**250**	**223**	**27**	**93**	**39**	**785**	**355**	**430**
IM&T	Electronic Patient Record	F6409	190	70	56	14	0		190	56	134
	Vitalpac	G0007	30	12	1	11			30	1	29
	eDMS	F6447	160	67	0	67			160	0	160
	Wireless network upgrade	G0073	302	175	174	1	129		302	303	(1)
	Server warehouse infrastructure incl. storage	G0078	75	75	25	50			75	25	50
	Telephony system replacement	G0059	95	95	0	95			95	0	95
	Cyber security	G0071	50	21	0	21	7		50	7	43
	Fixed network infrastructure	F6498	100	42	0	42	9		100	9	91
	Datacentre	G0075	50	50	5	45	0		50	5	45
	Virtual desktop infrastructure	G0076	25	10	2	8			25	2	23
	Equipment refresh	G0077	50	21	0	21	4		50	4	46
	Sub total IM&T		**1,127**	**638**	**264**	**374**	**149**	**0**	**1,127**	**413**	**714**
ESTATES	GE Turnkey works for Radiology equipment replacement programme		200	50	0	50	125		200	125	75
	Southport A&E Redesign	G0068	485	250	176	74	43	533	485	752	(267)
	Ward reconfigurations	G0064	140	140	108	32		30	140	138	2
	Medical gasses	G0067	30	30	23	7	3		30	26	4
	UPS Theatre	G0053	100	50	0	50		142	100	142	(42)
	Waste management storage facilities		100	100	0	100			100	0	100
	Theatre airplant controls		45	45	0	45			45	0	45
	Generator connectors		65	65	0	65			65	0	65
	Fire compartmentation	G0052	165	105	12	93			165	12	153
	Fire Precautions - Fire Doors	G0019	45	45	7	38			45	7	38
	Discharge lounge	G0074	134	134	130	4			134	130	4
	Spinal isolation works		200	75	0	75			200	0	200
	Additional Car Parking		50	0	0	0			50	0	50
	Sexual Health Accomodation		200	0	2	(2)			200	2	198
	Capital team	F6305	155	71	85	(14)		106	155	191	(36)
	Aseptic isolator		30	0	0	0			30	0	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,144**	**1,160**	**543**	**617**	**171**	**811**	**2,144**	**1,525**	**619**

FACILITIES	Catering equipment	G0026	100	60	0	60			100	0	100
	Sub total FACILITIES		**100**	**60**	**0**	**60**	**0**	**0**	**100**	**0**	**100**
	CONTINGENCY	**F6301**	**155**	**155**	**48**	**107**			**155**	**48**	**107**
	Capital plan excluding donations and IFRIC 12		**4,311**	**2,263**	**1,078**	**1,185**	**413**	**850**	**4,311**	**2,341**	**1,970**
OTHER	Donated assets	000000	120	30	125	(95)			120	125	(5)
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,488	557	392	165		1,096	1,488	1,488	0
	Sub total Donations and IFRIC 12		**1,608**	**587**	**517**	**70**	**0**	**1,096**	**1,608**	**1,613**	**(5)**
	TOTAL CAPITAL SPEND		**5,919**	**2,850**	**1,595**	**1,255**	**413**	**1,946**	**5,919**	**3,954**	**1,965**

Actual year to date spend is £1,595k with a further £2,359k committed

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3 October 2018

Agenda Item	TB241/18	Report Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 1 April 2017 – 31 March 2018
Executive Lead	Therese Patten, Director of Strategy		
Lead Officer	Chris Pilkington, Emergency Preparedness Manager		
Action Required *(Definitions below)*	✓To Approve ☐ To Assure ☐ For Information		☐ To Note ☐ To Receive

Executive Summary

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be brought before Trust Board to assure them that the organisation is meeting its obligations. This is the Annual Report for the year April 17 to March 18.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
✓**SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
☐ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
✓**SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*	
CQC KLOEs ☐ Caring ✓ Effective ☐ Responsive ✓ Safe ☐ Well Led	**GOVERNANCE** ✓ Statutory Requirement ☐ Annual Business Plan Priority ☐ Best Practice ☐ Service Change
Impact *(is there an impact arising from the report on any of the following?)*	
✓ Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	✓ Legal ☐ Quality & Safety ✓ Risk BAF/HLRR Ref 011 ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact Assessment* **must** *accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*	
Approve: To formally approve the EPRR Annual Report 2018.	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

Southport and Ormskirk Hospital NHS Trust

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

ANNUAL REPORT 1 APRIL 2017 – 31 MARCH 2018

1 EXECUTIVE SUMMARY

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be brought before Trust Board to assure them that the organisation is meeting its obligations. This is the Annual Report for the year April 17 to March 18.

Responsibility for Resilience within the UK sits with the Civil Secretariat. Failure to meet the set out obligations can lead to prosecution via relevant government agency. NHS England oversees the arrangements within NHS England organisations and provides assurance to the Local Resilience Forum via the Local Health Resilience Partnership. This body of work is known as Emergency Preparedness, Resilience and Response (EPRR).

The Trust must be able to continue to deliver key services during times of disruption as part of the wider health economy. In doing so it must ensure patient and staff safety and take into account stakeholder considerations. This report is to update the Board on annual progress in this matter and sets out how the Trust meets its obligations. The Trust is required to have an up-to-date Major Incident Plan and Business Continuity Plan. These must be updated in the event of major incidents, exercises and/or other learning.

The responsibility for Emergency Preparedness, Resilience and Response sits within the portfolio of the Chief Operating Officer (COO). The work is managed on a daily basis by the Emergency Preparedness Manager and supported by an Associate Specialist from the Emergency Department. The work programme is managed through the Resilience Group, which the COO chairs. The Resilience Group meets monthly with representatives from across the organisation and reports directly via the AAA report into Quality and Safety committee.

2 LEGAL OBLIGATIONS

As a Category 1 responder, the Trust has the following legal obligations:

a) Co-operation with other responders
b) Risk Assessment
c) Emergency Planning
d) Communicating with the public
e) Sharing information
f) Business Continuity Management

a) Co-operation with other responders

Throughout the year, the Trust has been represented at the Local Health Resilience Partnership (LHRP) Strategic and Practitioners meetings and relevant sub groups by Therese Patten and Chris Pilkington. Multi agency partners, including NHS England, provider Trusts, commissioners and other partners including the police were involved in the Cyber Attack Major Incident in May 2017. Other areas of co-operation with partner agencies such as Sefton Council have included involvement in preparing for events held locally such as The Open Golf at Royal Birkdale July 2017, the Southport Flower Show August 2017, Southport Air Show September 2017, British Musical Firework Championship September 2017 and the Christmas Lights Switch On November 2017.

b) Risk Assessment

The Trust risk assessment has been completed in line with National and Community Risk Registers and is reflected in the Trust Major Incident Plan. It should be noted that Pandemic Influenza remains as the highest risk on both community and national registers. Any items of concern or risk will be received at the Resilience Group (RG) meeting and added to the Trust Risk Register if required.

c) Emergency Planning

The Major Incident Plan and the Business Continuity Management Plan require Board approval and all other emergency plans are approved at the Resilience Group. Emergency Plans are reviewed three yearly as a minimum, and shared with multi agency partners. Once developed, plans are exercised to ensure they are fit for purpose. This year the significant revisions of the Major Incident Plan (V7) and Business Continuity Management Plan (V6) have been conducted, in response to the cyber-attack. Our resilience has been further strengthened by the addition of three Mobile Telecommunication Privileged Access Scheme (MTPAS) phones which could be used in a Major Incident if networks become congested. In such a case the mobile phone network operators will be asked by the Police Gold Commander to invoke MTPAS thereby giving emergency responders a much higher likelihood of being able to make calls.

d) Communicating with the public

The Trust continues to explore ways of communicating with the public. Social media has great potential to help the NHS reach patients and service users who do not use traditional communications and engagement channels. During the year the Trust has used a range of methods to communicate with the public, including local radio, local TV, local press, Facebook, Twitter. The Trust is in the final stages of developing a new website and the Resilience Group will support developing appropriate EPRR tools and communications within this.

e) Sharing information

Under the CCA 2004 responders have a duty to share information with partner organisations. This is seen as a crucial element of civil protection work, underpinning all forms of cooperation. ResilienceDirect is an online private network run by the Cabinet Office which enables civil protection practitioners to work together, across geographical and organisational boundaries, during the preparation, response and recovery phases of an event or emergency. The network helps organisations fulfil their obligations under the Civil Contingencies Act to co-operate and share information to ensure that action is coordinated.

f) Business Continuity Management

The Trust Business Continuity Management Plan is updated as a minimum every three years. The Plan sets out the framework that the Trust should follow when responding to disruption in line with legal obligations and EPRR guidance. Wards and departments are responsible for developing their own plans and updating them as a minimum every two years or sooner in the event of an incident or change of service.

The Trust experiences disruption to its Business Continuity through various incidents such as power outages, imaging equipment failures, IT downtime and is continually looking at ways to minimize the impact these incidents have. These incidents provide ways to learn from what has happened and we hold regular table top debriefs to enable action plans to be drawn up to address the issues raised. All incidents are discussed at the Resilience Group meetings and actions taken as appropriate.

3 MAJOR INCIDENT DECLARED 12 MAY 2017

On Friday 12 May 2017 the Trust was subject to a cyber-attack. It was apparent that due to the significant threat of infection that all computers and associated equipment should be switched off to minimize the potential loss of integrity of clinical systems and information. The Trust was therefore functioning entirely on paper without the support of a number of essential clinical systems. At 1pm the COO took the decision to declare a major incident.

In line with the major incident plan a strategic command and control structure was established. The COO assumed the role of Strategic Commander and a control room was established in the management office. In line with the major incident procedure all directions and communications were managed through the control room. A control room was established at Ormskirk ensuring clear lines of communication between the sites.

On declaring a major incident the strategic commander informed Regional Operational Control (ROC) at the North West Ambulance Service (NWAS) who have the responsibility of cascading this information throughout the NHS and partner network.

An operational control room was established in A&E under the direction of two senior consultants. The role of operational control was to manage patients safely in and out of the department. The department was supported by loggists and runners 24/7 for the duration of the major incident.

Through the Strategic Commander both hospital sites were managed and it was a single point of contact for ROC, NHS England, provider Trusts, commissioners and other partners including the police, fire and social services. Command meetings were held at regular intervals to ensure that the Strategic Commander was aware of issues as they developed and the mitigations were agreed and actioned consistently.

Strategic Command remained in place until the afternoon of Tuesday 16 May. By this point the organisation was in the process of bringing critical clinical systems back online and it was agreed to step down to business continuity processes. The Trust Business Continuity Plan is the framework that the Trust should follow when responding to disruption. Each area and department has a Business Continuity Plan which is developed locally.

By moving to Business Continuity the Strategic Commander stepped control of running the business back into Clinical Business Units (CBU). Each CBU was responsible for operational recovery and returning to business as usual. The Trust returned to normal functioning on Thursday 18 May. To ensure resilience Business Continuity procedures remained in place over the weekend, and were stepped down at 9am on Monday 22 May.

