NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 10.45 – 13.30 on Wednesday 7 November 2018
Ruffwood Suite, Education Centre, Ormskirk & District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				
TB250/18 (V)	**Chair's welcome & note of apologies** To note the apologies for absence	**Chair**	**5**	**10.45**
TB251/18 (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**		
TB252/18 (D)	**Minutes of the Meeting held on 3 October 2018** To **approve** the minutes of the Board of Directors	**Chair**		
TB253/18 (D)	**Matters arising action Logs - Outstanding & Completed Actions** To **review** the Action Logs and receive relevant updates	**Chair**		
TB254/18 (P)	**Staff Story: The Associate Nurse** To **receive** the presentation and **note** lessons learnt	**Michelle Kitson**	**15**	**10.50**
STRATEGIC CONTEXT				
TB255/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**10**	**11.05**
TB256/18 (D)	**Operational Business Planning - 2019/20** To **approve** the plans and process	**DoS**	**10**	**11.15**
QUALITY & SAFETY				
TB257/18 (D)	**Quality & Safety (Q&S) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of Q&S**	**5**	**11.25**
TB258/18 (D)	**Quality Improvement Plan Progress Update** To **receive** the monthly report	**DoN**	**10**	**11.30**

Ref No.	Agenda Item	Lead	Duration	Time
TB259/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**IMD**	**10**	**11.40**
TB260/18 (D)	**Workforce (WFC) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of WFC**	**5**	**11.50**
TB261/18 (D)	**Monthly Safe Nursing & Midwifery Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**10**	**11.55**
TB262/18 (D)	**Freedom to Speak Up Guardian Quarter 2 Report** To **receive** the report	**DoN**	**10**	**12.05**
PERFORMANCE				
TB263/18 (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**	**12.15**
TB264/18 (D)	**Audit Committee: Alert, Assure & Advise Report** To **receive** a highlight report including any escalated risks from the Committee	**Chair of Audit**	**5**	**12.20**
TB265/18 (D)	**Integrated Performance Report** To **receive** the monthly report. ***a. Quality Indicators*** ***b. Operational Indicators*** ***c. Financial Indicators*** ***d. Workforce Indicators***	**DoF** **DoN/MD** **COO** **DoF** **DoHR**	**20**	**12.25**
TB266/18 (D)	**Director of Finance Report** To **receive** the current financial position at Month 6 and progress on Internal Sustainability.	**DoF**	**10**	**12.45**
TB267/18 (D)	**Statement of Compliance 2018/2019 Core Standards Self-Assessment-Emergency Preparedness, Resilience and Response (EPRR)** To **approve** the self-assessment.	**COO**	**5**	**12.55**

Ref No.	Agenda Item	Lead	Duration	Time
GOVERNANCE/WELL LED				
TB268/18 (D)	**Risk Management:** **Risk Register** To **receive** the monthly report on the Corporate Risk Register	**DoN**	**5**	**13.00**
TB269/18 (D)	**Regulation and Compliance**: a) **Board & Senior Leaders Development , Well Led Review and Quality Improvement Training** To **approve** the programmes b) **External Well Led Review** To **receive** the report	**CoSec/ DoHR** **DoN**	**15**	**13.05**
TB270/18 (D)	**Items for Approval / Ratification:** a) **Statutory Instruments 2018/19: Scheme of Reservation and Delegation – Proposed Amendments** To **approve** the recommendation and the updated Scheme of Reservation & Delegation. b) **The Remuneration Committee's approval of the Interview Panel's recommendation that Dr Terence Hankin be appointed Medical Director subject to the relevant checks and due diligence including Regulation 5 of the FPPT Regulations** To **ratify** the decision of the Remuneration Committee held 3 October 2018. c) **Utilisation Loan Application** To **ratify** the decision taken under Emergency Powers to approve the application of the loan application d) **2018 Education & Training Self-Assessment Report (SAR)** To **ratify** the decision taken by Non-Executive Director members of the Workforce Committee, the Chief Executive, Interim Medical Director, Director of Human Resources	**CoSec** **Chair** **CoSec** **IMD**	**5**	**13.20**

Ref Nº.	Agenda Item	Lead	Duration	Time
TB271/18 (V)	**Questions from Members of the Public**	**Public**	**5**	**13.25**
CONCLUDING BUSINESS				
TB272/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**	**5**	
TB273/18 (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**		
TB274/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**		**13.30**
TB275/18 (V)	**Date and time of next meeting:** **Wednesday 5 December 2018**, 09.00am The Family Life Centre, Southport	**Chair**		**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, 3 October 2018

Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 7 November 2018)

Present

Richard Fraser, Chair
Jim Birrell, Non-Executive Director
Ged Clarke, Non-Executive Director
Juliette Cosgrove, Director of Nursing
Julie Gorry, Non-Executive Director
Jugnu Mahajan, Interim Medical Director
Silas Nicholls, Chief Executive
Therese Patten, Director of Strategy/Deputy Chief Executive
Steve Shanahan, Director of Finance
Gurpreet Singh, Non-Executive Director

In Attendance

Pauline Gibson, NED Designate
Steve Christian, Chief Operating Officer
Jane Royds, Associate Director of HR
Audley Charles, Company Secretary
Caroline Griffiths, NHS Improvement
Samantha Scholes, Interim PA to the Company Secretary

Apologies:

David Bricknell, Non-Executive Director

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB226/18	**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 welcomed Mr Christian in his role as Chief Operating Officer and Ms Patten in her additional role as Deputy Chief Executive. Apologies were received from Dr Bricknell.	
TB227/18	**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 Interim Company Secretary. Ms Patten and Mrs Royds declared an interest in agenda item **TB244/18.**	
TB228/18	**Minutes of the Meeting Held On 5 September 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 5 September 2018. Action: **Amend the date of the previous Public Board to 5 September as referred to in the title of the paper.** **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the above amendment.	
TB229/18	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: • **Human Resources Contractual Agreement with St Helens & Knowsley (StHK):** remained on-going. • **TB188/18 Quality Improvement Plan (QIP) Progress Update:** included in October agenda.	
TB230/18	**Patient Story: A Patient's Journey and the Complaints Process:** Mrs Michelle Kitson	
	The Chair welcomed Mrs Kitson who presented the Patient's Journey and Complaints process. ***The story had kindly been shared by the patient's next of kin who was offered the opportunity to share it at the end of a complaints process. The patient's next of kin requested that the data subject be anonymised.*** Mr X described the experiences of his wife's care at Southport DGH, some of which was excellent, but lapses in care and some things that 'could and should' have gone a lot better were also highlighted. His wife had a diagnosis of cancer and her journey was shared with the Trust Board as part of her story. In June 2016 his wife attended the A+E department at Southport District General Hospital with severe abdominal pain which led to her receiving urgent surgery. Unfortunately, a number of weeks later following surgery her clinical condition worsened and she sadly died. Following the death of his wife Mr X wrote to the Chief Executive of	

	the Trust with comments about her care and treatment. This focused on the lack of assistance received when requested to meet personal and nutritional needs, and particularly omissions of care and the management of pain. He also highlighted a poor complaints process which caused delays and consequently led Mr X to contact the Parliamentary and Health Service Ombudsman. When talking more about his experiences Mr X also highlighted some other observations regarding inaccuracies and illegibility within documentation. He also felt that temporary staff do not have the same level of commitment, and his perception as a relative was that Trust staff were demoralised due to pay and workload. He also shared that his wife was concerned at times as she could not fully understand those staff for whom English was maybe not their first language, and felt at times that they did not understand her. Following on from the meeting with the Director of Nursing and Assistant Director of Integrated Governance, a formal letter of apology signed by the Chief Executive and Trust Chair had been received by Mr X. The Chair thanked Mrs Kitson for the presentation. He also thanked the Director of Nursing and Assistant Director of Integrated Governance, for their actions in actively seeking to discuss the situation with Mr X. He added that the apology had been deserved and there was much to reflect on. It was clear that issues which could have been considered peripheral to medical care, i.e. food, dignity and compassion were equally important and that the Patient Story had brought a sense of reality to the members of the Board. Mr Nicholls commented that the observation about staffing was well made and lessons had been learned. The Trust had to balance functioning within its means and making the right decisions for the right reasons, particularly in relation to medical staffing. Responses to complaints should be meaningful, acknowledging the complainant and their family's experience and actions implemented. He added that each complaint letter received was read by himself plus the response approved, prior to it being sent. Mrs Gorry observed that the Patient Story was very important, demonstrating the reality of patient experience. Lessons learned must result in actions. The Duty of Candour required organisations to be quick to acknowledge complaints and apologies made. She added that complaints from those who could articulate their concerns were different from those who found it difficult to do so and asked what mechanisms were in place for patients who mentioned concerns to ward staff. Mrs Kitson responded that any	

	concerns were shared at ward level and the patient referred to herself for follow up. Mrs Gorry asked if temporary/agency staff behaviours or actions were fed back to the agency and Ms Cosgrove responded that that now happened, recognising that it had been inconsistent in the past. If individual staff were found not to be demonstrating the values of the Trust, then their line manager or agency would be informed and a plan of action implemented. The valuable work and effort afforded by all staff was also recognised. The Chair acknowledged that not all cases of inadequate provision or complaints would be brought to the attention of the Trust, however, the Board was 100% committed to addressing those and he thanked Mrs Kitson again for the presentation. The Chair added that the whole Board conveyed their thanks and appreciation to Mr X and his family for their time and effort along the whole journey and added the Board's sincere condolences for their loss. **RESOLVED:** The Board **received** the presentation.	
STRATEGIC CONTEXT		
TB231/18	**Chief Executive's Report**	
	Mr Nicholls presented the report. He welcomed Ms Patten to her new role as Deputy Chief Executive in addition to her role of Director of Strategy. Mr Nicholls added that Dr Terry Hankin, currently Deputy Medical Director at St Helens & Knowsley (StHK) would join the Trust in the New Year as the substantive Medical Director and Dr Mahajan would continue as the Interim Medical Director until that time **Winter** Demand for emergency services continued to rise year on year across the NHS. The Trust was no exception with adult attendances at Accident & Emergency (A&E) in the year to August already up by 8.1% which had consisted of 5% increase from the Southport & Formby Clinical Commissioning Group (CCG) and 13% from West Lancashire CCG. In the previous two months, the Trust had seen the two largest A&E attendance ever with more than 190 patients needing care on one day in August. Those were challenging times for everyone involved in healthcare	

	and thanks was given for the hard work of staff our Trust was better prepared than ever. **A&E Extension** The final phase of the work which started in September to extend and refurbish A&E at Southport was on track and should be completed by the end of December 2018. **Hospital Open Day** Mr Nicholls stated that he was delighted by the response to the Open Day at Southport Hospital held on Saturday 8th September. It was the first since 2011 and the torrential rain hadn't dampened the enthusiasm of 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 which staff and volunteers clearly have for the Trust was self-evident as they showed off the services and work they do. The Open Day was combined with the Annual General Meeting and the opening of a Garden of Reflection. The garden was for use by patients, visitors and staff who wish 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. Mr Nichols thanked staff, volunteers and partners for their support. The Chair commented that it was disappointing to learn of a 13% increase in attendance at A&E from West Lancashire CCG. The community contract now provided by Virgin Care and funded by the CCG for that area had not reduced the pressure on A&E as proposed. Ms Patten added that 16 additional people attending A&E per day resulting in the requirement of two additional clinicians plus associated staff and resources. **RESOLVED:** The Board **received** the Report	
QUALITY & SAFETY		
TB232/18	**Quality & Safety Committee - Alert, Advise and Assure (AAA) Highlight Report**	