The Trust had a comprehensive lessons learnt process after the major incident. Feedback was collated from all wards and departments which was fed into a de-brief session on 5 June. The Trust were part of a regional de-brief organised by NHS England on 11 July 2017. During the major incident there were particular concerns about the resilience of radiology equipment and regional contingencies to support single points of failure. This concern was fed back to NHS England.

4 EMERGENCY DEPARTMENT MODULAR BUILD 24 MARCH 2018

A 60m-high crane was positioned in the duck pond car park at Southport Hospital to lift four ready-built modules into place to assemble for the A&E extension.

Parking, traffic and pedestrian access was disrupted while the work was under way and there was also disruption for some patients in Wards 9A and 9B during the lifting work however, this was kept to a minimum. Access for emergency ambulances was unaffected. Staff volunteered to come on site to offer any support required.

A robust planning process was implemented before the date of delivery with Business Continuity plans enacted to ensure the safe continuation of services during the period.

5 TRAINING

Training and awareness sessions have been held with various groups across the Trust including staff who cover on-call at Tactical and Operational levels. Training has been delivered to our Tactical and Strategic Commanders by external partners including NHS England. The Trust received Loggist training from NHS England in November 2017.

Project Argus and Project Griffin are government initiatives led by Merseyside Police Counter Terrorism Support Agency (CTSA). Training sessions were delivered during the year to Trust staff by the CTSA.

6 EXERCISES

NHS England EPRR guidance sets out the following requirements for training:

- Internal Communications Exercise: Minimum frequency – every six months
- Table Top Exercise: Minimum frequency – every twelve months
- Live Exercise: Minimum frequency – every three years

A requirement of the NHS England Emergency Preparedness, Resilience and Response Core Standards requires Acute Trusts to participate in planned exercises with external partner organisations. The Trust participated in the following exercises this financial year:

- ‘Exercise OPUS Resilience’ Disaster Victim Identification 20 December 2017 held at Merseyside Fire and Rescue Service, Balliol Road, Bootle, Liverpool.

Our internal Major Incident communications cascade was tested during the Major Incident in May 2017 and another internal Communication Exercise was held on 10th November 2017.

To check Chemical, Biological, Radiological, Nuclear and explosive (CBRNe) Preparedness, awareness sessions were held in November 2017 with appropriate members of staff to check their level of knowledge and the reliability of the decontamination equipment.

7 GOVERNANCE AND OVERSIGHT

The workplan for EPRR is managed through the Resilience Group which reports progress, through the AAA reporting system to the Quality and Safety Committee. The workplan and actions are managed on a monthly basis.

As a Category 1 responder the Trust must report progress and assurance for emergency planning direct to Trust Board.

8 COMPLIANCE WITH STATUTORY AND NON-STATUTORY REGULATION

The Trust is required to complete an annual EPRR Core Standards self-assessment for NHS England and submit a statement of compliance to the Trust Board. Compliance levels are *Full, Substantial, Partial* and *Non-compliant*. In the submission for 2017/18 the Trust was rated Substantial. In comparison with other Trusts in Merseyside, there were 12 Trusts rated Substantial, 7 were rated Full, 1 was rated Partial. An Improvement Plan was developed and agreed with the Accountable Emergency Officer.

This year the self-assessment will be brought to Trust Board in November 2018, along with the Major Incident Plan.

9 RECOMMENDATION

In line with the legal obligations as a Category 1 responder to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place, Trust Board is asked to approve this Annual Report on Emergency Preparedness, Resilience and Response (EPRR). The arrangements the Trust has in place as outline in this Annual Report are in line with our legal obligations as set out in Civil Contingencies Act 2004 and NHS England EPRR guidance.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item	**TB242/18**	**Report Title**	**Development and Management of Procedural Documents**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary & Data Protection Officer		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

Policy Management has recently been transferred to the Trust Secretariat/Corporate Governance. The process for managing policies was not as robust as it should be as a result the Policy has been reviewed to ensure that the process is more user friendly and more logical in the steps taken.

The Policy has been updated and improvements made in the following ways:

- Changes to the approval and ratification process
- The creation of a Policy Review Group to replace the Virtual Groups hitherto in place. This Group will report into the Finance, Performance and Investment Committee
- A provision in the Policy for emergency powers to be evoked in the event of expediting the approval of a Policy
- Strengthening the reporting and monitoring process
- Monitoring by Policy Review Group, Finance, Performance & Improvement and Audit Committee
- Audit to be undertaken by the Audit Team

The following Appendices are attached as supporting documents:

- Policy for Development and Management of Procedural Documents
- Terms of Reference of Policy Review Group

Recommendation

The Board is asked to **approve** the revised Policy and the Policy Review Group

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*

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✓ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
✓ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
✓ Caring	✓ Statutory Requirement
✓ Effective	✓ Annual Business Plan Priority
✓ Responsive	✓ Best Practice
✓ Safe	✓ Service Change
✓ Well Led	

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

☐ Compliance	☐ Legal
☐ Engagement and Communication	☐ Quality & Safety
☐ Equality	☐ Risk
☐ Finance	☐ Workforce

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

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

Once approved, the Policy will be uploaded on the Trust's Intranet by the Trust Secretariat and an alert sent to all staff by the Communications Team

Previously Presented at:

☐ Audit Committee	☐ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
☐ Finance, Performance & Investment Committee	☐ Workforce Committee

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

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

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Development and Management of Procedural Documents

Corporate 68

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Target Audience				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate Staff**
Policy Leads/Authors	✓	✓	✓	✓

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Explanation of terms used in this policy

Procedural Documents - the collective term for policies, procedures or guidelines.

Policy - sets out the aims and principles under which services, groups, or units will operate. A policy outlines roles and responsibilities, defines the scope of the subject covered, and provides a high level description of the controls that must be in place to ensure compliance.

Standard Operating Procedure - a prescribed and established procedure detailing all relevant steps and activities to be followed in carrying out a given process, operation, or in a given situation. They are specific, factual and to the point and tell you how it must be done.

Guideline - is a description of a 'best practice' way to work based on the best available evidence when no applicable standard is in place; it is not usually a requirement but is strongly recommended and tells you how it may be done.

Ratification - the process by which a policy or procedure is officially accepted as the approved document for the organisation following appropriate consultation and approval.

Approval - formal confirmation by the organisation's designated group or committee that the document meets the required standards and may go forward for ratification.

Consultation - seeking the views, opinions and advice from people or Groups who are directly involved with the policy area or will be affected by the content of the policy. Consultation is designed to improve transparency and decision-making and to ensure the arrangements set out are workable and practical to implement.

Draft - a preliminary version in the development of a procedural document, which will be subject to consultation, changes and amendments before final approval is granted.

Stakeholders - those individuals that are involved or affected by the policy who can usefully contribute, comment and agree to the content of the document. Stakeholders may be internal or external to the Trust for example, directors, managers, governors, employees, trade union representatives, service users, commissioners, carers, service user groups and others representing the local community.

Archiving - the collating and recording of obsolete policies, strategies and procedures for retrieval when required.

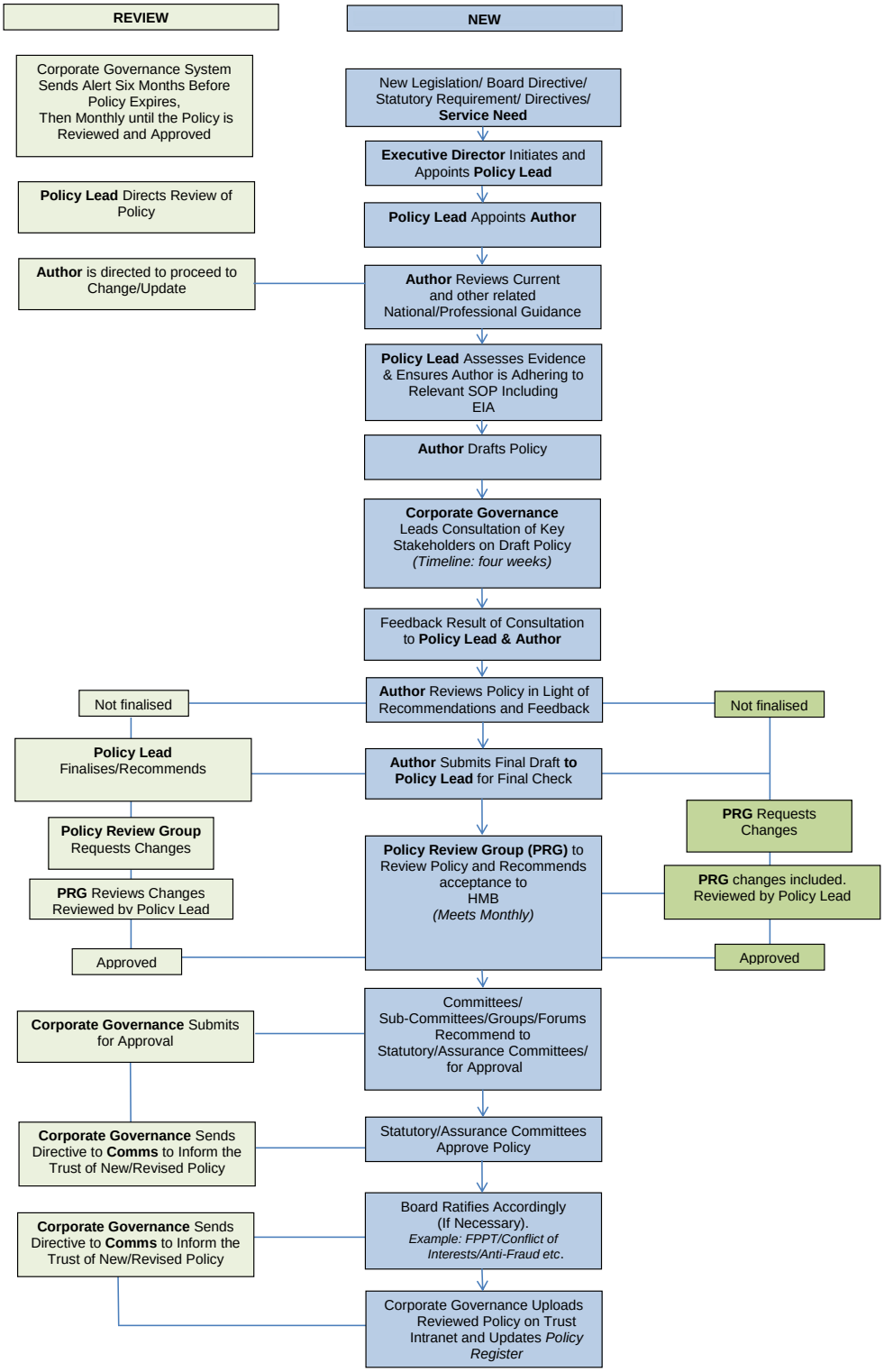
Policy Review Group – a forum established to review all policies and procedures to ensure compliance with guidance and format as set out in the SOP.

LocSIPPS- One of the recommendations of the Surgical Never Events Taskforce report was to develop a set of high-level national standards of operating department practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures.

The National Safety Standards for Invasive Procedures (NatSSIPs) were published in September 2015 to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. The NatSSIPs cover all invasive procedures including those performed outside of the operating department.

The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This will be done by organisations working in collaboration with staff to develop their own set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs).

PROCESS FOR THE DEVELOPMENT, DISSEMINATION & MANAGEMENT OF TRUST POLICY DOCUMENTS



Document name:	*Development and Management of Procedural Documents*
Document type:	Policy
What does this policy replace?	Update of previous policy (Policy for the Creation and Review of Procedural Documents)
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	Date & Versions here (V6) List revisions done and dates The Policy has been updated and improvements made in the following ways: • Changes to the approval and ratification process • The creation of a Policy Review Group to replace the Virtual Groups hitherto in place • A provision in the Policy for emergency powers to be evoked in the event of expediting the approval of a Policy • Strengthening the reporting and monitoring process
Next review:	August 2020
Approved by:	Board of Directors
Developed by:	Company Secretary
Executive Lead:	Company Secretary
Contact for advice:	Trust Secretariat

1. INTRODUCTION

Policies and procedural documents are designed to provide a framework against which the Trust adheres to legal and regulatory requirements and good practice. They also support staff in discharging their duties, ensuring consistent behaviour across the Trust.

2. PURPOSE

The aim of this policy is to ensure a well governed, structured and systematic approach to the development, review, ratification, implementation and archiving of all procedural documentation in use throughout Southport and Ormskirk Hospital NHS Trust.

3. OBJECTIVES

The objectives of the policy are to set out the processes to achieve the following:-

- To set out the approach to development and approval of policies and procedural documents;
- To provide a standard template for policy documents;
- To ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure;
- To describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance;
- To describe the process for version control to ensure people have access to – and are operating to - the most current version;
- To describe how the Trust and the Board can receive assurance that the Trust's policies are effectively managed.
- To ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.

4. PROCESS

4.1. Development of a new Procedural document

The Trust will identify the need to develop new procedural documents in line with the priorities of the organisation e.g. national guidance, legislation, organisational changes, service requirements and evidence-based practice whether in the form of the latest research, audit findings, national inquiries or serious investigation reports.

The relevant director will initiate the process to develop a new policy/procedure in line with service priorities and appoint a policy development lead. A Policy Register is maintained by the Trust Secretariat/Corporate Governance to prevent part or whole duplication of another approved policy or procedure in operation. The policy development lead will liaise with Trust Secretariat/Corporate Governance, which will check the register to ensure that the proposed policy does not duplicate any other policy work. Where a potentially similar policy is already in operation, the policy development lead will discuss with their director whether it is more prudent to develop this policy further rather than develop a new policy.

If it is clear that no similar policy exists the Trust Secretariat/Corporate Governance will allocate the proposed policy/procedure to be developed a unique reference identifier.

Trust Secretariat/Corporate Governance will liaise with the Trust Librarian to undertake a review of all relevant national and professional guidance related to the policy on behalf of the policy development lead. On receipt of this information, the policy lead will focus on completing the 'process' section of the policy/procedure i.e. the main body of the document. The policy lead may wish to consider whether this task would benefit from establishing a 'task and finish' group of key operational staff from across the trust, to ensure that the policy is workable and practical to implement.

The policy lead, in conjunction with the Trust Secretariat/Corporate Governance and a task and finish group should also consider if an overarching trust-wide policy could be developed with several standard operating procedures to support and supplement the policy. This alternative option will ensure the total number of trust policies are kept to a manageable number.

Another important aspect of this task will be to complete an implementation plan **Appendix 1** to fully consider all of the issues associated with policy implementation e.g. the need for additional resources and in particular, what training will be required, liaising with the Head of Training as necessary. This will ensure that implementation is always considered at the very beginning of policy development and whether it is achievable within the resources available. On completion of the plan, the policy lead will approve it.

Trust Secretariat/Corporate Governance will complete the other supporting sections of the policy and be responsible for the draft and final production of the document on behalf of the policy development lead.

4.2. Review of Procedural Documents

The policy available on the Trust's Intranet is the current version and the one by which the Trust stands even if the review date has passed. An expired date does not automatically indicate that the policy/procedure has been superseded.

All procedural documents are subject to review within approved time scales. Most policy/procedure reviews should take place **within 3 years** dependent on the policy area. However, a review may take place earlier if new evidence becomes available that renders this necessary e.g. changes in legislation, or to reflect changes to working practices.

Trust Secretariat/Corporate Governance will maintain a Policy Register to ensure all procedural documents are current, in date and relevant. They will also ensure the policy review takes place within the stated timeframe by notifying the policy lead/author in good time that a review is required.

The detail of the review will vary depending on the policy topic but it should take account of the most up-to-date evidence-based practice available. The Trust Secretariat/Corporate Governance will liaise with the Trust Librarian to undertake a

review of all relevant national and professional guidance related to the policy on behalf of the policy development lead.

If the review indicates that only minor amendments are required, which will not alter current practice and as such involve no significant change to the document, there is no requirement to consult on the revised policy. This may include 'Appendices,' which can be reviewed, revised and replaced by the policy lead without the need to follow the consultation process. The updated policy will go forward for approval to the relevant approving group/committee.

If the review indicates significant changes in current practice and major amendments to the document will be required, the procedures outlined in 4.1 above, for development, consultation, approval and ratification apply and must be followed.

If a policy lead is unclear whether the proposed changes to a policy constitute a significant change to current practice or not, they should consult with the Corporate Governance, who will provide advice on this matter.

Where significant changes to current practice are proposed, the policy lead must ensure they also undertake a review of the likely equality impact assessment and complete a new implementation plan. Policy details listed on the back page of the policy will be updated by the Trust Secretariat/Corporate Governance.

4.3. Style and Format of Procedural Documents

Standard templates have been developed for the formation of policies Appendix 2, standard operating procedures/LocSIPs Appendix 3 and guidelines Appendix 4. The Trust Secretariat/Corporate Governance will be responsible for ensuring these procedural documents are produced in a standardised corporate style and format, which is concise and clear, using unambiguous terms and language.

4.4. Equality Impact Assessment Process

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide the "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the (Equality Act 2010)"; in effect to undertake equality analysis assessments on all policy documents.

Southport and Ormskirk Hospital NHS Trust recognises that some sections of society experience prejudice and discrimination The Equality Act 2010 specifically recognises the 'protected characteristics' of age, disability, gender, race, religion or belief, sexual orientation and transgender, pregnancy / maternity and marriage/civil partnership.

The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in its role as a major employer. The Trust believes that all people have the right to be treated with dignity and respect and is committed to, the elimination of unfair and unlawful discriminatory practices.

This policy provides a system for administering the management, identification and authorisation of organisational wide procedural documents, ensuring that they are produced and managed in a consistent way. An equality analysis of this policy has been completed and shows no evidence of impact against any protected groups.

4.5. Privacy Impact Assessment (PIA)

The Trust has an obligation under the Data Protection Act 1998 and its own information policy to ensure that all information is processed fairly, lawfully and in line with expectations. To this end, the Trust has an implemented process of Privacy Impact Assessments (PIAs). A Privacy Impact Assessment of this policy has been completed and shows no evidence of impact against any Information Governance risks

4.6. Consultation

In order to obtain approval for a policy, submission to the relevant group/committee must be accompanied by evidence of robust consultation. The policy lead and task and finish group, will identify those stakeholders directly or indirectly involved and engaged with the policy area, who should take part in the consultation process and advise the Trust Secretariat/Corporate Governance accordingly. The consultation process will be managed by the Trust Secretariat/Corporate Governance on behalf of the policy lead.

To allow a reasonable time for responses, an ideal consultation period of four weeks for comments is to be set with the exact period confirmed with each circulation.

All comments received will be recorded by Trust Secretariat/Corporate Governance for the policy lead to consider and for the document to be amended accordingly. Where this results in a substantial change to the consultation document, a revised draft document will be sent out again to stakeholders for further consultation and comment.

Only when the policy lead is fully satisfied that the consultation process has been completed and comments and amendments have been included or reasons stated for suggestions not being used, the final draft will be forwarded to the appropriate group/ committee for approval.

4.7. Review

All policy/procedural documents together with a completed Equality Impact Assessment Tool and Implementation Plan will be submitted to the Policy Review Group (PRG). The PRG will make recommendations to the relevant Committee or the Board for approval.

Members of the PRG will consist of:

- Company Secretary (Chair)
- Information Governance Manager (Deputy Chair)
- Deputy Medical Director, or nominated representative
- Head of Risk
- Assistant Director of Nursing (Safer Staffing)
- Assistant Director of Operations – rotational or nominated representative
- Assistant Director of Human Resources Governance
- Estates & Facilities Lead
- Assistant Director of Finance

4.8. Approval

The final draft of a new or revised policy/procedure should be approved by the appropriate committee or group. The approving committee/group will be responsible for the subject matter, or area of practice within the trust so its members have the collective specialist knowledge and experience needed to give formal approval. Where unusually, there is no appropriate group, policies should be submitted to the Director responsible for the policy area for approval.

4.9. Ratification

Although some policies may have been approved by an assurance committee, they may need to be ratified by the Board of Directors.

4.10. Dissemination

All policies and procedures can be accessed electronically via the Trust's Intranet. For a limited time, all newly uploaded policies and procedures are highlighted in a prominent position, to alert and direct staff who access the Intranet, to their publication and availability.

Departmental managers, team leaders and professional leads are responsible for having a system in place within their sphere of responsibility that ensures their staff are aware of, and have read and understood relevant new and revised policies. Additionally, it is strongly recommended that relevant new policies are read within team/department meetings, to consider the relevance to that service/department.

Every month, the PRG will develop a Report, which includes a section giving details of all new policies and procedures that have been ratified and uploaded on to the Trust's intranet. Each Group is required to confirm that all relevant policies and procedures have been disseminated to their staff. This report is submitted to the Finance, Performance & Investment Committee providing assurance of compliance for each policy. This process is designed to provide assurance and accountability that effective dissemination of policies and procedures is taking place throughout the organisation.

Policies and procedures of relevance to corporate-based staff are forwarded separately by the Trust Secretariat/Corporate Governance to all corporate heads of departments every month for dissemination to their staff via the Trust Bulletins. A feedback form will be provided to ensure compliance with each policy and procedure.

Every month a list of procedural documents that have been uploaded to the intranet in the previous month are also distributed to all Trust staff via the Trust Bulletins.

4.11. Implementation

All policies need to identify arrangements for training, support and implementation as necessary. All Directors, Assistant Directors, service managers, heads of departments, team leaders and professional leads, are responsible for ensuring policies are effectively implemented and their staff receive any training that is required.

4.12. Document Control including Archiving Arrangements

The Trust Secretariat/Corporate Governance is responsible for maintaining the Policy Register of all current, active policies and procedures and for overseeing the recording, storing, archiving and controlling of policies.

To enable effective tracking and retrieval of procedural documents, each document is allocated a unique reference identifier. Each identifier is made up of the following components:-

- Trust initials i.e. SOHNHST
- Followed by an abbreviation of the policy category e.g. Corp = Corporate
- Followed by the initials of the type of procedural document e.g. POL = Policy
- Finally, an originator number is then allocated to the identifier e.g. 01
- Example = SOHNHST-CORP-POL-01 (current version control is more specific)

SOPs and guidelines will follow a similar numbering pattern but include a component to the overarching policy they link to e.g. SOHNHST-CORP-SOP-01-1

In this example, Health and Safety is the policy category, SOP is an abbreviation of standard operating procedure, '01' is the health and safety policy it links to and 1 is the number of the standard operating procedure.