	Mr Singh presented the report. **Quality & Safety** Mr Singh, as Chair of the Committee, presented the report. The Committee alerted on: • *Fracture Neck of Femur Pathway* - (Best Practice Tariff (BPT). The Committee was concerned that for 2016/17 the Trust did not meet the national targets, only 32.28% of patients achieved BPT; areas of concern were: patients to theatre over 36 hrs and patients having an Orth-geriatrician review in 72 hours (main concern). Investment was required to appoint an Orth-geriatrician Consultant /SAS doctor and for Planned Care CBU to expand their Acute Physician establishment. A Business Case would be written and presented to a future Hospital Management Board. • A single Microbiologist with infection control lead and clinical priorities remained in the Trust, which had resulted in the non-collection of CQIN data, which had not been submitted for this year. Mr Singh congratulated Ms Cosgrove and Dr Mahajan for arranging the recent meeting, which set out safety priorities. It had been a good, insightful meeting and he offered his thanks. **RESOLVED:** The Board **received** the report.	
TB233/18	**Quality Improvement Plan**	
	Ms Cosgrove presented the report. The issues raised by the Care Quality Commission (CQC) in its report issued in March 2018 following its inspection in December 2018 are at the forefront of management's list. Following the inspection and report, the Trust had been working with stakeholders to make the required improvements and since March 2018 the Trust had invested £1.25m to fund: • The extension and refurbishment to A&E. The final phase began in September on a larger 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 2018. The £136,000 unit provided a more comfortable experience for patients waiting to go home and helped free up ward beds for newly admitted patients.

In relation to staffing numbers, since March 2018 the A&E Department had recruited additionally:

- Eight (8) Whole Time Equivalent (WTE) Band 5 Registered Nurses
- Observation area Two (2) WTE Band 5s and one (1) WTE band 6
- CDU Two (2) WTE Band 5s.
- Two and a half (2.5) Emergency Department (ED) Consultants had been recruited and were due to start in October 2018.

Following review and evaluation of supporting evidence, it was recommended that 21 actions be moved to Green (subject to sign off). Therefore, of the 97 improvement actions, 74 would be rated amber (on track to deliver), 21 Green (action completed) and two blue (delivered and sustained) based on current reviews and progress.

Ms Cosgrove reported that preparation for the forthcoming CQC inspection of March/April 2019 was underway and would be complete by December. A recent CQC relationship visit to Ormskirk A&E had been very pleasing. The Board should be assured and satisfied with progress to date.

Mr Birrell asked how the review around the Elderly status which had been planned with Leeds Teaching Hospital (LTH) was progressing, to which Ms Cosgrove replied that it had been delayed due to LTH's clinicians not having sufficient capacity to undertake it, however, it remained a priority to undertake in 2018. The Trust had appointed Meg Langley as Head of Older Peoples' Care in September 2018 and she was driving the 'Red to Green' process to focus on swift, safe patient discharge. A report on progress would be received by the Quality & Safety Committee in November 2018.

Mr Nicholls added that the delay in the review had been disappointing, however, NHS Improvement (NHSI) had identified that LTH were excellent and therefore the Trust was willing to wait to have access to the best support.

Mrs Griffiths (NHSI) commented that the lack of pace on the matter did not result from the Trust or Board. The regional perspective was

	that the Trust was very focused, with a clear, quick turnaround. Mr Clarke observed that there had been numerous consultant recruitment panels, which Non-Executive Board members had actively supported resulting in the appointment of ED consultants in August and September. Mr Nicholls added that staff were starting to feel confident to apply for permanent roles in a Trust with a long-term future and thanked the Non-Executives for their expertise and valuable input in the recruitment process. The Board **received** the report.	
TB234/18	**Monthly Mortality Report**	
	Dr Mahajan presented the report on Quarter 3. **Summary Hospital-level Mortality Indicator (SHMI)** 117 was questioned and had resulted from rises due to winter pressures. **Hospital Standardised Mortality Ratio (HSMR)** The 12-month rolling HSMR for April was 120.8. which was slightly down on the previous month, and 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. **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 was recognised that elderly patients with numerous comorbidities who were sedentary because of illness were particularly susceptible to lower respiratory tract infections. A revised pneumonia pathway was being scoped on 17 October 2018 and implemented from 1 November 2018 which would incorporate new processes to ensure that patients were given the most appropriate treatment as soon as pneumonia was recognised whether it was community or hospital acquired.	

	Crude Mortality: The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for July was 26.99. That had been a great improvement since January when during winter pressures, numbers peaked at 48.85. **Reducing Avoidable Mortality Project (RAM) – August / September 2018** The Reducing Avoidable Mortality Project continued to drive six work streams with activities on track with the exception of those areas identified as risks below. Future project reporting would change in line with the functionality of new programme software, 'Smart Sheets' over the next month. The tool would change the way the Trust worked with the responsibility for activity updates moving directly to staff and an improved suite of project reporting for analysis and progress updates. Mr Birrell observed that a lot of work had taken place and it had been 6-9 months since the Pneumonia External Review, which Dr Mahajan assured the Board would be reported on in November. Mr Shanahan commented that the Structure Judgement Review data range had fluctuated, to which Dr Mahajan responded that 80% had been assessed, however, the screening tool required readjustment which would be examined once that had stabilised. Mr Christian added that the performance distribution radar charts evidenced compelling narrative for ownership within the organisation to realise real change. **RESOLVED:** The Board **received** the report	
TB235/18	**Workforce Committee (WFC)**	
	Mrs Gibson, as Chair of the Committee presented the report. The Committee alerted on: • *Sickness Absence Policy*. It was agreed three months ago to operate to the new policy with an expectation of sign it off within three months. Despite extensive meetings, which had included the CEO, the policy returned to the next JNC meeting on 27 September. The WFC	

had agreed an expected deadline of November meeting to finalise the policy.

- *Mandatory Training Decisions*
  At present clinical experts were making decisions on what training was mandatory and there was no overarching view or consideration to that decision making. That had been a previous alert from the Committee and there needed to be a decision as to which forum those decisions would be taken and to then add to the Committee's Terms of Reference.

DoHR

The Committee advised on:

- *Staff Survey Action Plans*
  The Committee could provide some level of assurance on mandatory training, however, this was an 'advise' which required support from all members of the Board. The balance for staff between patient safety, the day to day job and completing Staff Survey, on occasion resulted in conflicting pressures. The Committee was pleased to report that some areas were making good progress. Human Resources staff had been pro-active and visited Departments to encourage staff to complete the Staff Friends & Family Test.

The Committee assured on:

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

  It was vital that that continued to be owned by the Trust and not just HR and everyone should be encouraged to engage and execute it with their staff. It would make a huge cultural contribution to Vision 2020.

Mrs Gibson added that she would like to commend the efforts of the HR team, noting how they had gone the extra mile to produce the document. She stated that she would like to formally place on record her thanks to the Team.

RESOLVED:
The Board **received** the report

<table>
<tr><td>TB236/18</td><td>Monthly Safe Nurse & Midwifery Staffing Report</td><td></td></tr>
<tr><td></td><td>Ms Cosgrove presented the report.

The Board was advised that the current nurse staffing risk reported as High (12) via the risk register (ID 1368). This resulted from vacancies and some sickness.

For the month of August 2018 the Trust reported safe staffing against the national average (90%) at 89.97% which was in line with the previous month.

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

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

August 2018 data:
<table>
<tr><th></th><th>Funded WTE</th><th>Contracted WTE</th></tr>
<tr><td>Registered</td><td>867.35</td><td>761.93</td></tr>
<tr><td>Non -registered</td><td>377.78</td><td>336.54</td></tr>
<tr><td>Total</td><td>1,245.13</td><td>1,098.47</td></tr>
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RESOLVED:
The Board received the report.</td><td></td></tr>
<tr><td>TB237/18</td><td>Guardian of Safe Working (GOSW) Annual Report</td><td></td></tr>
<tr><td></td><td>Dr Chapman presented the report.

Exception Report Overview (1st August 2017– 31st July 2018)</td><td></td></tr>
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	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.

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

There were significant numbers of Exception Reports not signed off as completed by the trainees. Dr Chapman considered the important element of the process was the Review Meeting and agreed outcome between the trainee and supervisor. That had 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 were submitted by trainees in their first 4 years of training. More experienced trainees had submitted reports when there was a concern about safety due to unfilled shifts.

Upon review five episodes were not deemed to be suitable for Exception Reporting; four related to leave requests and one related to the clocks changing.

2. *PAYMENT AND FINES*

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

Payment for Time Off In Lieu (TOIL) generated from Exception Reports from 1st August 2017 to 31st July 2018 was £1,723.80.

3. *IMPROVEMENTS*

A) Double Bleep Carrying
This had reduced. The Executive Medical Director was now aware of all episodes of Double Bleep carrying reported. Recent episodes of Double Bleep carrying had related to last minute locum cancellation or sickness.

B) Paediatric Trainee Support
Improved support for Paediatric trainees was recognised by HENW. Trainees had also reported improved levels of satisfaction.

C)) Improved Bank Holiday Staffing
Trainee Bank holiday staffing was now the same as week end staffing which had 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 was now in place and functioning.

E) Mersey Internal Audit Agency (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 dated back many years. Work to enlarge and upgrade the Mess facilities at Southport had been agreed and started in September.