Thereafter, all versions of policies will keep the same unique reference identifier, with a different version number being used for each review. If the review involves significant changes to the document, a new version number will be allocated e.g. 1.0, 2.0, 3.0. However, if the review only generates minor amendments, the version number will be changed to read, 1.1, 1.2 and so on. Details of the review and the new version number will be made in the Review and Amendment History at the end of each document.

When the review is complete and the new version of the policy has been approved and/or ratified as appropriate, the Trust Secretariat/Corporate Governance will upload the new or updated policy on to the Trust's Intranet, removing the replaced version where there is one.

The Trust Secretariat/Corporate Governance maintains a Register of all Archived Policies. Master copies of all archived policies, in both PDF and Microsoft word versions, are stored electronically and where only paper versions exist these are also stored centrally by the Trust Secretariat/Corporate Governance.

The Trust Secretariat/Corporate Governance is responsible for archiving the older versions of all policies using the tracking and retrieval system described above and controls access to all archived policy information. Copies of archived policies/procedures documents can be obtained on request. Policy leads are encouraged to keep copies of archived versions of their policy for their own future reference purposes.

Archived policies are retained for 25 years from the year of replacement, primarily for litigation purposes.

5. PROCEDURES CONNECTED TO THIS POLICY

SOP 1 – Writing an Operational Policy/Local Safety Standard for Invasive Procedures. **This is an example to follow when writing a policy.**

6. LINKS TO RELEVANT LEGISLATION

The Equality Act 2010

The Equality Act came into force on 1st October 2010 and brought together over 116 separate pieces of legislation into one single Act to provide a legal framework to protect the rights of individuals and advance equality of opportunity for all. The Act simplifies, strengthens and harmonizes the current legislation to provide a new discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

6.1. The Freedom of Information Act 2000

This Act provides public access to information held by public authorities. It does this in two ways, public authorities are obliged to publish certain information about their activities and members of the public are entitled to request information from public authorities.

The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities, unless there is a good reason for them not to. This is sometimes described as a presumption or assumption in favour of disclosure.

The Act does not give people access to their own personal data (information about themselves) such as their health records. If a member of the public wants to see information that a public authority holds about them, they should make a subject access request under the Data Protection Act 1998.

6.2. The Data Protection Act 2018

The Data Protection Act came into force in May 2018, replacing the 1998 Act, to control the way information is handled and to give legal rights to people who have information stored about them. It sets out strict rules for people who use or store data about living people and gives rights to those people whose data has been collected. The law applies to data held on computers or any sort of storage system, including paper records. On 25 May 2018, the Information Commissioner's Office was given new powers to issue monetary penalties requiring organisations to pay for serious breaches of the Data Protection Act 2018.

6.3. Links to Relevant National Standards

6.3.1. NHS Resolution Risk Management Standards

In 2013, NHS Resolution carried out a review of the risk management standards and assessments process and decided that the time was right to end the current process. However, the standards reflect good risk management practice and continue to provide a useful reference point when developing organisational procedural documents.

6.4. Links to other key policy/s

- CORP 92 Corporate Records
- CORP 111 Privacy Impact Assessment
- Standard Operational Procedure for Meeting

6.5. References

NHS Resolution, 2017. NHS Resolution *Delivering Fair Resolution and Learning from Harm.* Available from https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Our-strategy-to-2022-1.pdf

The Plain English Campaign. *How to write in plain English*. [Accessed 20 September 2017] Available from www.plainenglish.co.uk

The Equality Act 2010. (c15). London: The Stationery Office. [Online]. [Accessed 20 September 2017] Available from https://www.legislation.gov.uk/ukpga/2010/15/contents

The Equality and Human Rights Commission website provides further guidance, updates and resources in relation to equality impact assessments and the effect of the Equality Act 2010: https://www.equalityhumanrights.com/en

The Freedom of Information Act 2000 (c 36). London: The Stationery Office. [Online]. [Accessed 20 September 2017] Available from https://www.legislation.gov.uk/ukpga/2000/36/contents

The Data Protection Act 2018 (c 12). London: The Stationery Office. [Online]. [Accessed 26 September 2018] Available from http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

7. DUTIES

Title	Role	Responsibilities
All Employees and Other Workers	Adherence	Have a duty to read, adhere to and maintain up-to-date awareness of policies and procedures as laid down in job descriptions and contracts of employment; to know where policies are stored and how to gain access to them. • Attend training as required, to familiarise themselves and enable compliance with, policies relevant to their role and responsibilities • To co-operate and contribute to the development of policies and procedures relevant to their duties • To inform their line manager if they identify any part of a policy/procedure that is no longer relevant
Ward Managers/ Team Leaders/ Senior Nurses	Implementation	Responsible for the practical day-to-day implementation of the policy ensuring that:- • All staff are aware of their role under the policy • Staff have received sufficient training and/or are competent to implement the policy • Records are kept as specified • Ensuring that all incidents/issues relating to this policy and area of practice are reported
Business Unit Governance Committees	Monitor	Monitor and review all incidents, complaints and claims relating to this area of practice and policy within their Business Unit. Receive the results and recommendations of all related completed audits and be responsible for monitoring action plans to Implement changes to current practice until completion

Business Unit Leads (ADOs, AMDs and HoN)	Leads	Lead discussions around this topic area and policy at Business Unit Governance Committee meetings • Oversee the completion of audits in respect of the topic area and policy. • Provide updates on this area of practice and policy within their Group to the Business Unit Governance Committee. • Provide support and guidance regarding resources to enable this policy to be implemented • Systems are put in place to enable this policy to be implemented within their service areas • All managers are aware of the policy and promote good practice
Trust Secretariat/Corporate Governance	Administration and support	Co-ordination, administration and management of all trust procedural documents • Supporting document authors through the development, consultation, approval and ratification process • Document Control including Archiving Arrangements
Policy Leads/Authors	Review Lead	Completing the 'process' section of the policy/procedure i.e. the main body of the document for new and revised polices • Establishing a 'task and finish' group of key operational staff from across the trust as necessary, to ensure the policy is workable and practical to implement
Policy Review Group	Review	Ratification of all approved trust policies and procedures
Approving Groups/Committees/Board	Approval	Approving all policies and procedures that relate to their subject matter or area of practice
Executive Directors	Executive Lead	Identify and agree which policies are required relevant to their individual portfolio to ensure every policy has a designated named Executive Director • Appoint a Policy Lead for each policy within their individual portfolios

8. TRAINING

What 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 and monitor that staff have this training?
Writing procedural documentation to a high standard	Members of the Trust Secretariat to support policy leads	No	Training will be delivered internally	Trust Secretariat/Corporate Governance	Training will continue until a team member is competent to undertake this task	Trust Secretariat/Corporate Governance

9. EQUALITY IMPACT 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 is readily available from the policy coordinator. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Trust Secretariat/Corporate Governance.

10. 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 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.

11. MONITORING COMPLIANCE WITH THIS DOCUMENT

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission standards, NHS Resolution Risk Management Standards and Monitor Compliance.

Methods may include:

- monitoring and analysis of incidents, performance reports and training records;
- reports to assurance committees and the Board
- audit;
- checklists;
- monitoring of delivery of actions plans through CBUs and departments.

Monitoring this policy is working in practice What key elements will be monitored? (measurable policy objectives)	**Where described in the policy?**	**How will they be monitored? (method + sample size)**	**Who will undertake this monitoring by Audit?**	**How Frequently?**	**Group/Committee that will receive and review results**	**Group/Committee to ensure actions are completed**	**Evidence this has happened**
Review and Revision arrangements	Section	An audit of 10% of all documents. A random sample representing 10% of all procedural documents will be selected from the Corporate Governance Policy Register	Audit Team	Annual	Finance, Performance & Investment Committee	Finance, Performance & Investment Committee	Completed action plan signed off / minutes of meeting
Procedural documents are produced in a standardised format	Sections	An audit of 10% of all documents. A random sample representing 10% of all procedural documents will be	Audit Team	Annual	Policy Review Group	Policy Review Group	Completed action plan signed off / minutes of meeting

		selected from the Corporate Policy Register					
Consultation Process	Section	An audit of 10% of all Corporate Governance policy folders for evidence this has been followed correctly	Audit Team	Annual	Finance, Performance & Investment Committee	Finance, Performance & Investment Committee	Completed action plan signed off / minutes of meeting
Document approval process	Section	An audit of 10% of all Corporate Governance policy folders for evidence of the minutes of approving groups' meetings	Audit Team	Annual	Finance, Performance & Investment Committee	Audit Committee	Completed action plan signed off / minutes of meeting

		confirming approval					
Review process	Section	An audit of 10% of all Corporate Governance policy folders for evidence of ratification by members	Audit Team	Annual	Policy Review Group	Finance, Performance & Investment Committee	Completed action plan signed off / minutes of meeting
Dissemination and Implementation of procedural documents	Sections	A random sample representing 10% of all procedural documents will be selected from the Register of each Group	Audit Team	Annual	Finance, Performance & Investment Committee	Audit Committee	Completed action plan signed off / minutes of meeting
Document Control including archiving	Section	Archived Policies	Audit Team	Annual	Finance, Performance & Investment Committee	Audit Committee	Completed action plan signed off / minutes of meeting

11.1. Appendix 1 Policy template

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

Southport and Ormskirk Hospital NHS Trust

Policy Template

Title of Policy

Target Audience (Amend to reflect who should view the policy)				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**

The blue comments in each section are a guide for you; please delete them as you complete each section Red text are (below) sections to be completed by policy author

Ref.	Contents	Page
	Explanation of terms	
	Flowchart explaining process	
1.0	Introduction	
2.0	Purpose	
3.0	Objectives	
4.0	Process	
5.0	Procedures connected to this Policy	
6.0	Links to Relevant Legislation	
6.1	Links to Relevant National Standards	
6.2	Links to other Key Policy/s	
6.3	References	
7.0	Roles and Responsibilities for this policy	
8.0	Training	
9.0	Equality Impact Assessment	
10.0	Data Protection Act and Freedom of Information Act	
11.0	Monitoring this Policy is Working in Practice Policy Implementation Plan	

Appendices

Delete table where a policy has no additional appendices

Explanation of terms used in this policy

Please provide the definitions/explanations of any unfamiliar or unusual words used in this policy

Flowchart of process to be included

Insert flow chart here

1.0 Introduction

Provide a summary description of the background to this policy and why the policy is needed.

2.0 Purpose

Explain the main aim of this policy

3.0 Objectives

Identify and list the key objectives this policy is intended to achieve

NB: The first three sections of the policy will be limited to one page.

4.0 Process

This section forms the main focal point and body of the document. Describe the process or procedure and course of action required to implement and comply with the policy. Be explicit. The process/procedure needs to be clear and concise. Where it will help the reader consider including flow charts or diagrams to support the process outlined in the policy.

Some policies may require more than the number 4.0 section, in which case adjust the numbering for all other subsequent headings and amend the contents page accordingly.