	4. *AREAS OF CONCERN* A) *Medicine Staffing* Although five Speciality and Associate Specialist (SAS) doctors had been appointed, none had a start date and the Executive Team had not approved the Business Case for Clinical Fellows. Unless these staffing changes were implemented before December 2018 Dr Chapman 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 Health Education North West (HENW) inspection. B) *Information Provided by Deanery and Lead Employer* Information about trainees who would be starting each rotation was frequently supplied late and did not detail trainees working part-time, off on maternity or sick leave. That prevented rostering of appropriate work schedules and meeting the required six week notice period prior to trainee start date. C) *Rota Gaps in Surgery* Surgery and Trauma and Orthopaedics had experienced unfilled posts at Second Year Foundation Junior Doctors (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 those 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 remained low. Although Trainee Doctors' Forum time was protected there was no one else to do the trainees' work whilst they were away from their clinical duties. From August a change of day was being trialled to see if this improves attendance. **RESOLVED:** The Board **approved** the annual report.	
PERFORMANCE		
TB238/18	**Finance, Performance & Investment Committee (FP&I): Alert, Advise and Assure (AAA) Report**	

Mr Birrell as Chair of the Committee presented the report.

The Committee alerted on:

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

There was significant stability, with some variation, in the Trust which was unusual for a Trust with financial challenges.

The Committee was advised on:

- An internal Winter Plan had been developed, however discussions continued regarding out of hospital care, which was a matter of concern.

The Committee assured on:

- The recent initiatives to improve waiting times at the Southport A&E department had resulted in a significant improvement during August.

The CEO commented that there had been friction with the CCGs relating to the Winter Plan. The Trust had implemented all of its internal plans and had planned to add additional capacity at Ormskirk with Virgin Health Care; however, key support from one of our commissioners was not forthcoming. The Chief Executive had written to Sefton CCG's Accountable Officer and NHS England about the concerns and the reversal of approach.

He also congratulated the team on the improvement of waiting times at Southport A&E and recognised that there was critical pressure at Ormskirk, which was a risk.

Ms Cosgrove added that she and Mr Christian had met with the CCGs and had scrutinised the winter plans, the gaps and associated risks which required escalation. She acknowledged that that had proved difficult.

Ms Roberts explained that the escalation areas which had been put in place for Winter 2017/18 remained open throughout 2018, at a cost of £350k which had not been paid for.

The Chair added that Southport & Ormskirk Hospital NHS Trust had planned and organised itself for winter and looked to commissioners to do likewise.

	RESOLVED: The Board **received** the report.	
TB239/18	**Integrated Performance Report (IPR)**	
	Mr Shanahan introduced the report details of which are in the Board Pack. The report's format had been revised and condensed following consultation. Statistical Process Control charts would be included in the November report. Mrs Anita Davenport would explain in detail the report format, including the 60+ KPIs which had been incorporated, in the afternoon's Workshop with the Board and key members of staff. Each Director spoke to their areas of responsibility and answered questions raised **Quality Indicators** were summarised by the Director of Nursing and Interim Medical Director in such areas as: • Safe • Mortality • Stroke • Caring • Delivering Same Sex Accommodation • Friends & Family Test **Operational Indicators** were presented by the Chief Operating Officer summarising the following areas: • A and E 4-hour compliance • Red to Green • Ambulance Handovers • Diagnostic Waits • 62-day GP referral to treatment • 62-day Pathway Analysis Mr Birrell stated that non-Cancer targets should be included in the report, which Mr Shanahan agreed would be picked up at the Finance Investment & Performance Committee. **Financial Indicators** were presented by the Director of Finance Mr Shanahan would report on the Financial items in the Director of Finance Report and highlighted that the Trust was unlikely to reduce its agency spend. **Workforce Indicators** were presented by the Associate Director of Human Resources and Director of Nursing • Well Led	

	• Duty of Candour • Sickness rate • Personal Development Review (PDR) • Mandatory Training **RESOLVED** The Board **received** the report	
TB240/18	**Director of Finance Report**	
	Mr Shanahan presented the report. At Month 5 the Trust's financial performance showed a deficit of £13.516M against a deficit plan of £13.279M which was £237K worse than plan. • Agency spend was rising, particularly in nursing • CIP delivery was the main cause of the adverse performance in August. • There were a number of other risks which, if not addressed, would lead to the Trust not achieving the planned deficit of £28.8M • The main risks were CIP and agency spend. • Based on the current run rate the outturn will be in the region of £30-32M deficit. • There was no plan at that stage to amend the forecast outturn from £28.8M deficit. MIAA was expected to report on tariff discussions with CCGs by 26 September 2018. There was a risk of sanctions being applied due to the Trust previously not signing up to the control total and it was identified that commissioners would not be required to re-invest the money in the Trust. Mr Nicholls commented that the Trust's plan was to deliver on the planned deficit and the option of discounted or free services for CCG would cease and be reflected in contract negotiations. **RESOLVED:** The Board **received** the report.	
TB241/18	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report 1 April 2017 – 31 March 2018**	
	Ms Patten, as the previous Chief Operating Officer, presented the report. As a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) the Trust was legally obliged to ensure it had robust Business Continuity Management and Emergency Preparedness arrangements in place. The Trust's Scheme of Reservation and Delegation required that an annual report must be brought before	

	Trust Board to assure them that the organisation was meeting its obligations in that matter. The Trust was subjected to a cyber-attack in May 2017 which was declared a major incident. The Trust had a comprehensive lessons learnt process following that. Feedback was collated from all wards and departments which was fed into a de-brief session on 5 June 2017. The Trust was 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. That concern was fed back to NHS England. The Trust was 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 were 'Full', 'Substantial', 'Partial' and 'Non-compliant'. In the submission for 2017/18 the Trust was rated as 'Substantial'. In comparison with other Trusts in Merseyside, 12 Trusts were rated Substantial, 7 were rated Full, 1 was rated Partial. An Improvement Plan was developed and agreed with the Accountable Emergency Officer. For 2018, the self-assessment would be brought to Trust Board in November 2018, along with the Major Incident Plan. Ms Cosgrove advised that the CQC had identified that there was a risk in handover and gaps in business continuity which Mr Christian, as the new Chief Operating Officer, should be aware of. **RESOLVED** The Board **approved** the Annual Report.	**COO**
GOVERNANCE/WELL LED		
TB242/18	**Policy for Development and Management of Procedural Documents**	
	Mr Charles presented the report. Policy Management had recently transferred to the Trust Secretariat/Corporate Governance. The process for managing policies was not as robust as it should be and as a result the Process had been reviewed to ensure that it was fit for purpose, user-friendly and logical in the steps undertaken. The report had been recommended for approval by the Executive Team, (ETM) Information Governance Steering Group (IGSG) and the Hospital Management Board.	

	The Policy had 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 would report into the Risk and Compliance Group. • A provision in the Policy for emergency powers to be evoked in the event of the need to expedite 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. Mr Clarke congratulated Mr Charles on the comprehensiveness of the revised policy and processes and asked which Audit Team would undertake audit of the policies. Mr Charles responded that would be the Clinical Audit Team which would audit if the Policy was working but compliance against policies would be undertaken by MIAA, the Trust's Internal Auditors. Mr Charles detailed that reports would be provided quarterly to Audit Committee, monthly to the Risk and Compliance Group after a suggestion from the Director of Nursing that the Risk and Compliance Group was best placed to receive this rather than the Information Governance Steering Group and annually to the Board. Mrs Gorry asked what mechanism was in place to ensure that agency and bank staff were made aware of new or revised policies. Ms Cosgrove replied that that was the responsibility of the directorate or department for whom they work. The Chair congratulated Mr Charles on the robust, revised policy and requested that clarification of responsibilities be more defined. **RESOLVED** The Board **approved** the Policy.	**CoSec**
TB243/18	**Risk Management:** **Board Assurance Framework and Risk Register & Performance Management**	
	Mr Charles presented the report. There had been some progress in terms of assurances and controls for all risks but gaps remained in controls and assurances that prevent a lowering of risk scores at the time of the report.	

	Risk owners were reminded that they 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 close the gaps. They could now be updated using the Trust's Risk Management System-Datix **RESOLVED** The Board **received** the report.	
TB244/18	**Items for Approval/Ratification**	

	• **Scheme of Reservation & Delegation – Budget Adjustment**
	The Board approved the recommendation and the updated Scheme of Reservation & Delegation.
	
	Budget holders to be made aware of the new arrangements.
	
	Ms Patten and Mrs Royds left the meeting at this juncture because of the item below.
	
	• **Ratification of recommendation by the Remuneration & Nominations Committee.**
	  • The Board **ratified** the recommendation of the Remuneration Committee's approval of the Interview Panel's recommendation of the appointment of the Deputy Chief Executive, taken on 3 October 2018.
	
	  • The Board **ratified** the Virtual Remuneration and Nominations Committee's recommendation of approval of the Director of Human Resources, taken on 13 September 2018, subject to Transfer of Undertakings (Protection of Employment) (TUPE).
	
	Ms Patten and Mrs Royds re-joined the meeting.
		DoF

TB245/18	**Questions From Members of the Public**	
	No questions were raised.	
CONCLUDING BUSINESS		
TB246/18	**Any Other Business**	
	Mr Nicholls stated that the Board was the final one for the Chair, Mr Fraser. He thanked Mr Fraser for his guidance and leadership of the Trust having steered it through difficult and challenging times. He continued by saying that the Chair had helped him personally and he could not have had better support.	