5.0 Procedures connected to this Policy

Please list any standard operating procedures that relate to this policy

6.0 Links to Relevant Legislation

Please provide a summary of the key legislation this policy relates to, to help the reader develop a greater understanding of the importance of this policy.

6.1 Links to Relevant National Standards

Please provide a summary of the key national standard(s) this policy relates to, to help the reader develop a greater understanding of the importance of this policy.

6.2 Links to other key policy/s

Please include a summary of any other key policy that would help the reader develop a greater understanding of how this policy links to it.

6.3 References

Please list only the references that were key to the development of this policy, which would signpost the reader to a greater understanding of this subject, or area of practice.

7.0 Roles and Responsibilities for this Policy

Using the table below, this section is to identify those Trust staff/groups/individuals with responsibility for implementing the policy

Title	Role	Responsibilities

8.0 Training

Using the table below, this section should describe the training which staff require to enable implementation of this policy. Any training needs identified in the table below should be more than just making staff aware of the policy. Please ensure you discuss the above with the Head of Learning and Development as part of the consultation process.

What 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 and monitor that staff have this training
		If yes, please refer to it for details on training requirements, and update frequencies				

9.0 Equality Impact Assessment The following statement should always be included

Southport and 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 is readily available from the policy coordinator. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Integrated Governance Team.

10.0 Data Protection and Freedom of Information The following statement should always be included

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 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.

11.0 Monitoring this policy is working in practice

Using the table below identify how the Trust will ensure that the policy is working effectively in practice

What key elements will be monitored? (measurable policy objectives)	Where described in policy?	How will they be monitored? (method + sample size)	Who will undertake this monitoring?	How Frequently ?	Group/ Committee that will receive and review results	Group/ Committee to ensure actions are completed	Evidence this has happened

12. POLICY IMPLEMENTATION PLAN

An Implementation template document for policy leads to use is available in a Word document on the intranet

Policy Title	
Is this New or revision of an existing policy	
Name and role of Policy Lead	
Give a Brief Overview of the Policy	
What are the main changes in practice that should be seen from the policy?	
Who is affected directly or indirectly by this policy?	

Implications

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**
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**

Implications cont'd/…	
Have the financial impacts of any changes been established?	
Explain the issues?	**Explain how this has been resolved**
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Policy Details

The table below is designed to ensure there is proper document control for the continued development and application of this policy – **Corporate Integrated Governance only**

Title of Policy	
Unique Identifier for this policy is	
State if policy is **New** or **Revised**	
Previous Policy Title where applicable	
Policy Category Clinical, HR, Corporate, Infection Control, Finance etc.	
Executive Director *whose portfolio this policy comes under*	
Policy Lead/Author *Job titles only*	
Committee/Group responsible for the approval of this policy	
Consultation with	
Month/year consultation process completed	
Month/year policy approved	
Month/year policy ratified and issued	
Next review date	
Implementation Plan completed	
Equality Impact Assessment completed	
Previous version(s) archived	
Disclosure status	
Key words for this policy	

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

12.1. Appendix 2 SOP

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

NHS Southport and Ormskirk Hospital NHS Trust

Standard Operational Procedure (SOP) / Local Safety Standard for Invasive Procedures (LocSIP) Template

Title of Procedure/ LocSIP

Target Audience (Amend to reflect who should view the procedure/ LocSIP)				
Who should read this SOP:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**

The blue comments under each heading are a guide for you; please delete them as you complete each section
Explination of terms

A flowchart can be ideal to cover all of the below

Why we have a procedure? (Background)

Briefly set out the background to the procedure, making reference to any legislation, legal requirements and national or international guidance. Consider the driving forces or why the procedure is necessary e.g. to ensure patient safety, compliance standards are met, best practice etc.) and what adherence will achieve

What overarching policy the procedure links to?
Every standard operating procedure should link to an overarching policy

Which services of the trust does this apply to?

Where is it in operation? Complete the table below with a for the appropriate areas, and identify who should read this SOP

Who does the procedure apply to?

- **Competencies required**

When should the procedure be applied? (Context)

- **State In what circumstances/situations this procedure should be applied**

How to carry out this procedure (step step-by-step information)

- **Methodology and procedures.** The meat of the issue -- list all the steps with necessary details, including what equipment needed. Cover sequential procedures and decision factors.
- **Clarification of terminology**. Identify acronyms, abbreviations, and all phrases and provide an explanation of terms used
- **Additional Information/ Associated Documents** Use this section to list any documentation associated with the described procedure to ensure that the user can identify the appropriate document(s) to use.
- **Any safety warnings** To be listed alongside the steps where it is an issue.
- **Equipment and supplies.** Complete list of what is needed and when, where to find equipment, standards of equipment, etc.
- **Cautions and interferences**. Basically, a troubleshooting section. Cover what could go wrong, what to look out for, and what may interfere with the final, ideal product.

Where do I go for further advice or information?
Roles and responsibilities of key staff in relation to this procedure

8.0 Training

Using the table below, this section should describe the training which staff require to enable implementation of this SOP. Any training needs identified in the table below

should be more than just making staff aware of the policy. Please ensure you discuss the above with the Head of Learning and Development as part of the consultation process.

What aspect(s) of this SOP 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 and monitor that staff have this training
		If yes, please refer to it for details on training requirements, and update frequencies				

9.0 Equality Impact Assessment The following statement should always be included

Southport and 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 SOP is readily available from the policy coordinator from the overarching policy. If you require this SOP in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Integrated Governance Team.

10.0 Data Protection and Freedom of Information The following statement should always be included

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 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.

11.0 Monitoring this SOP is working in practice

Using the table below identify how the Trust will ensure that the policy is working effectively in practice

What key elements will be monitored? (measurable objectives)	Where described in SOP?	How will they be monitored? (method + sample size)	Who will undertake this monitoring ?	How Frequently ?	Group/ Committee that will receive and review results	Group/ Committee to ensure actions are completed	Evidence this has happened

Appendix

SOP Implementation Plan

An Implementation template document for policy leads to use is available in a Word document on the intranet

SOP Title	
Is this New or revision of an existing policy	
Name and role of SOP Lead	
Give a Brief Overview of the SOP	
What are the main changes in practice that should be seen from the SOP?	
Who is affected directly or indirectly by this SOP?	

Implications	
Will staff require specific training to implement this SOP and if yes, which staff groups will need training?	
Explain the issues?	**Explain how this has been resolved**
Are other resources required to enable the implementation of the SOP e.g. increased staffing, new documentation?	
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of SOP Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Standard Operating Procedure/ Local Safety Standard for Invasive Procedures Details

Unique Identifier for this SOP is	
State if SOP is **New** or **Revised**	
Policies Category	
Executive Director *whose portfolio this SOP comes under*	
Lead/Author *Job titles only*	
Committee/Group Responsible for Approval of this SOP	
Month/year consultation process completed	
Consultation with	
Month/year SOP was approved	
Next review due	
Disclosure Status	
Key words relating to this SOP	

12.2. Appendix 3 Guideline

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

NHS Southport and Ormskirk Hospital NHS Trust

Trust Guideline

Title

Target Audience (Amend to reflect who should view the Guideline)				
Who should read this Guideline:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**

The blue comments below each heading are a guide for you; please delete them as you complete each section

A flowchart can be ideal to cover all of the below

Rationale /Background
Why is this guideline needed? A guideline is a description of a 'best practice' way to work, based on the best available evidence **when no applicable standard is in place**.

Purpose of the Guideline
State the key objectives for having this guideline

Explanation of Terms used in this guideline
Please provide the definitions/explanations of any unfamiliar or unusual words used in this guideline

Best Available Evidence
What the best available evidence recommends
Presentation of the evidence required to inform key decisions in a simple, accessible format
Review of the relevant, valid evidence on the benefits, risks, and costs of alternative decisions

Who does this Guideline apply to?
Who should read this guideline?
Competencies required

When should the Guideline be applied?
Context - state in what circumstances/situations this guideline should be followed

Putting the Guideline into Practice
This may include:-
General Principles to be followed
Flowchart / Algorithm where this would be helpful to the reader
A description of a 'best practice' way to work
Identification of the key decisions and their consequences
Key Points of learning

Where do I go for further advice or information?
Roles and responsibilities of key staff in relation to this guideline

What overarching policy the guideline links to?
Every guideline should link to an overarching policy. Policy for the Development and Management of Procedural Documents

References
Please give accurate details of all references quoted as this is integral to the overall validity of the guideline

8.0 Training

Staff may receive training in relation to this guideline, where it is identified in their appraisal as part of the specific development needs for their role and responsibilities.

Please refer to the Trust's Mandatory & Risk Management Training Needs Analysis for further details on training requirements, target audiences and update frequencies

What 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 and monitor that staff have this training
		If yes, please refer to it for details on training requirements, and update frequencies				

9.0 Equality Impact Assessment

Please refer to overarching policy

Data Protection Act and Freedom of Information Act

Please refer to overarching policy

11.0 Monitoring this policy is working in practice

In the event of new evidence or a planned change in the process(es) described within this document or an incident involving the described process(es) within the review cycle, this guideline will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

What key elements will be monitored? (measurable Guideline objectives)	Where described in Guideline?	How will they be monitored? (method + sample size)	Who will undertake this monitoring?	How Frequently ?	Group/ Committee that will receive and review results	Group/ Committee to ensure actions are completed	Evidence this has happened

Guideline Title	
Is this New or revision of an existing Guideline	
Name and role of Guideline Lead	
Give a Brief Overview of the Guideline	
What are the main changes in practice that should be seen from the Guideline ?	
Who is affected directly or indirectly by this Guideline ?	

Implications

Implications	
Will staff require specific training to implement this Guideline and if yes, which staff groups will need training?	
Explain the issues?	**Explain how this has been resolved**
Are other resources required to enable the implementation of the Guideline e.g. increased staffing, new documentation?	
Explain the issues?	**Explain how this has been resolved**

Implications cont'd/…	
Have the financial impacts of any changes been established?	
Explain the issues?	**Explain how this has been resolved**
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Guideline Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Guideline Details

Unique Identifier for this Guideline is

State if Guideline is **New** or **Revised**	
Policies Category	
Executive Director *whose portfolio this Guideline comes under*	
Lead/Author *Job titles only*	
Committee/Group Responsible for Approval of this Guideline	
Month/year consultation process completed	
Consultation with	
Month/year Guideline was approved	
Next review due	
Disclosure Status	
Key words relating to this Guideline	

Review and Amendment History Version	Date	Description of Change
1.0		New Guideline

Policy Implementation Plan

An Implementation template document for policy leads to use is available in a Word document on the intranet

Policy Title	Corp 68 Development and Management Procedural Documents
Is this New or revision of an existing policy	Revision
Name and role of Policy Lead	A Charles, Company Secretary

Give a Brief Overview of the Policy

The aim of this policy is to ensure a well governed, structured and systematic approach to the development, review, approval, ratification, implementation and archiving of all procedural documentation in use throughout Southport and Ormskirk Hospital NHS Trust.

What are the main changes in practice that should be seen from the policy?

The Policy has been updated and improvements made in the following ways:

- Changes to the approval and ratification process
- The creation of a Policy Review Group to replace the Virtual Groups hitherto in place
- A provision in the Policy for emergency powers to be evoked in the event of expediting the approval of a Policy
- Strengthening the reporting and monitoring process
- Monitoring by Policy Review Group, Finance, Performance & Improvement and Audit Committee
- Audit to be undertaken by the Audit Team

Who is affected directly or indirectly by this policy?

All Trust Staff and visitors

Implications

Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training? **No**	
Explain the issues? **N/A**	**Explain how this has been resolved** N/A
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation? No	
Explain the issues?	**Explain how this has been resolved**

Implications cont'd/…	
Have the financial impacts of any changes been established? **N/A**	
Explain the issues?	**Explain how this has been resolved**
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Policy Details

Title of Policy	Development and Management of Procedural Documents
Unique Identifier for this policy is	SOHNHST-CORP- Pol 05.1.0
State if policy is **New** or **Revised**	Revised
Previous Policy Title where applicable	Development and Management Procedural Documents
Policy Category Clinical, HR, Health & Safety, Finance etc.	Corporate 68
Executive Director whose portfolio this policy comes under	Director of Nursing, Midwifery, AHP's, Quality and Governance
Policy Lead/Author Job titles only	Assistant Director of Integrated Governance
Committee/Group responsible for the approval of this policy	Quality and Safety Group
Month/year consultation process completed *	July 2017
Month/year policy approved	June 2017
Month/year policy ratified and issued	July 2017
Month/year policy reviewed	August 2018
Reviewed by the Board	TBC
Next review date	July 2020
Implementation Plan completed	Yes
Equality Impact Assessment completed	Yes
Previous version(s) archived	Yes
Disclosure status	Can be disclosed to patients and the public
Key words for this policy	'procedural,' 'policy for policies,' 'procedure,' 'standard operating procedure,' 'SOP

Revision History

Version	Date	Author	Status	Comment
1.0.0	Sept 2009	SL	Superseded	Archived
2.0.0	March 2012	DL	Superseded	Archived
3.0.0	Feb 14	DL/IG	Superseded	Archived
4.0.0	Feb 2016	DL	Superseded	Archived
5.0.0	July 2017	Assistant Director Integrated Governance	Superseded	Archived
5.1.0	September 17	Assistant Director Integrated Governance	Superseded	Archived
6.0.0	August 18	Company Secretary	Current	Intranet

To be completed and attached to any policy document when submitted to the Policy Review Group for consideration and recommendation of approval.

Date of Assessment: _____

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		POLICY FOR THE DEVELOPMENT, APPROVAL AND DISSEMINATION AND MONITORING OF POLICY AND PROCEDURAL DOCUMENTS
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		The overall aim of the policy is to describe the Trust's approach to the development and approval of policies and procedural documents. All staff
3	**Who is the overall Lead for this assessment?**		Company Secretary and Data Protection Officer
4	**Who else was involved in conducting this assessment?**		Corporate Governance Manager
5	**Have you involved and consulted patients and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		The Executive Management Team was consulted on the original development of the policy. Feedback from the NHS LARMS assessment has also been considered in developing the policy. N/A
6	**What equality data have you used to inform this equality impact assessment?**		N/A
7	**What does this data say?**		N/A
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**Yes/ No**	**Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact.**
8.1	**Race**	No	N/A
8.2	**Disability**	No	N/A
8.3	**Gender**	No	N/A
8.4	**Age**	No	N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.5	**Sexual Orientation**	No	N/A
8.6	**Religion or Belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		
9c	**Promotes good relations between different equality groups;**		
9d	**Public Sector Equality Duty – "Due Regard"**		
10	**Have you developed an Action Plan arising from this assessment?**		No
11	**Assessment/Action Plan approved by:**		**Signed:** **Date:** **Title:** Company Secretary
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Diversity Lead:*** **Please note that the EIA is a public document and will be published on the website. Failing to complete an EIA could expose the Trust to future legal challenge.**		

If you have identified a potential discriminatory impact of this policy, please refer it to the Associate Director of Human Resources together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Associate Director of Human Resources

Southport and Ormskirk Hospital NHS Trust

Policy Review Group
Terms of Reference

PB126/18 Appendix 2

TOPIC AREAS	DETAILS
Responsibilities	To scrutinise and review Trust policies and related documentation and make recommendations for approval under authority delegated by the Board of Directors.
Remit	**The Group will**: • Scrutinise and review policies to ensure they follow NHS guidance and Trust's directives and provide the relevant assurance committee and the Board with a summary of its recommendations and the rationale for same • Recommend related documentation for approval • Ensure that documentation is presented in the Trust format and has been catalogued on the Trust database • Monitor the adherence to the developmental processes to maintain the quality of documentation
Accountability Arrangements	The Group is accountable to the Board of Directors through its assurance Committees.
Membership/Attendees	**Membership:** • Company Secretary (Chair) • Information Governance Manager (Deputy Chair) • Deputy Medical Director, or nominated representative • Head of Risk • Assistant Director of Nursing (Safer Staffing) • Assistant Director of Operations – rotational or nominated representative • Assistant Director of Human Resources Governance • Estates & Facilities Lead • Assistant Director of Finance

	In Attendance: Other staff of the Trust may be requested to attend for specific matters. Where a member is unable to attend routinely, an appropriate deputy, who will attend on a regular basis should be nominated and notified to the Chair.
Quorum	A quorum will consist of four members, one of whom must be the Chair or Deputy Chair and the Head of Risk.
Chair	The Company Secretary will chair the meeting
Administrative Support	Administrative support will be provided by the Trust Secretariat. Agenda and papers will be circulated not less than one week prior to the meeting.
Reporting Arrangements	The Group will provide a summary report outlining the policies recommended for approval to the Executive Management Team (ETM), Hospital Management Board (HMB) for review and the relevant assurance committee and to the Board of Directors if applicable.
Frequency of Meeting	The Group shall meet monthly but may move two-monthly once all policies are in date and systems and processes are working to their optimum. The Chair may call an additional or special purposes meeting if he/she considers one is necessary or evoke emergency powers as set out in Section:7 of the Policy for Management of Policies where it is crucial for compliance and regulatory reasons that a policy be approved. Such powers may be exercised by the Chair, Vice Chair, a clinician on the Group and the Head of Risk
Standards	National Health Service Resolution Risk Management Standards, all standards at level 1.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item	**TB243/18**	**Report Title**	**Board Assurance Framework (BAF)**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Company Secretary		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The BAF is board owned and is a tool to put before the Board so that it can be assured that the Trust's six strategic objectives are not being impeded by associated principal risks. The Corporate Risk Register deals with operational risks.

The BAF comes to the Board and Audit Committee on a quarterly basis. Specific reports on principal risks go to each of the assurance committees every two months. Good practice suggests that there should be synergy between the BAF and the Risk Register.

There has been some progress in terms of assurances and controls for all risks but there are still gaps in controls and assurances that prevent a lowering of risk scores at the time of this report.

It is suggested that members should not only look at the assurances and controls in place but gaps in controls and assurances and the associated Action Plans and delivery dates to closes the gaps.

A look at the above will show that moderate progress is being made especially in risks: 1,5 and 6 with slower progress in the others.

The BAF is now on Datix and risk owners have been updating their risks on this syste. As stated elsewhere there is a plan to link BAF and Corporate risks to the KPIs which would enhance the reporting mecahanism

Recommendation:

The Board is asked to **receive** the report

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
✓ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*

✓ **SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
✓ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
✓ **SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
✓ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
✓ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
✓ Caring	✓ Statutory Requirement
✓ Effective	✓ Annual Business Plan Priority
✓ Responsive	✓ Best Practice
✓ Safe	✓ Service Change
✓ Well Led	

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

✓ Compliance	✓ Legal
✓ Engagement and Communication	✓ Quality & Safety
✓ Equality	✓ Risk
✓ Finance	✓ Workforce

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

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

The BAF risks to be linked to the KPIs

Previously Presented at:

☐ Audit Committee	✓ Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
✓ Finance, Performance & Investment Committee	☐ Workforce Committee

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

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

Board Assurance Framework report

NHS
Southport and Ormskirk Hospital
NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
25/01/2018	1783	Director of Strategy	Audley Charles	Principal Risk 1: Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards			
Description	Potential Cause: Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels • Lack of robust plans across healthcare systems • Loss of Commissioner support • Inability to respond to requirements to flex capacity as there is a mismatch with their plans. Potential Effect: Loss of existing market share. • Stranded fixed costs due to poor demand management / QIPP. • Difficult to manage capacity plans. Potential Impact: Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance.						
Controls	Sefton Transformation Board Vision 2020 complete and presented to Trust Board Sept 18 Strategy developed with commissioners. Compliant Contracts in place for 2017/18. Commissioner alignment meetings in place. Contingency plans for withdrawal from services developed. Care For You Initiative - clinical models in development Board to Board meetings with CCGs. Local Delivery Systems x 2 Operational Plan IT Strategy Tri-Board with CCG's Healthwatch liaison meetings to support clinical workstreams Developing Experience of Care Strategy Friends and Family Test Local Patient Questionnaires and feedback Patient representation at meetings Patient Survey Dementia Friends Complaints and Compliments Policy Safe at All Times			Gaps in Controls	Operational plan in development Communication and Engagement Strategy not in place PCBC on track for completion end December Delay in delivering Transformational CIP Schemes		

	Vanguard and partnership working - mutual aid Local Authority Scrutiny A&E Delivery Group Commissioner Contract and Quality Meetings Discharge to assess with community providers and commissioners RAS GIRFT being incorporated into speciality strategic plans Acute Sustainability Programme in progress									
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Unlikely (2)	Catastrophic (5)	10	High Risk	15	10	High Risk	24/09/2018	31/12/2018	
Assurance	CEO's reports to Board (L1) Director of Clinical Services reports re review of services (L1) reported to Board. Finance Reports include contractual and commissioning issues, where relevant reported to Board (L1) Progress of agreeing contracts reported via Finance to Board annually (L1) Business Cases involving commissioners reported, where these occur, reported to Board (L1) Minutes of Network/Alliance meetings (L2) Update reports from Community Partnership Network (L2) Minutes of Monthly Contract Review Meetings (L2) Monthly CEO Patch Meetings (L2) Quarterly review against plan (Titration system) Monthly meetings with CCG's CBU's Governance Meetings FP&I Reports Weekly Executive Team Meeting DOF's Monthly Report to Board Operational Plan reporting to Board now in place						**Gaps in Assurance**	Review of relationship management processes may be required. Periodic reports on externally facing activities		
Action Plan	Develop, implement, embed and review Communication and Engagement Strategy Develop Plans to deliver Transformational CIP Schemes Consider the need for review of strategic planning Produce reports on Operational Plan to the Board To conduct an objective setting and strategic planning exercise with the Board. Review of the strategic plan and associated risk management processes (BAF)						**Action Plan Due Date**	31/10/2018 30/11/2018 29/06/2018 30/04/2018 31/03/2019 31/03/2019	**Action Plan Rating**	Little or No Progress Made Moderate Progress Made Completed Completed Little or No Progress Made Little or No Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1822	Director of Nursing & Quality	Audley Charles	Principal Risk 2: Poor clinical outcomes and safety records			
Description	Potential Cause: • Failure of national performance target (cancer, RTT) • Failure to reduce delayed transfers of care in the changing NHS environment Potential Effect: • High numbers of people waiting for transfer from inpatient care. • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience. • Failure of KPI's and self- certification • Reputational damage leading to difficulty in recruitment. Potential Impact: • Services may be unaffordable. • Quality of care provided to patients may fall. • Loss in reputation. • Failure to meet contractual requirements.						
Controls	Staff engagement strategy Quality Visits by NEDs and EDs Duty of Candour Healthwatch Review Freedom to Speak Up Speak Up Champion (NED appointed by Board) Speak Up Guardian Appointed Freedom to Speak Up/Raising Concerns Policy Monthly CBU Quality and Safety Reports Incident Reporting Quality Account CQC Improvement Plan Partnership working across STPs Trust SCOPE Values "Safe at all times" Programmes established Weekly sustainability scrutiny meetings with plan monitoring/ QIA process Embedded Governance structure and processes National surveys for service users Patient forum and patient groups You said, we listened, we did boards Lessons learned feedback CBU has recruited additional resource within the Governance team Trust Vision and Values Strategic Objectives Board Assurance Framework Extreme Risk Register Operational Plan Apprenticeship Strategy HR Policies Care for You programme Staff Engagement			**Gaps in Controls**	Low response rate on Friends & Family Test with unfavourable results Clinical leadership development to provide a culture of trust and candour Perceived inequity of treatment or rewards between and within staff groups No Stakeholder Engagement Strategy Communication and Engagement Strategy not in Place IMT strategy not finalised Staff survey for 2017/18 received, identified areas where Trust performing worse than national average: Support from immediate managers, effective team working, staff able to contribute towards improvements at work, quality of appraisals and fairness and effectiveness of procedures relating to reporting incidents.	