	The Chair thanked Mr Nicholls and stated he was proud of what the Trust and the Board had achieved and also proud to have spent two years helping to improve the Trust for the public it served. He would continue as Chair of a neighbouring Trust and hoped that the Trusts could work together. He thanked members for their friendship and requested that they co-operate with, welcome and support the incoming Chair. Mr Fraser added that the Trust was at an exciting point in time with a vibrant future for staff, volunteers and the public.	
TB247/18	**Items for the Risk Register/changes to the BAF**	
	There were no additional items or changes.	
TB248/18	**Message from the Board**	
	There was no message from the Board.	
TB200/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 7 November 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	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 7th November

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

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	**DoHR**	Sep 2017	Sep 2018	**November 2018** Key steps are being taken to bring this to fruition, not least the approval of a decision to appoint the ADHR as Director of HR for the Trust subject to TUPE arrangements. Talks are ongoing with regards to transfer of other services.	**GREEN**
TB241/18	Oct 2018	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report 1 April 2017 – 31 March 2018**	For 2018, the self-assessment would be brought to Trust Board in November 2018, along with the Major Incident Plan	**COO**	Nov 2018	Nov 2018	**November 2018** This is an item on the agenda	**GREEN**

Public Board Matters Arising Action Log as at 7th November

Southport and Ormskirk Hospital NHS Trust

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COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Completion Date	Status Outcomes	BRAG STATUS
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- COMPLETED** Was combined as part of the agenda for the October Board	**BLUE**
TB244/18	Oct 2018	**Items for Approval/Ratification**	The Board **approved** the recommendation that the Scheme of Reservation & Delegation be amended to take account of revised budgetary signatory responsibility. The new arrangements to be circulated to relevant personnel.	**CoSec**	Nov 2018	Nov 2018	**November 2018- COMPLETED** This was circulated 9 October and the Scheme of Reservation and Delegation on the Trust's intranet updated to reflect the change.	**BLUE**
TB235/18	Oct 2018	**Workforce Committee AAA Report**	A decision about which Forum Mandatory Training decisions should be taken needed to be made and then added to the relevant Terms of Reference (TORs).	**DoHR**	Nov 2018	Nov 2018	**November 2018- COMPLETED** This part of the Workforce Performance Report which is discussed at the Workforce Committee monthly. It has always been part of the agenda so there is no need to review the Terms of Reference of the Committee	**BLUE**

Public Board Matters Arising Action Log as at 7th November

Southport and Ormskirk Hospital NHS Trust

BRAG Status Key

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Completion Date	Status Outcomes	BRAG STATUS
TB242/18	Oct 2018	**Policy for Development and Management of Procedural Documents**	Clarification of responsibilities to be more clearly defined within the document.	**CoSec**	Nov 2018	Nov 2018	**November 2018- COMPLETED** This has been clearly listed within the Policy	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB255/18**	**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

The key areas listed in the report are:

- Vision 2020 Strategy
- Trust chosen for national programme to improve orthopaedic care
- Red2Green fully operational by the New Year
- £480,000 IT award to improve bed management and patient flow
- Time to Shine staff awards

Recommendation:

To **note** key issues and update from the CEO.

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)*
N/A

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 – NOVEMBER 2018

Change is coming with our Vision 2020 Strategy

Since I started with the Trust in April, I've been delighted by how ready colleagues are to rise to the challenge of making the Trust the best it can be for patients.

Cash may have paid for the improvements to services we've made this year, like the Day Surgery Unit at Ormskirk or the Surgical Assessment Unit at Southport, but it's the dedication of staff that made them happen.

The next couple of years are crucial to building on that success and making this organisation the model for smaller NHS hospitals in the 21st Century I know it can be.

That's the ambition and aspiration behind Vision 2020.

It is our roadmap to how we will become a successful and sustainable provider of healthcare for local people.

There are four themes at the heart of Vision 2020:

- Become a leading community general hospital, specialising in the care of older people
- Invest in our hospitals to make them fit for the 21st Century
- Become a successful integrated care organisation, delivering seamless hospital-to-home care that works for patients
- Create a regional hub for routine planned care, run from a dedicated hospital

The Vision 2020 strategy is underpinned by tasks we must make progress on if we're to become that model organisation. Key among them is achieving a CQC rating of "good", reducing avoidable deaths and getting a grip of our financial deficit.

Trust chosen for national programme to improve orthopaedic care

We are one of a small number of NHS trusts working to develop the next phase of the national Getting It Right First Time (GIRFT) programme for orthopaedics.

The aim of GIRFT is to improve the quality of NHS care by reducing unwarranted variations and ensuring patients get the best care at the best cost.

Importantly, it is led by frontline clinicians who are experts in the areas that they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis.

The programme is led by Prof Tim Briggs, who developed and pioneered the approach in orthopaedics, and is National Director of Clinical Quality and Efficiency for NHS Improvement.

He will support us creating a highly productive "hot and cold" model of orthopaedic care, specifically for trusts like ours operating on more than one site. (A "hot" site deals with

trauma such as serious falls while a “cold” site focuses on planned surgery like joint replacement.)

The work was formally launched on 17 October at Ormskirk hospital by Prof Briggs at an event attended by clinical staff and other stakeholders.

The programme of work is planned to take six months and will be formally evaluated by the GIRFT team. The intention is for the lessons learnt to be then rolled out across the wider NHS.

This is an exciting development and will be a key enabler in modernising our orthopaedic pathway.

Red2Green fully operational by the New Year

Sometimes older patients get “stuck” in hospital which the systems and silos that exist in health and social care can make worse.

It is well known that many “stuck” patients are in the last 1,000 days of their life.

Our Red2Green programme focuses on the most valuable currency in healthcare: patients’ time.

By focusing on the last 1,000 days, we are asking staff to act to prevent “red days”; that is days when blockages and obstacles stop a patient moving closer to going home. In that way as many days as possible become “green days”.

Following some early successes, the entire executive team is sponsoring the roll out of Red2Green across the Trust with the intention it being fully operational by the New Year.

£480,000 IT award to improve bed management and patient flow

The Trust has been awarded £480,000 to upgrade and develop our IT systems around bed management and patient flow this winter.

In particular we are looking at the feasibility of putting into place an integrated bed management system that would give a real-time view of capacity in nursing and residential homes.

If we can achieve this it would be a major step forward in our ability to effectively manage our capacity as a single system.

Time to Shine-staff awards

We held our 10th staff awards at Formby Hall on Friday 12th October. It was a new name for what were formerly the Pride Awards, a new look and a new venue.

Time to Shine was a wonderful opportunity to celebrate the commitment, dedication and professionalism of everyone who works and volunteers at the Trust.

Nearly 250 staff and guests attended the event which was hosted by A&E consultant Dr Mike Aisbitt. Awards were presented to 12 staff members, teams and a volunteer.

Nominations were made by staff with the exception of the People's Health Hero Award which patients and their families were asked to nominate.

Silas Nicholls, Chief Executive

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB256/18**	**Report Title**	**Operational Business Planning - 2019/20**
Executive Lead	Therese Patten, Deputy Chief Executive/Director of Strategy		
Lead Officer	Donna Lynch, Head of Programme Management Office (PMO)		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

The 'approach to planning guidance' was published by NHS Improvement (NHSI) and NHS England (NHSE) on 16th October. An initial 2019/20 plan is required by 14 January 2019, with the submission of the final 2019/20 organisation operating plan required by 4 April 2019. The document attached sets out the process and timetable to meet this deadline.

There will also be the requirement to submit a system wide 5-year plan signed off by all organisations within the Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). NHS Improvement and NHS England will be publishing 5-year commissioner allocations in December 2018, giving systems a high degree of financial certainty on which to plan. NHSI and NHSE are currently developing the tools and materials that organisations will need to respond to this, the final date for the 5-year plan is summer 2019.

The Board is asked to **approve** the process for the development and sign-off of the 2019/20 Operational Business Plan.

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)*

Clinical Business Units (CBUs), Executive Directors and Corporate Teams are required to attend the Operational Planning Session scheduled for 22 November.

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

OPERATIONAL BUSINESS PLANNING - 2019/20

1 Executive Summary

Planning is a dynamic and continuous process; plans do not set a fixed picture for the future, but a developing one. It is however, important to at a fixed point give consideration as to where we are and where we need to be. This is in order that we sufficiently understand our priorities, opportunities and challenges identifying any actions that we need to take to address them. It is timely now to develop an Operational Business Plan for 2019/20.

2 Vision 2020

Vision 2020 describes what we want to do and the Single Improvement Plan sets out how we are going to achieve it. We have set ourselves the task of making significant progress by 2020 and so here set out seven stretching objectives we will achieve within the next two years:

- A CQC rating of good (with no individual ratings which are 'inadequate')
- A score of 100 for HMSR and SHMI
- A fully implemented new modern and integrated pathway for the care of frail older patients
- A fully implemented new, modernised and efficient pathway for the effective delivery of orthopaedic services
- The opening of a Post-Operative Care Unit at Ormskirk Hospital
- Clear system agreement and a recognised process on becoming an Integrated Care Organisation
- Reduce our deficit below £25m

It is expected that these along with the NHS planning guidance will form that basis of the planning assumptions and priorities for the Operational Business Plan 2019/20.

3 Business Planning Process

The business planning process this year will commence with Quality Core Service Reviews, linked to CQC preparation of the Provider Information Return (PIR). This detailed information, once completed, will be aggregated up to give a view of the Trusts 'Core Services' i.e.

- Urgent & Emergency Services
- Medical Care (including older people's care)
- Surgery (both Southport & Ormskirk)
- Critical Care
- Out Patients (both Southport & Ormskirk)
- Spinal Injuries
- Maternity
- Services for Children and Young People

In order that our business plans identifies and addresses the quality issues at core service level, the Quality Core Service Review aggregated information, as taken from the Provider Information Requirement (PIR), is required for completion in **Appendix 1**.

In order that the Trust can develop an operational business plan is it suggested that a bottom up approach is adopted that supports CBUs to identify their plans to address the Vision 2020 across the following headings:

- Quality
- Activity
- Workforce
- Finance
- CIP (Capital Improvement Programmes)
- Capital

This will enable us to collate a Trust wide plan and comply with NHS planning guidance for the publication of a detailed financial, workforce and activity plan for 2019/20.

A Business Plan Workshop has been scheduled in November where Vision 2020 will be considered from a quality, financial and activity and perspective. A draft agenda for this session is also attached in **Appendix 3**.It will be an opportunity for CBUs to develop outline plans to support the delivery of the vision, with support from executive and corporate colleagues. The Operational Business Plan Template for completion can be found in **Appendix 2**.

This will be followed by a Star Chamber, in December, where CBUs will feedback to the executive team their draft operational business plans opportunities, risks and mitigation and potential areas for investment and divestment.

4 Timescales of Key Dates

The 'approach to planning guidance' was published by NHS Improvement and NHS England on 16th October (**Appendix 4**) preliminary submission to NHSI and NHSE is required by the 14 January, which will be discussed at the Trust Board on 9 January 2019. The final submission of the organisation operating plan is required by 4 April 2019. This timeline has been taken into consideration for the Trust planning process.

The table below outlines the key dates for the production of the Business Plan 2019/20.

Item	Forum	Date
Operational Business Plan Outline	Senior Managers Meeting	10 October 2018
Operational Business Planning Launch	Hospital Management Board	18 October 2018
Business Planning Group Session	Executives, Senior Leaders Corporate and Operational	22 November 2018
CBUs work-up Business Plans	In CBUs	During November
Star Chamber	Executives, CBU Triumvirate	December 2018
Initial plan – activity and efficiency focussed with headlines	Trust Board	9 January 2019
NHSI&E Submission – Initial 2019/20	External Submission	14 January 2019

Plan		
Draft Business Plan – Approval	FP&I Committee	25 March 2019
Final Business Plan – Approval	Trust Board	3 April 2019
NHSI&E Submission – final 2019/20 organisation operating plan	External Submission	4 April 2019

5 Strategic Planning

There will also be the requirement to submit a system wide 5-year plan signed off by all organisations within the STPs and Integrated Care Systems (ICSs). NHS Improvement and NHS England will be publishing 5-year commissioner allocations in December 2018, giving systems a high degree of financial certainty on which to plan. They are currently developing the tools and materials that organisations will need to respond to this, the final date for the 5-year plan is summer 2019. Once the documentation has been received we will develop a plan to support the production of this 5-year plan.

6 Recommendations

Trust Board is asked to approve the process for the development and sign-off of the 2019/20 Operational Business Plan.

Appendix 1 - Quality Core Service Review

	QUALITY	**STRATEGIC FIT**	**WORKFORCE**	**DELIVERABILITY**
Core Services	*Clinical safety standards and constitutional standards are met*	*Service fits within Vision 2020 and future strategic direction*	*Specific concerns in terms of shortages of numbers and/or skills*	*Can this service continue to be delivered or is a partner required*
Urgent & Emergency Services				
Medical Care (including older people's care)				
Surgery (both Southport & Ormskirk)				
Critical Care				
Out Patients (both Southport & Ormskirk)				
Spinal Injuries				
Maternity				
Services for Children and Young People				

Appendix 2 – Operational Business Plan Template

	CBU Priorities	Key Actions	Risks	Timescales	Support Required
Quality					
Activity					
Finance					
Workforce					
CIP					
Capital					

Appendix 3

Southport and Ormskirk Hospital NHS Trust

DRAFT BUSINESS PLANNING GROUP SESSION

Thursday, 22 November, 13:00 – 16:00
Venue to be confirmed

Invitees

- Triumvirate & CBU Management Team

Corporate Business Partners
- Finance
- Business Intelligence
- Human Resources
- Procurement

Other corporate support
- Project Management Office
- Estates
- Quality
- Capital
- Information Management & Technology

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Duration	Time
PRELIMINARY BUSINESS				
BPG001/17 (V)	**Chair's Welcome, Introduction & Note Of Apologies** To note the apologies for absence	**Chair**	**5**	**13:00**
CORE BUSINESS				
BPG002/17 (D)	**Vision 2020**	**CEO**	**10**	**13:05**
BPG003/17 (D)	**Quality Context**	**DoN**	**10**	**13:15**
BPG004/17 (V/D/P)	**Financial Context** - including commissioners' intentions	**DoF**	**10**	**13:25**
BPG005/17 (V/D/P)	**Activity Impact** - including in-year achievement and trajectories	**HoIG**	**10**	**13:35**
BPG006/17 (V/D/P)	**Outline Workshop Outputs**	**DoS**	**10**	**13:45**
BPG007/17 (V/D/P)	**Clinical Business Unit (CBU) Workshops**	**CBU ADOs**	**120**	**13:55**
CONCLUDING BUSINESS				
BPG008/17 (V)	**Any Other Business**	**Chair**	**5**	**15:55**
BPG009/17 (V)	**Date and Time of Next Meeting** **TBC**	**Chair**		**CLOSE**

To:
CCG AO
Trust CE

CC:
NHS Improvement and England Regional Directors
NHS Improvement and England Regional Finance Directors

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Publications Gateway Reference 08559 16 October 2018

Approach to planning

The Government has announced a five-year revenue budget settlement for the NHS from 2019/20 to 2023/24 - an annual real-term growth rate over five years of 3.4% - and so we now have enough certainty to develop credible long term plans. In return for this commitment, the Government has asked the NHS to develop a Long Term Plan which will be published in late November or early December 2018.

To secure the best outcomes from this investment, we are overhauling the policy framework for the service. For example, we are conducting a clinically-led review of standards, developing a new financial architecture and a more effective approach to workforce and physical capacity planning. This will equip us to develop plans that also:

- improve productivity and efficiency;
- eliminate provider deficits;
- reduce unwarranted variation in quality of care;
- incentivise systems to work together to redesign patient care;
- improve how we manage demand effectively; and
- make better use of capital investment.

This letter outlines the approach we will take to operational and strategic planning to ensure organisations can make the necessary preparations for implementing the NHS Long Term Plan.

Collectively, we must also deliver safe, high quality care and sector wide financial balance this year. Pre-planning work for 2019/20 is vitally important, but cannot distract from operational and financial delivery in 2018/19.

Planning timetable

We have attached an outline timetable for operational and strategic planning; at a high-level. During the first half of 2019-20 we will expect all Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to develop and agree their strategic plan for improving quality, achieving sustainable balance and delivering the Long Term Plan. This will give you and your teams sufficient time to consider the outputs of the NHS Long Term Plan in late autumn and the Spending Review 2019 capital settlement; and to engage with patients, the public and local stakeholders before finalising your strategic plans.

Nonetheless, it is a challenging task. We are asking you to tell us, within a set of parameters that we will outline with your help, how you will run your local NHS system using the resources available to you. It will be extremely important that you develop your plans with the proper engagement of all parts of your local systems and that they provide robust and credible solutions for the challenges you will face in caring for your local populations over the next five years. Individual organisations will submit one-year operational plans for 2019/20, which will also be aggregated by STPs and accompanied by a local system operational plan narrative. Organisations, and their boards / governing bodies, will need to ensure that plans are stretching but deliverable and will need to collaborate with local partners to develop well-thought-out risk mitigation strategies. These will also create the year 1 baseline for the system strategic plans, helping forge a strong link between strategic and operational planning. We will also be publishing 5-year commissioner allocations in December 2018, giving systems a high degree of financial certainty on which to plan.

We are currently developing the tools and materials that organisations will need to respond to this, and the timetable sets out when these will be available.

Payment reform

A revised financial framework for the NHS will be set out in the Long Term Plan, with detail in the planning guidance which we will publish in early December 2018. A number of principles underpinning the financial architecture have been agreed to date, and we wanted to take this opportunity to share these with you.

Last week we published a document on ‘NHS payment system reform proposals’ which sets out the options we are considering for the 2019/20 National Tariff.

In particular, we are seeking your engagement on proposals to move to a blended payment approach for urgent and emergency care from 2019/20. The revised approach will remove, on a cost neutral basis, two national variations to the tariff: the marginal rate for emergency tariff and the emergency readmissions rule, which will not form part of the new payment model. The document will also ask for your views on other areas, including price relativities, proposed changes to the Market Forces Factor and a proposed approach to resourcing of centralised procurement. As in

previous years, these proposals would change the natural 'default' payment models; local systems can of course continue to evolve their own payment systems faster, by local agreement.

We believe that individual control totals are no longer the best way to manage provider finances. Our medium-term aim is to return to a position where breaking even is the norm for all organisations. This will negate the need for individual control totals and, in turn, will allow us to phase out the provider and commissioner sustainability funds; instead, these funds will be rolled into baseline resources. We intend to begin this process in 2019/20.

However, we will not be able to move completely away from current mechanisms until we can be confident that local systems will deliver financial balance. Therefore, 2019/20 will form a transitional year, in which we will set one year, rebased, control totals. These will be communicated alongside the planning guidance and will take into account the impact of distributional effects from any policy changes agreed post engagement in areas such as price relativities, the Market Forces Factor and national variations to the tariff.

In addition to this, we will start the process of transferring significant resources from the provider sustainability fund into urgent and emergency care prices. The planning guidance will include further details on the provider and commissioner sustainability funds for 2019/20.

Incentives and Sanctions

From 1 April 2019, the current CQUIN scheme will be significantly reduced in value with an offsetting increase in core prices. It will also be simplified, focussing on a small number of indicators aligned to key policy objectives drawn from the emerging Long Term Plan.

The approach to quality premium for 2019/20 is also under review to ensure that it aligns to our strategic priorities; further details will be available in the December 2018 planning guidance.

Alignment of commissioner and provider plans

You have made significant progress this year in improving alignment between commissioner and provider plans in terms of both finance and activity. This has reduced the level of misalignment risk across the NHS. We will need you to do even more in 2019/20 to ensure that plans and contracts within their local systems are both realistic and fully aligned between commissioner and provider; and our new combined regional teams will help you with this. We would urge you to begin thinking through how best to achieve this, particularly in the context of the proposed move to blended payment model for urgent and emergency care.

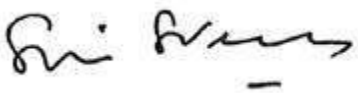
Good governance

We are asking all local systems and organisations to respond to the information set out in this letter with a shared, open-book approach to planning. We expect boards and governing bodies to oversee the development of financial and operational plans, against which they will hold themselves to account for delivery, and which will be a key element of NHS England's and NHS Improvement's performance oversight. Early engagement with board and governing bodies is critical, and we would ask you to ensure that board / governing body timetables allow adequate time for review and sign-off to meet the overall timetable.

The planning guidance, with confirmation of the detailed expectations, will follow in December 2018. In the meantime, commissioners and providers should work together during the autumn on aligned, profiled demand and capacity planning. Please focus, with your local partners, on making rapid progress on detailed, quality impact-assessed efficiency plans. These early actions are essential building blocks for robust planning, and to gauge progress we will be asking for an initial plan submission in mid-January that will be focussed on activity and efficiency (CIP / QIPP) planning with headlines collected for other areas.

Thank you in advance for your work on this.

Yours sincerely



Simon Stevens
Chief Executive
NHS England

Ian Dalton
Chief Executive
NHS Improvement

Annex

Outline timetable for planning	Date
NHS Long Term Plan published	Late November / early December 2018
Publication of 2019/20 operational planning guidance including the revised financial framework	Early December 2018
Operational planning	
Publication of • CCG allocations for 5 years • Near final 2019/20 prices • Technical guidance and templates • 2019/20 standard contract consultation and dispute resolution guidance • 2019/20 CQUIN guidance • Control totals for 2019/20	Mid December 2018
2019/20 Initial plan submission – activity and efficiency focussed with headlines in other areas	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
Draft 2019/20 organisation operating plans	12 February 2019
Aggregate system 2019/20 operating plan submissions and system operational plan narrative	19 February 2019
2019/20 NHS standard contract published	22 February 2019
2019/20 contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Final 2019/20 organisation operating plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions and system operational plan narrative	11 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Summer 2019

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE**
MEETING DATE:	**29th October 2018**
LEAD:	**MR JIM BIRRELL**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Seven new risks have been added to the Risk Register, including one that highlights staffing shortages in the Anaesthetic Department that has implications for both critical care and surgical lists.
- Over recent months there has been an increased number of 12-hour breaches due to the lack of mental health in-patient/assessment facilities.
- The Committee expressed concerns about the Trust's Speech and Language Therapy Services so agreed to discuss the matter in more detail at their next meeting.