	Maternity services Strategy Results from 2017/18 Staff Survey show the Trust is performing better than national average for; staff working extra hours, staff suffering work related stress, staff experiencing discrimination at work, staff witnessing potentially harmful errors and staff attending work despite feeling unwell Organisational Development Strategy went to Trust Board June 2018 Quality Improvement Strategy in place (went to Board May 2018) The Experience of Care Strategy now in place.									
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Possible (3)	Catastrophic (5)	15	Extreme risk	15	12	High Risk	24/09/2018	31/12/2018	
Assurance	Workforce & Organisational Development Committee (L3) STEIS and Incident Reporting (L2) Developing Gap in Care Strategy (L1) FPPT Report (L3) Governance Reports (L2) Staff Magazine (L1) Integrated Performance Report Director of Clinical Services reports re review of services (L1) Emergency Planning Annual Report (L1) Weekly Quality Improvement Development Group (L1) Patient Flow Project by EY (L3) Quality & Safety Committee Trust Board Clinical Effectiveness Committee Weekly Patient Flow Project Report to ETM Freedom to Speak Up Champion in post						**Gaps in Assurance**	No Engagement Strategy Slow Improvement between CQC Inspection		
Action Plan	Freedom to Speak Up Champions to be appointed across the Trust Develop the Experience of Care Strategy (including FFT) Finalise Workforce & OD Strategy Implement Recommendations of Culture Review Robust medical job planning process to be in place Operational Plan 19/20 to be developed to include all specialities with plans for sustainable delivery in future. Develop, implement, embed and review Strategic Plan						**Action Plan Due Date**	31/07/2018 29/06/2018 31/05/2018 30/11/2018 30/11/2018 30/11/2018 31/12/2018	**Action Plan Rating**	Completed Completed Completed Moderate Progress Made Moderate Progress Made Little or No Progress Made Actions Almost Completed

Strategic Objective	SO3 - Provide care within agreed financial limit				Link to BAF	
Business Unit	Executive Management		Specialty		Location	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
04/04/2018	1823	Director of Finance	Audley Charles	Principal Risk 3: Failure to live within resources leading to increasingly difficult choices for commissioners

Description

Potential Cause:
• Failure to deliver the required levels of CIP.
• Failure to effectively control pay and agency costs.
• Failure to generate income from non-core healthcare activities
• Failure to manage outstanding historic debt.
• Services display poor cost-effectiveness
• Failure to streamline corporate services.

Potential Effect:
• Additional CIPs may need to be identified and delivered.

Potential Impact:
• Reductions in services or the level of service provision in some areas.
• Potential loss in market share and or external intervention.

Controls	Gaps in Controls
PMO Governance improved with roles and responsibilities CIP lead appointed 5 year long term financial model (LTFM) Cash support through agreed loan arrangements Annual Financial Plan including target to reduce underlying deficit Financial governance arrangements in place at a number of levels: FP&I Committee/CBU's Monthly governance meeting and performance meetings with Execs Directorate (budget scrutiny at this level) Revised CIP planning processes and PMO co-ordination of planning and delivery. Weekly CIP review meetings Turnaround Director in post with following addressed: Discretionary Spend Policy, CQUIN Group, Business Development Group & Investment sub-Committee (BDISC) Director of Finance Report to FP&I and TB CIP plan for 2018/19 in place	Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU directorate Modelling of Acute Sustainability into 5 year LTFM to provide savings from any reconfiguration in line with Sefton Transformation Board Strategy

Risk Levels	Likelihood	Consequence	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Initial)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	16	Extreme risk	16	12	High Risk	25/09/2018	31/12/2018

Assurance	Gaps in Assurance
Hospital Management Board Finance, Performance & Investment Committee (L2) Southport & Ormskirk Improvement Board meets monthly BAF-Quarterly to Board and Audit Committee (L1) 13 week rolling cashflow forecast agreed by NHSE (L1) CIP Reviews through through fortnightly Sustainability Scrutiny Meetings Internal and External audit reports and opinion at Audit Committee Monthly Performance Review Boards Executive Team Meeting Weekly Update	Lack of robust Financial recovery Plan that delivers an acceptable I&E deficit positon

Action Plan	Action Plan Due Date	Action Plan Rating
Modelling of emerging clinical options in progress as part of the work of the strategy development. The next step in clinical assurance of the models is the visit of the Yorkshire and Humber Clinical Senate on	31/12/2018 30/11/2018	Moderate Progress Made

	2nd October. Ensure consistency of financial analysis, reporting and control across all areas within the Trust. Roll out of financial training to all relevant staff and reinstate budget holder workshops. Re-launch HFMA e-learning modules. Turnaround Director required as directed by NHS-I to support delivery of 2018/19 financial plan of £28.8m deficit or less. Develop Plans to deliver Transformational CIP Schemes		29/03/2019 31/08/2018 30/11/2018		Moderate Progress Made Little or No Progress Made Completed Moderate Progress Made

Strategic Objective		SO4 - Deliver high quality, well-performing services						Link to BAF	
Business Unit		Executive Management		Specialty		Location			
Opened	ID	ADO/Exec Lead	Risk Lead	Title					
04/04/2018	1824	Chief Operating Officer	Audley Charles	Principal Risk 4: Failure to meet key performance targets leading to loss of services					

Description

Potential Cause:
- Failure to deliver NHS Constitutional Targets
- Failure to deliver the quality aspects of contracts for the commissioners
- Patients experience indicators may show a decline in quality
- Breach of CQC regulations
- Poor Bed Management processes impact on patient safety

Potential Effect:
- Poor patient outcome and standards of care.
- Inaccurate or inappropriate media coverage or reputational damage

Duplication of services with negative impact on CIP

Potential Impact:
- Potential loss of licence to practise.
- Potential loss of reputation.
- Financial penalties may be applied.
- Poor NHSI Governance Risk Rating

Controls	Gaps in Controls
All Band 4 Discharge Team recruited and start in October 2018 Surgical Access Unit opened in September 2018 Ambulatory Care ACU-significant increase in activity RTT-above target Substantive COO appointed to start in October 2018 Interim Performance Manager in post who is undertaking a review of Integrated Performance Report (IPR) Performance Review Boards Performance Management framework (awaiting sign-off following changes to NHSI's SOF and CQC inspection regime) Performance Development Framework (signed-off by Board) Monthly case note reviews IM&T Strategy Data Quality Policy & Reporting Integrated Performance Report & FP&I & Trust Board A & E Estates Redesign Plan 62 day cancer care plan project plan designed Southport and Ormskirk Safe at All Times Programme Improvement Board CBUs Governance processes Risk Registers Hospital Management Board Team Meetings EY Rapid Governance Review undertaken, new structures proposed Safer - Red to Green Project Implemented	Extension of Sytsem C contract to incorporate products specified in the IT Strategy Roadmap Delivery of A&E 4 hour target Management of sickness absence Sickness absence policy requires review

Risk Levels	Likelihood	Consequence	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Initial)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review

	Likely (4)	Major (4)	16	Extreme risk	16	12	High Risk	25/09/2018	31/12/2018
Assurance	Winter Planning and Length of Stay discussed at weekly Performance Improvement Board (PFIB) Revised Integrated Governance Structure to enhance reporting with Improvement Board and Performance Review Board Weekly activity data reported to CBUs Turnaround Director in post Endoscopy Project in place to deliver endoscopy diagnostic targets Finance Performance and Investment Committee Southport & Ormskirk Improvement Board (SOIB) Monthly Mortality Operational Group Monthly Performance Review Board (PRB) for each CBU CBU Governance meetings QIA process to approve all CIPs Monthly contract meeting with Commissioners Engagement of EY to address patient flow Monthly Report to FP&I committee Monthly Report to Q&S Committee Report to Mortality Operational Group Monthly Trust-level and CBU-level dashboard for performance forum Monthly Reports presented to CBU governance meetings Performance against A&E 4 hour target report to Board monthly Hospital Management Board Improvement Board Performance Review Boards						**Gaps in Assurance**	A&E 4 hour target longstanding issues in relation to poor patient flow and subsequent impact Sickness absence amongst the worst rates of all acute Trusts. Poor performance a longstanding issue Mixed sex accommodation –due to poor patient flow across the hospital estate, no assurance can be given in relation to breaches within critical care when patients are ready to be moved to a general ward. Diagnostic waiting times not met Communication and Engagement Strategy not in Place No clear and concise integrated performance framework and associated report 62 day cancer performance-some improvements have been realised but underlying issues within certain tumour groups remain Mortality: above expected limits for some time	
Action Plan	Engagement of EY to address A&E performance and patient flow issues HR to take urgent steps to amend Sickness Absence Policy. Negotiations on-going. IT Strategy to be developed Address issues with diagnostic waiting times Development of a clear and concise integrated performance framework and associated report						**Action Plan Due Date**	31/10/2018 30/11/2018 04/07/2018 31/10/2018 31/10/2018	**Action Plan Rating** Completed Actions Almost Completed Completed Little or No Progress Made Moderate Progress Made