ADVISE

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

- The Clinical Effectiveness Committee (CEC) will review the recent deterioration in performance on treating patients with a fractured neck of femur within 36 hours.
- The methodology used for capturing data on compliance with the "Duty of Candour - Evidence of Discussion" standard is under review; if necessary, a report on remedial action will be brought back to the Committee.
- good progress has been made on the introduction of Structured Judgement Reviews (SJR) although the sensitivity of the tool requires adjustment to enable the Trust to meet the national target of examining 20% of relevant cases in-depth.

ASSURE

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

- An analysis of Trust compliance with Bereavement Services good practice guidelines was broadly positive. However, there is a need to improve the facilities available for the families/carers of a bereaved/dying patient.
- The Quality Assurance Panel, which will oversee progress on the Quality Improvement Plan, is up and running.
- The revised Pneumonia Pathway should be agreed later this week.
- As per the AQUA report, the Trust is out-performing the regional average on 6 out of 8 sepsis indicators, which reflects the significant improvements implemented over recent months.
- An IT update highlighted that clinicians feel they are receiving better and more timely support from IT, which is resulting in earlier implementation of new/upgraded clinical IT systems.

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)

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB258/18**	**Report Title**	**Quality Improvement Plan Progress Update**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery & Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
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 the Quality Improvement Plan and progress made in relation to actions and recommendations identified following the Core Services and Well Led Care Quality Commission (CQC) Inspections in November / December 2017 and the unannounced responsive inspection of Urgent and Emergency Services in March 2018.

The report also includes the Trust's preparation plan for future regulatory visits and a programme of work to March 2019.

Recommendation:
The Board is asked to **receive** the report for assurance.

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)*

The plan will be continuously reviewed and updated as necessary.

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE

1. Purpose of Report

This paper provides the Trust Board with an update on the development of the 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 the unannounced responsive inspection of Urgent and Emergency Services in March 2018.

2. Background

As reported previously to the Trust Board, 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.

3. Urgent & Emergency Services Quality Improvement Plan

The CQC undertook an unannounced safe and responsive inspection of urgent and Emergency Care in March 2018. The CQC Quality Report was recently published in September 2018 which it made a number of recommendations including 12 Must Do regulatory actions and 11 Should Do actions, seven of the actions were identified as requirements at the previous inspection in November 2017 and are therefore already incorporated into the existing quality improvement plan. The Trust was asked to develop an improvement plan detailing the actions the Trust is taking to improve quality of care for patients as a result of the inspection findings. The plan was submitted to the CQC on 11 October 2018 and a copy of the Quality Improvement Action Plan can be found at **Appendix 1**.

Themes from the inspection actions identified for core services and urgent and emergency care 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

4. Update

A high level update on progress and delivery can be found below. The process for the sign off of completed actions has been reviewed and the Trust has adopted the assurance process described in Section 5. Following initial review and evaluation of supporting evidence, of the 97 improvement actions, 73 are currently rated amber (on track to deliver), 19 green (action completed) and five blue (delivered and sustained). This is an improvement from the previous month as three additional actions have moved from green to blue. The focus in November is to test and review evidence to identify additional amber actions which are on track to move to green as actions completed.

Trust overall BRAG rating

Rating	Must Do	Should Do	Total
Delivered and Sustained	3	2	5
Action Completed	7	12	19
On track to deliver	49	24	73
No progress / Not progressing to Plan	0	0	0
TOTAL	59	38	97

BRAG rating monthly reported completion

Rating	Baseline	June 18	July 18	August 18	Sept 18	Oct 18
Delivered and Sustained	0	1	1	1	2	5
Action Completed	0	0	6	22	21	19
On track to deliver	97	96	90	74	74	73
No progress / Not progressing to Plan	0	0	0	0	0	0

The Trust has also been asked to contribute to the factual accuracy checking of the draft CQC 'Review of Health Services for Children Looked After and Safeguarding in Sefton', the CCG was inspected in July 2018, a number of actions have been identified for the Trust and other provider organisations, progress will be monitored through the CCG Action Plan.

5. Compliance

The evidence and assurance process has been refreshed focusing on impact and sustained improvement in each area. This is reviewed by a Quality Assurance Panel and reported to Quality and Safety Committee and the Board for assurance. This will enable committees to challenge evidence of improvement

and sustainability in the long term. Going forward the Trust will also use *'Smartsheets'* to store improvement evidence and generate progress reports.

The first Quality Assurance Panel met on 10 October to review evidence for six actions, the panel was chaired by Director of Nursing, and included medical and nursing representatives from all clinical business units as well as corporate / operational representative. The groups discussed six items of improvements and agreed that five areas could be moved to blue subject to additional 'go and see' assurance visits, and one item was conformed as green however the panel recommended a number of actions to be completed prior to moving this item to blue. An example of a completed template can be found at **Appendix 2**.

The actions reviewed included:

- Improve the levels of nursing staff that have completed mandatory training in the Spinal Unit
- Ensure that patients' privacy dignity and respect is maintained at all times and that patients cannot be overseen or heard by inappropriate persons when receiving care and treatment
- Raise awareness of Female Genital Mutilation (FGM) in adult A&E and have an appropriate policy in place for these cases
- Ensure the Trust has an effective system in place to meet their legal obligations in relation to fit and proper persons employed at director level.
- Availability of oxygen and suction on all bed spaces in clinical areas.
- The Administration area for Community Midwives to be fit for the purpose for which it is being used, including provision for ensuring the privacy of a service user when speaking on the telephone and between professions.

6. Quality Improvement Delivery Groups

The Deputy Director of Nursing (Risk, Compliance & Engagement) is currently reviewing all of the Improvement Projects, to review the status, further information will be provided for Quality and Safety Committee to review on behalf of the Board, an update will be provided to Board in December 2018.

7. Quality Visit / Well Led Preparation

In October 2018, the Board approved the Trust's Preparation Plan for future regulatory inspections. The priority is to demonstrate improvement and ensure that all functions in the Trust are fully engaged with the regulatory requirements and process anticipating any core services and well led inspections in March 2019.

- Demonstrating improvement since 2017 in key areas identified in CQC report
- Shift safety of care domain in Urgent Care from Inadequate to Requires Improvement (RI) and well led from medical care and surgery from Inadequate to RI

- Reviewing standards across all core services in detail
- Reviewing evidence of improvement since 2017
- Developing a strong baseline for a future trajectory for a Good rating over next 2 years, which includes a focus on quality improvement methodology, quality improvement plan, culture, governance and leadership and engagement.

In order to ensure the above points are implemented, we have:

- Commenced an 'all core service' self-assessment process against the CQC's five domains and Key Lines of Enquiry (KLOE) to identify strengths, weaknesses and any gaps in compliance, this will also support the Trust's Business Planning process.
- In November 2018 a mock Provider Information Request (PIR) will also be undertaken at Trust level to ensure any gaps in system and processes are highlighted.
- A shadow Quality Review of core clinical services will take place in early December 2018, this will replicate a full unannounced CQC core service inspection.
- The Trust has also engaged external support from AQUA and MIAA to prepare for the Well Led aspect of the quality inspection.

8. Quality Summit

The Trust is holding a Quality Summit in January 2019 to support the relaunch of the quality priorities and progress against the quality improvement plan. It will also contribute towards the development of a quality improvement culture through showcasing best practice tools, the use of actual case studies (including Learning from Deaths and Reducing Avoidable Mortality) and giving recognition to staff who have delivered quality improvement. The event will introduce our quality partners including AQuA, NHSI, The Academy of Fabulous NHS Stuff and Quality Ambassadors. It will provide an opportunity to clearly demonstrate the golden thread of quality improvement from Board to Ward.

Recommendation

The Board is asked to **receive** progress identified in this report as **assurance** that systems and processes are in place to deliver quality improvement.

No	Source Document	Core Service	Must Do / Should Do	KLOE	Themes	Area for improvement	Actions to be delivered	Target Date	Executive Lead	Action Owner	Outcomes	Measure & Evidence	Status
98 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Safe & Effective Staffing	Ensure sufficient medical and nursing staff are deployed in the department to meet the need of patients. This was a requirement at our previous inspection in November 2017.	Complete staffing review to determine medical and nursing staffing requirements to deliver safe care Ensure rotas are completed a minimum six weeks in advanced and signed off by Matron / Directorate Manager Establish daily safer staffing huddles for nursing with additional meetings throughout day as required to review staffing and acuity.	Feb-19	Director of Nursing / Medical Director	Matron / Associate Medical Director	Appropriate numbers of medical and nursing staff with appropriate skill mix on duty on every shift Business case approved for increase of ED consultants from 6 to 10 WTE and Advanced Nurse Practitioners (ANPs and Physicians Assistants (PAs).	Staffing rotas (nursing) Staffing rotas (medics)	
99 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Access & Flow	Ensure patients are treated and cared for in an environment that meets their needs and protects their privacy and dignity. This was a requirement at out last inspection.	Ensure all policies and procedures are in place to minimise risk of patients being nursed on corridor i.e. Nursing on Corridor SOP, Full to Capacity Protocol, Trust Escalation Policy Audit ED patient safety checklist to ensure timely assessment of where patient is being nursed is undertaken Complete ED estates work to ensure patients cared for in an environment that meets their needs and protects their privacy and dignity. Opening of SAU to stream surgical patients from ED and use of ACU to stream ambulatory patients Business case to be approved and presented at HMB to increase opening times of ACU to maximise streaming from ED Monitor CDU activity Increased triage capacity and open enhanced care needs room Develop dashboard and review weekly with a number of metrics including 4-hour performance, corridor usage and increase visibility of pressures in department across the Trust	31 Oct 18 13 Sept 18 9 Oct 18 Dec 18	Director of Nursing	Matron / Associate Medical Director	ED estate more appropriate to meet patient's needs and protects their privacy and dignity. Patients not to be nursed on corridors	Matrons Checklist Dashboard to review a number of metrics including 4-hour performance, corridor usage and increase visibility of pressures in department across the Trust Patient feedback / complaints	
108 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Access & Flow	Ensure patients receiving treatment have privacy and their dignity respected. This was a requirement from our previous inspection in November 2017.	Ensure all policies and procedures are in place to minimise risk of patients being nursed on corridor i.e. Nursing on Corridor SOP, Full to Capacity Protocol, Trust Escalation Policy Audit ED patient safety checklist to ensure timely assessment of where patient is being nursed is undertaken Complete ED estates work to ensure patients cared for in an environment that meets their needs and protects their privacy and dignity. Opening of SAU to stream surgical patients from ED and use of ACU to stream ambulatory patients Business case to be approved and presented at HMB to increase opening times of ACU to maximise streaming from ED Monitor CDU activity Increased triage capacity and open enhanced care needs room Develop dashboard and review weekly with a number of metrics including 4-hour performance, corridor usage and increase visibility of pressures in department across the Trust	31 Oct 18 13 Sept 18 9 Oct 18 Dec 18	Director of Nursing	Matron / Associate Medical Director	ED estate more appropriate to meet patient's needs and protects their privacy and dignity. Patients not to be nursed on corridors	Matrons Checklist Dashboard to review a number of metrics including 4-hour performance, corridor usage and increase visibility of pressures in department across the Trust Patient feedback / complaints	
105 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	RESPONSIVE	Access & Flow	Improve the escalation process to ensure senior decision makers are involved in the process as soon as possible. This was a requirement at our last inspection in November 2017.	Ensure all policies and procedures are in place to minimise risk of patients being nursed on corridor i.e. Nursing on Corridor SOP, Full to Capacity Protocol, Trust Escalation Policy Monitor CDU activity Develop dashboard and review weekly with a number of metrics including 4-hour performance, corridor usage and increase visibility of pressures in department across the Trust	31 Oct 18 Dec 18	Chief Operating Officer	Associate Director of Operations	Reduction in people being nursed in the corridor Utilisation of safety hub Full capacity protocol in use and fit for purpose	Audit of escalation process	
100 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Medicines Management	Prescribe and administer pain relief in a timely way to ensure patients are not left in pain for long periods of time. This was a requirement at our last inspection in November 2017.	Agree PGD for management of pain relief including timely administration Develop Training Programme and Implementation Plan All band 6s and 7s completing PGD training online and are assessed in clinical practice Audit to ensure compliance with timely administration	1 Oct 18 Commenced Target 30 Nov 18 January 19	Director of Nursing / Medical Director	Matron / Associate Medical Director	PGDs agreed and in place. All band 6s and 7s completing PGD training online and are assessed in clinical practice Reduction in complaints regarding pain management	Annual Audit with pharmacy % Trained PGDs Audit of timeliness of administration of pain relief Patient feedback / complaints	

No	Source Document	Core Service	Must Do / Should Do	KLOE	Themes	Area for improvement	Actions to be delivered	Target Date	Executive Lead	Action Owner	Outcomes	Measure & Evidence	Status
106 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Medicines Management	Make sure processes for the management of medicines is robust, that expired drugs are removed and replaced and oral medicines are dates and disposed of once expired. This was a requirement at our previous inspection in November 2017.	Identify and Monitor effectiveness of dedicated Pharmacy technician to work with ED Complete stock , storage and expiry date check twice weekly and evidence Controlled drugs checked daily and review stock and evidence	Dec-18	Medical Director	Associate Medical Director	Robust medicines management process and policy in place regular audits planned	Secure dedicated pharmacy technician for ED with clear roles and responsibilities Medicines management safety audits to be undertaken and remedial actions identified and implemented	
103 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	IPC	Adhere to infection prevention and control standards including cleaning of rooms, and follow hand hygiene and other infection control processes. This was a requirement at our last inspection in November 2017.	Practice Educator to continuing with hand hygiene training Replace curtains with disposable curtains Review of 24/7 housekeeper / assistant available in ED. Daily monitoring of the environment HON of nursing to meet IPC team to review IPC input	Sept 18 March 18 April 18 ongoing	Medical Director	Matron / Associate Medical Director	Improved IPC standards across the ED Improved Standards of cleanliness across the ED	Improvement of HEAT inspection scores. Daily environment audits IPC KPI compliance	
109 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Access & Flow	Ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department.	Opening of SAU to stream surgical patients from ED and use of ACU to stream ambulatory patients Open new CDU Increased triage capacity and open enhanced care needs room (due for completion Dec 18.) Revise Nursing on Corridor SOP, Full to Capacity Protocol, Escalation to ensure consistency. Develop dashboard and review weekly with a number of metrics including 4-hour performance, corridor usage and increase visibility of pressures in department across the Trust Complete ED estates work to ensure patients cared for in an environment that meets their needs and protects their privacy and dignity.	 31 Oct 18 13 Sept 18 9 Oct 18 Dec 18	Chief Operating Officer	Associate Director of Operations	estates work completed to support patient flow monitoring of flow via safety hub SOPs in place	audit of SOP KPI re usage of SAU/ACU/CDU Audit ED safety checklist Audit of full capacity protocol (table top exercise)	
101 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Access & Flow	Improve the triage process and take responsibility for patients brought to the department by ambulance as soon as handover has been carried out, administer their medicines and manage their needs. Staff must follow national guidance and patient pathways to ensure patients receive treatment that meets best practice.	Complete estate redesign to expand triage capacity as current triage room is unable to meet demand in attendances and improve ambulance handover times by separating ambulance and walk in presentations Introduction of triage training competency framework Train staff using competency framework and raise awareness of national guidance and patient pathways Continue to monitor handover times (in partnership with NWAS)	31 Oct 18 1 Sept 18 30 Nov 18 Ongoing	Director of Nursing / Medical Director	Matron / Associate Medical Director	Improved timely triage process in place More appropriate environment for patients to be triaged following ambulance handover National guidance and patient pathways adhered to	Reduction in ambulance handover times % triage compliant Completions of Complete ED estates work to ensure patients cared for in an environment that meets their needs and protects their privacy and	
107 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Access & Flow	Ensure all staff follow the same triage process and assess patients in order of urgency and not chronology.	Complete estate redesign to expand triage capacity as current triage room is unable to meet demand in attendances and improve ambulance handover times by separating ambulance and walk in presentations Introduction of triage training competency framework Train staff using competency framework and raise awareness of national guidance and patient pathways Continue to monitor handover times (in partnership with NWAS)	31 Oct 18 1 Sept 18 30 Nov 18 Ongoing	Director of Nursing / Medical Director	Matron / Associate Medical Director	Improved timely triage process in place More appropriate environment for patients to be triaged following ambulance handover National guidance and patient pathways adhered to	Reduction in ambulance handover times % triage compliant Completions of Complete ED estates work to ensure patients cared for in an environment that meets their needs and protects their privacy and dignity.	
102 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Documentation	Improve the quality of record keeping. This include completion of risk assessments, NEWS, safeguarding and capacity assessments and storage of paper records to ensure no information is lost or misfiled.	Complete roll out and improvement in new patient documentation Complete spot check audits to ensure documentation is being completed correctly Complete audit of appropriate risk assessment and commencement of relevant documentation Raise awareness of storage of patient documentation as part of huddle Introduction of Vital Pac to remove lose leaf documentation and electronically store patient information	July 18 8 Oct 18 31 Oct 18 Dec 18	Director of Nursing / Medical Director	Matron / Associate Medical Director	Improved quality of record keeping (accuracy) Improved storage of records within the department	Results of MCA / DoLs quarterly audits Results of documentation audits (October 18) .	
104 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	SAFE	Data Validation	Improve data validation oversight and validation.	Map ED data collection systems and processes Review and develop data quality function and sign off process	Apr-18	Director of Finance	Head of Business Intelligence	Improved data validation function in place	Minutes from IG steering group and IMT	

No	Source Document	Core Service	Must Do / Should Do	KLOE	Themes	Area for improvement	Actions to be delivered	Target Date	Executive Lead	Action Owner	Outcomes	Measure & Evidence	Status
110 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Must Do	RESPONSIVE	Access & Flow	Work collaboratively with other departments around the hospital to improve the length of time patients wait to see specialist medical staff and reduce the length of time before a decision whether to admit or not is made.	Opening of SAU to stream surgical patients from ED and use of ACU to stream ambulatory patients Open new CDU Expand frailty team to in-reach into ED to expand to 7 day service Agree and implement Internal Professional Standards	 20 Sept 18 Oct 18	Chief Operating Officer	Associate Director of Operations	Patients cared for by appropriate speciality in appropriate location frailty team visible in AE Ownership of internal professional standards from all specialties across the Trust.	SAU operational process and data relating to admissions and conversions to in patient Review delays of 4 and 12 hr breaches and RCAs Audit response times from specialties	
111 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Medicines Management	Work towards a system that allows simple medicines such as pain relief to be given without the need for a doctors prescription as this will enable patients to receive timely pain relief	Agree PGD for management of pain relief including timely administration Develop Training Programme and Implementation Plan All band 6s and 7s completing PGD training online and are assessed in clinical practice Audit to ensure compliance with timely administration	1 Oct 18 Commenced Target 30 Nov 18 January 19	Director of Nursing / Medical Director	Matron / Associate Medical Director	PGDs agreed and in place. All band 6s and 7s completing PGD training online and are assessed in clinical practice Reduction in complaints regarding pain management	Annual Audit with pharmacy % Trained PGDs Audit of timeliness of administration of pain relief Patient feedback / complaints	
112 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Medicines Management	Ensure the ambient temperature of the medicines storage room is monitored to make sure medicines are stored within their accepted temperature range.	Identify and Monitor effectiveness of dedicated Pharmacy technician to work with ED Complete stock , storage and expiry date check twice weekly and evidence	Dec-18	Medical Director	Associate Medical Director	Robust medicines management process and policy in place regular audits planned	Secure dedicated pharmacy technician for ED with clear roles and responsibilities Medicines management safety audit to be undertaken and remedial actions identified and implemented Fridge and room temperatures	
116 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Medicines Management	Monitor ambient temperature in drug rooms to ensure medicines are stored within their recommended temperature ranges.	Identify and Monitor effectiveness of dedicated Pharmacy technician to work with ED Complete stock , storage and expiry date check twice weekly and evidence	Dec-18	Medical Director	Associate Medical Director	Robust medicines management process and policy in place regular audits planned	Secure dedicated pharmacy technician for ED with clear roles and responsibilities Medicines management safety audit to be undertaken and	
118 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Medicines Management	Have a robust process to make sure controlled drugs are routinely checked in line with trust policy.	Identify and Monitor effectiveness of dedicated Pharmacy technician to work with ED Complete stock , storage and expiry date check twice weekly and evidence Controlled drugs checked daily and review stock and evidence	Dec-18	Medical Director	Associate Medical Director	Robust medicines management process and policy in place regular audits planned	Secure dedicated pharmacy technician for ED with clear roles and responsibilities Medicines management safety audits to be undertaken and remedial actions identified and implemented	
113 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Safe & Effective Staffing	Continue the work being carried out to ensure are staff attend their mandatory training in a timely manner.	Practice Educator to support mandatory training compliance Ensure departmental performance against target is visible at all times Targeted training to ED staff not compliant to be rolled out by Practice Educator. Compliance monitored at ward managers monthly communications meeting Undertake data cleansing exercised re medic compliance (this is also picked up through medical appraisal)	Dec-18	Associate Director of HR	Matron	Mandatory training compliance in line with target	Mandatory training complete as per plan	
114 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	IPC	Consider having a robust process in place to ensure cannulas are checked for early signs of infection by staff within the department in line with best practice.	Cannulation sites should be checked as per protocol prior to fluids or medications Audit ED patient safety checklist to ensure hourly assessment of where patient is being nursed is undertaken Introduction of Vital Pac to evidence cannulation checks as part of routine observations	DATE	Medical Director	Associate Medical Director	Patient safety checklist compliance evidence of cannulation checks	Audit of cannulation checks complete Patient safety checklist in use & audit Review and audit data following roll out of vital pac	
115 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Medicines Management	Have a robust system in place to support patients who are self-medicating in the department whilst waiting for treatment.	Ensure patients who have their own medicines have this documented on the prescription chart Adhere to Trust self medication policy and undertake staff awareness training	Nov-18	Director of Nursing	Matron	Patients own medications stored appropriately and returned to patient/transferred with patient as needed Documentation of agreement from patient to self medicate	Audit of self medication policy	
117 [2018]	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Medicines Management	Have a process for monitoring the compliance of staff against the hospital policy of prescribing all oxygen.	Identify clinical lead to lead Trust wide oxygen audit Clinical audit team to support clinical lead Raise awareness of oxygen prescribing through staff huddles to prompt medics to prescribe timely Implement session at medical / clinical induction programme re oxygen prescribing	Dec-18	Medical Director	Associate Medical Director	Oxygen prescriptions compliant with policy Audit undertaken and actioned	Audit of oxygen prescribing	