Strategic Objective		SO5 - Ensure staff feel valued in a culture of open and honest communication				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1825	Director of HR	Audley Charles	Principal Risk 5: Failure to attract and retain staff			
Description	Potential Cause: • Difficulty recruiting and retaining high-quality staff in certain areas • Low levels of staff satisfaction, health & wellbeing and engagement • Insufficient provision of training, appraisals and development. Potential Effect: • Low levels of staff involvement and engagement in the trust's agenda. • High than average vacancy rates. • Failure to deliver required activity levels / poor staff productivity • Higher than average sickness rates Potential Impact: • Poor patient experience and outcomes. • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation embed new ways of working. • CEO/Senior Team Visits • CEO Focus Group • Reduced ability to deliver high quality service with low morale • Poor response to NHS Staff Survey						
Controls	Organisational Development Strategy Improved recruitment and induction processes Staff engagement and awareness programme in place Divisional Staff induction Corporate staff Induction Education and development processes in place Appraisal compliance and training attendance monitored Mandatory training PDR Robust employment checks (FPPT) Disclosure Barring Service (favour CRB) Quality Visits by NEDs and EDs Professional Bodies Checks and Balances for clinicians (NMC/GMC) Duty of Candour/Safe Care HealthWatch Review Staff Survey Sickness Absence Policy – under review Staff Engagement Strategy Speak Up Champion & Guardian Recruitment Strategy Retention Strategy Annual staff Appraisal Executive blog Freedom to Speak Up Guardian appointed NHSi Nursing Retention Programme NHSi Health and Wellbeing Project Staff friends & family test additional pulse check questions			Gaps in Controls	Lack of local in year feedback in relation to staff views / staff surveys Temporary status of staff in leadership roles can have an adverse impact on staff engagement Recruitment & Retention of staff Strategy Lack of OD resource Lack of focused resource for staff engagement		

	Workforce and OD Strategy Partnership Working								
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Major (4)	12	High Risk	12	9	High Risk	21/09/2018	31/12/2018
Assurance	ADHR of Workforce Reports to Board (L1) Staff survey and values update work reported specifically and through Quarterly workforce reports to Board (L1) Annual NHS Staff Survey (L3) NHSI's Single Oversight Framework-Workforce metrics (L3) Appraisal and PDRs (L1) Staff Induction (L1) Workforce & OD Committee Weekly Executive Team Meeting Monthly Corporate Induction Monthly JNC meeting Bi-Monthly JSMC meeting Monthly E&D meeting CEO Walkabout Weekly Joint Quality Visits by NEDS and Executive Directors Working with NHSI on Recruitment and Retention Board Development Plan and Board Development Workshops in place						**Gaps in Assurance**	No Communication & Staff Engagement Strategy Survey Action Plans - value based interviewing project Inability to finance key projects relating to staff development Staff Survey update report to the Board	
Action Plan	Succession Planning Strategy in Workforce & OD Plan Workforce Strategy to be developed Communication & Engagement Strategy to be developed As part of Annual business cycle develop Cycle of Board Development Review Annual Staff Award - Pride Awards Exit Interview Procedure to be reviewed and implemented						**Action Plan Due Date**	31/05/2018 31/05/2018 31/10/2018 30/04/2018 31/07/2018 30/09/2018	**Action Plan Rating** Completed Completed Moderate Progress Made Completed Completed Actions Almost Completed

Strategic Objective		SO6 - Establish a stable, compassionate leadership team				Link to BAF	
Business Unit		Executive Management		Specialty		Location	
Opened	ID	ADO/Exec Lead	Risk Lead	Title			
04/04/2018	1826	Director of HR	Audley Charles	Principal Risk 6: Inability to provide direction and leadership			

Description	Potential cause: • Ineffective leadership • Inadequate management practice Potential Effect • In low staff morale, • Poor outcomes & experience for large numbers of patients; • Less effective teamwork; • Reduced compliance with policies and standards; • High levels of staff absence; and • High staff turnover Potential Impact • Poor quality of patient service • Poor recruitment and retention of staff • Inability to provide viable patient care		
Controls	Trust's Vision & Values Single Leadership Plan accepted by NHSI Substantive CEO appointed Training, education and development (TED) strategy & programmes based on training needs analysis. Leadership and people management policies, processes & professional support (including management training & toolkits) Staff support and occupational health and wellbeing arrangements at Trust, CBU and Service levels Monthly and quarterly monitoring of workforce performance Deep dive reports to Committee investigating specific issues when required Staff communication Grievance & Disciplinary Policies Data Protection Policy (General Data Protection Regulations) Staff Survey Employment checks FPPT & Code of Conduct PDR Non-Executive directors' (NED) Skills mix Academic & Professional qualifications Unitary Board: Non-Executive and Executive directors are jointly responsible for decisions taken by board Governance Structure Board Development Session Board Timeout Sessions HR Governance Meetings Workforce and OD Committee Healthcare Leadership Model (-self-assessment tool 360 degree appraisals/- Edward Jenner online leadership programme/Management & Leadership Apprenticeships) Essential HR skills for managers Substantive E&D Manager in post Trust wide staff survey action plan CBU staff survey action plans	**Gaps in Controls**	Lack of local in year feedback in relation to staff views / staff surveys IPR to include information in relation to vacancy levels by CBU and by staff group Temporary status of staff in leadership roles can have an adverse impact on staff engagement Recruitment & Retention of staff Organisational Development Plan Equality & Diversity Policy Monitoring and reporting to Board and committees Access to leadership development programmes for clinicians

	Staff friends and family test + pulse check questions Workforce and OD Strategy Ongoing robust recruitment to Senior posts Appointment of substantive board									
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Initial)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Possible (3)	Major (4)	12	High Risk	12	9	High Risk	21/09/2018	31/12/2018	
Assurance	Workforce & Organisational Committee (L1) Staff Survey (L2) Staff Side Meeting with Management (L2) Trust's Vision and Values (L2) Internal Audit Reports (L3) Fit and Proper Persons' Test(FPPT) (L3) Directors' Code of Conduct (L2) Declaration of Interest for Board and Senior Managers (L2) Gifts and Hospitality & Commercial Interest Policy (L2) Standard of Business Conduct and Conflict of Interest Policy (L2) PDRs (L1) Board of Directors Annual FPPT and Code of Conduct (L2) LA reports to Audit Committee (L3) External Auditors Reports (L3) Counter Fraud Report to Audit Committee (L3) Declaration of Interests at every Board and Committees (L2) Health and Wellbeing Action Plan Education & Monitoring Report Monthly Workforce & Organisational Committee Monthly Remuneration Committee Monthly Leadership Executive Group Weekly Executive Team Meeting IPR to Board Monthly Annual Health & Safety Report HR & Workforce Report Ad hoc reports to Board (Staff Survey, Board Development, Board Induction) Corporate Induction Bi-Annual Staffing Report NEDs' Induction Pack in place Staff Friends and Family Test						**Gaps in Assurance**	Staff Engagement Strategy New Conflict of Interest Guidance not yet formalised in an approved policy Some processes need embedding within CBU and across the organisation to ensure robust Ward to Board communication and escalation Communication and Engagement Strategy not in Place No Healthcare Leadership Model - self assessment tool 360 degree appraisals Lack of robust Executive Director's Induction Pack Lack of NEDs Development Programme		
Action Plan	Establish Board Development Programme Set-up diversity training for staff Develop Staff engagement strategy Develop Organisational Development Plan Equality & Diversity Policy Monitoring and reporting to Board and committees to be developed New Staff Engagement Policy to be developed Develop and Implement Leadership Model Develop and Implement Recruitment & Retention Strategy Joint Workforce & OD Strategy						**Action Plan Due Date**	30/04/2018 31/07/2018 30/11/2018 31/05/2018 05/10/2018 30/11/2018 07/11/2018 30/11/2018 31/05/2018	**Action Plan Rating**	Completed Completed Moderate Progress Made Completed Actions Almost Completed Moderate Progress Made Actions Almost Completed Little or No Progress Made

					Completed

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

3rd October 2018

Agenda Item	TB244/18	Report Title	Statutory Instruments 2018/19: Scheme of Reservation and Delegation – Proposed Amendments
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Silas Nicholls, Chief Executive		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

Current approval levels in respect of non-pay revenue expenditure, requisitioning, ordering, payment of goods and services in Trust's Statutory Instruments 2018/19: Scheme of Reservation and Delegation 2018/19 are higher compared to other Trusts in similar financial position.

It is a standard turnaround procedure to significantly reduce the approval levels to insert additional degree of scrutiny into the system.

It is therefore proposed to amend / revise down the requisitioning limits.

Furthermore, to ensure that all business cases are subject to same scrutiny and review, the following measures have been introduced:

- new standard operating procedure for business cases;
- new form for business cases and statement of case; and
- new Business, Development and Investment Sub-Committee (BDISC)

The purpose of the BDISC is:

- to review all business cases;
- to approve business cases up to £50,000; and
- to make recommendations as to approval of business cases over £50,001 to Hospital Management Board and/or to Trust Board.

This change in this governance arrangement needs to be reflected in the *Scheme of Reservation and Delegation.*

Recommendation:
The Board is asked to **approve** the changes proposed to the relevant section in the Scheme of Reservation and Delegation.

Strategic Objective(s) and Principal Risks(s)

(*The content provides evidence for the following Trust's strategic objectives for 2018/19)*

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
☐ **SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
✓ **SO3** Provide care within agreed financial limit	*Failure to live within resources leading to increasingly difficult choices for commissioners*
☐ **SO4** Deliver high quality, well-performing services	*Failure to meet key performance targets leading to loss of services*
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
☐ **SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

Linked to Regulation & Governance *(the report supports …..)*

CQC KLOEs	**GOVERNANCE**
☐ Caring	✓ Statutory Requirement
✓ Effective	✓ Annual Business Plan Priority
☐ Responsive	☐ Best Practice
☐ Safe	☐ Service Change
✓ Well Led	

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

✓ Compliance	☐ Legal
☐ Engagement and Communication	☐ Quality & Safety
☐ Equality	☐ Risk
✓ Finance	☐ Workforce

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

Next Steps *(List the required Actions and Leads following agreement by Board/Committee/Group)*

Implement changes to Scheme of Reservation and Delegation with immediate effect.	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

The review of the Trust's 18/19 Statutory Instruments, namely of the Scheme of Reservation and Delegation concluded that some parts of the Operational Scheme of Reservation and Delegation are higher compared to other Trusts of similar size and in similar financial position.

It is therefore proposed that Section 4: Non Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods and Service of the Operational Scheme of Reservation and Delegation should be revised as follows:

CURRENT PROVISION	PROPOSED PROVISION	AUTHORISED By
4. Non Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods & Services	**4. Non Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods & Services**	
a) • All requisitions (stock/non-stock) up to £4,999	a) • All requisitions (stock/non-stock) up to £499	Authorised budget signatory
• All requisitions from £5,000 to £24,999	• All requisitions from £500 to £9,999	Budget Manager or Delegated Budget Manager
• All requisitions from £25k to £99,999	• All requisitions from £10k to £49,999	Prime Budget Holder
• All requisitions from £100k to £499,999 total cost	• All requisitions from £50k to £499,999 total cost	Chief Executive or Director of Finance
• Requisitions above £500,000	• Requisitions above £500,000	Trust Board approval

In addition to the above, to reflect the newly created *Business, Development and Investment Sub-Committee* which will be used to review all future business cases, it is proposed to add the following wording to the same section of the *Scheme of Reservation & Delegation*:

CURRENT PROVISION	PROPOSED PROVISION	DECISION MAKING BODY
4. Non Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods & Services	**4. Non Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods & Services**	
	f) • Approving new business cases up to £50,000	BDISC
	• Approving new business cases between £50,001 and £500,000	Hospital Management Board
	• Approving new business cases over and above £500,001	Trust Board