No	Source Document	Core Service	Must Do / Should Do	KLOE	Themes	Area for improvement	Actions to be delivered	Target Date	Executive Lead	Action Owner	Outcomes	Measure & Evidence	Status
119 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Deteriorating Patient	Have a robust process for making sure all appropriate sepsis patients are started on the sepsis pathway in line with best practice and be able to evidence compliance.	Launch revised sepsis pathway within ED Ensure all staff are trained in Sepsis pathway Monitor compliance in sepsis pathway through monthly audits	Nov-18	Medical Director	Associate Medical Director	Pathway launched and staff educated documentation evidence of pathway followed Safety Nurses to continue ongoing audits	Audit s and lessons learnt shared (RCEN and CQUIN)	
120 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Access & Flow	Ensure 'corridor' nurses are fully aware of the 'tag' process should they need to leave their designated corridor area.	SOP in place in the event that the corridor has to be utilised; Weekly monitoring of corridor usage; Awareness across the Trust of EDs escalation status real time including the number of patients on the corridor; Revise Nursing on Corridor SOP, Full to Capacity Protocol, Escalation to ensure consistency. Audit ED patient safety checklist to ensure hourly assessment of where patient is being nursed is undertaken Complete ED estates work to ensure patients cared for in an environment that meets their needs and protects their privacy and dignity. Develop dashboard and review weekly with a number of metrics including 4-hour performance, corridor usage and increase visibility of pressures in department across the Trust Appropriate handover of corridor patients as per SOP	Dec-18	Director of Nursing	Matron	Patients are safe and cared for when corridor is utilised dashboard developed and visible	Audit SOP dashboard in place	
121 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	SAFE	Access & Flow	Consider raising the profile of patients living with dementia or a learning disability to improve the support they receive in the department.	Use of AMT 4 (capacity test) on medical proforma to identify patients Introduction of red bag scheme (nursing homes) and raise awareness of patients to use passports Explore use of red flag for patients with dementia and LD Open enhanced care needs room to support patients with dementia (e.g. quiet room, arm chair, softer lighting) Identify dementia champion leads in ED Recruit to Head of Older People's Care with the Trust Increase the number of HCAs attending dementia training Consider creating photo albums and using bus stop in Observation ward	Dec-18	Director of Nursing	Matron	Head of Older Peoples care in post Diversional therapy tools in place and used within dep	Local dementia care audit performed Patient feedback and complaints	
122 (2018)	Southport and Ormskirk Hospital NHS Trust ED Inspection Report 2018	Urgent & Emergency Services	Should Do	RESPONSIVE	Access & Flow	Explore alternative ways of discharging patients waiting for social care packages to improve flow through the department.	Increase the levels of support from frailty team in reaching into ED Ensure Anticipatory care planning is in place to support alternatives to ED attendance/ admission Use frequent attenders group to review and agree plans in place to support patients identified as having frequent attendances (e.g. care plans in place for mental health patients) Open CDU to release some capacity in Observation ward to enable Observation ward to support patients requiring input from social teams, linking in with crisis support Establish Trust weekly length of stay meetings Trust to piloting 'home first'	Mar-19	Chief Operating Officer	Associate Director of Operations	Frailty team visible within ED frequent attenders reviewed and case managed as needed with key stakeholders	Discharge audit/figures reduced delays in transfers of care	

Delivered and Sustained
Action Completed
On track to deliver
No progress / Not progressing to Plan

Low
Moderate
High
Extreme

Southport and Ormskirk Hospital NHS Trust

Appendix 2

Urgent Care Action 'SHOULD DO' 54 - *Example*

CQC Reference 54	Action	Owner	Regulation
	The provider should raise awareness of FGM and have an appropriate policy in place for these cases.	*J Lawson – Matron*	*Regulation 13: Safeguarding service users from abuse and improper treatment*

2017 Report - The Trust had a local policy to guide the care and treatment and reporting of any incident of female genital mutilation (FGM). The policy contained the national pathway to be followed when seeing a patient who disclosed FGM or plans to undergo FGM. The trust's policy indicated that staff should complete an incident report via the Trust's incident reporting system should a women reporting FGM be seen. This would also trigger the national dataset to be completed and to be returned quarterly in line with national policy. Where appropriate a safeguarding referral would be made. The trust told us that all clinical staff had received some level of FGM awareness from mandatory safeguarding training. However, the department did not have the flowchart and staff were not aware of the process to follow in suspected or actual cases of FGM.

- *Spot checks March 18, May 18, July 18, Oct 18 FGM posters available / on display in ED*
- *ED Staff Safeguarding compliance Nursing Level 2 (July 18) 97%, Medics Level 2 85.19%*
- *FGM included in Adults and Children's Training*
- *Policy in Place.*

CQC noted compliance in March 2018 Report

- Following the last inspection, we wanted to make sure that staff had undergone training about domestic violence and female genital mutilation (FGM). We spoke with staff about safeguarding vulnerable people.
- Staff told us that domestic violence and female genital mutilation were included in safeguarding vulnerable people training. The staff we spoke with could tell us about female genital mutilation and the action they would take if they came across a victim or someone they had concerns about.
- There were laminated flyers and leaflets in the majors department and resuscitation department to support staff and to give to patients.

Policy	**Adults:** **In date :** *Yes* **Next Review :** *March 2019* **Review Process:** **Children :** **In date :** *Yes* **Next Review :** *July 2020* **Review Process:**		
Compliance	*CQC noted compliance in March 2018 Emergency Department Quality Report* *New Assistant Director of Safeguarding to review policy in relation to flowchart and content of training* *To test FGM knowledge / reporting and procedures in ED department (Oct / Nov 2018)* *Posters displayed in ED*		
Improvement (Audits or KPI's)	*Continue to achieve target, increase compliance to <90% - targeted training for non-compliance* *Safeguarding Teams to continue to visit ED on both sites to discuss FGM / test knowledge*		
Next Review	Review by Assistant Director of Safeguarding, ED Matron and Children's Safeguarding Lead		
Signed By: **Action Lead** **Panel Chair**	 *J Lawson* *J Cosgrove*	**Date**: *10.10.18*	**Assurance Forum:** Assurance Panel
Recommendation from Panel: To approve move from Green to Blue			

Review FGM awareness in Maternity, Gynae and Paeds, Sexual Health going forward to demonstrate improvement and Trust wide compliance

Share best practice from Trusts such as Liverpool Women's Hospital and derby Hospital regarding c

Further Assurance required:

ED Matron and Assistant Director of Safeguarding to ensure continued compliance

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
7 November 2018

Agenda Item	TB259/18	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

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 4 2017/18
- Hospital Standardised Mortality Ratio (HSMR) - May 2018
- Disease-Specific Mortality – May 2018
- Mortality Dashboard Highlights – August 2018

Reducing Avoidable Mortality (RAM) Project
An update is given on activity by project work stream, key risks and milestones in the project tracker.

Recommendation:

The Board 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.

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 ☐ 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)*

The Mortality Report to the December Trust Board will incorporate the quarterly Learning from Deaths Report.

Previously Presented at:

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

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 third month have been reported at 59.7%; only a marginal increase after an encouraging start in months one and two. Paper based mortality screening in the Trust will be discontinued in its entirety in the month of November, ensuring that all mortality reviews are undertaken with the SJR methodology through the Datix system.</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. 4 2017/18</td><td>May 2018</td><td>May 2018</td><td>August 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>4.0</td><td>Mortality Dashboard Highlights</td><td>A narrative is provided against highlighted points taken from the Mortality Dashboard for the reporting month of August.</td></tr>
<tr><td>5.0</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>6.0</td><td colspan="2">Format of Report</td></tr>
<tr><td>7.0</td><td colspan="2">Conclusion & Recommendations</td></tr>
<tr><td colspan="3">Appendices</td></tr>
<tr><td></td><td>Appendix 1</td><td>Mortality Dashboard Highlight Report, October 2018 reporting on the month of August 2018</td></tr>
</table>

1.0 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]

2.0 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 third month of the roll out of the SJR method, 59.7% of deaths were screened using the in-house tool. Further work is required to drive an increased rate of uptake and compliance for which a target of 80% had been set for October 2018.

The RCP recommends that the expected level of deaths triggered for an SJR review should between 10% and 20%; the tool will be revised to reduce sensitivity to reflect this after this change has been approved by the Mortality Operational Group on 12th November 2018.

Mortality Screening Summary - 03/10/2018

Month	No of Deaths	No of Deaths Screened	% Screened	No Triggering for SJR Review	% Triggering for Review	Trigger based on revised criteria	% Triggering for Review revised criteria
July	77	30	39.0%	18	60%	5	17%
August	66	38	57.6%	25	66%	7	18%
September	72	43	59.7%	33	77%	9	21%

Reasons for Trigger for Review

Month	No Triggering for SJR Review	Respiratory	Urological Infection	Sepsis	Coroner	Operative Procedure last 30 days	Inpatient Assessment by psychiatric services	Learning Disability	Doctor Concerns Identified
July	18	13	2	6	5	3	0	0	0
August	25	16	3	4	8	2	1	1	1
September	33	20	0	8	17	3	0	1	0

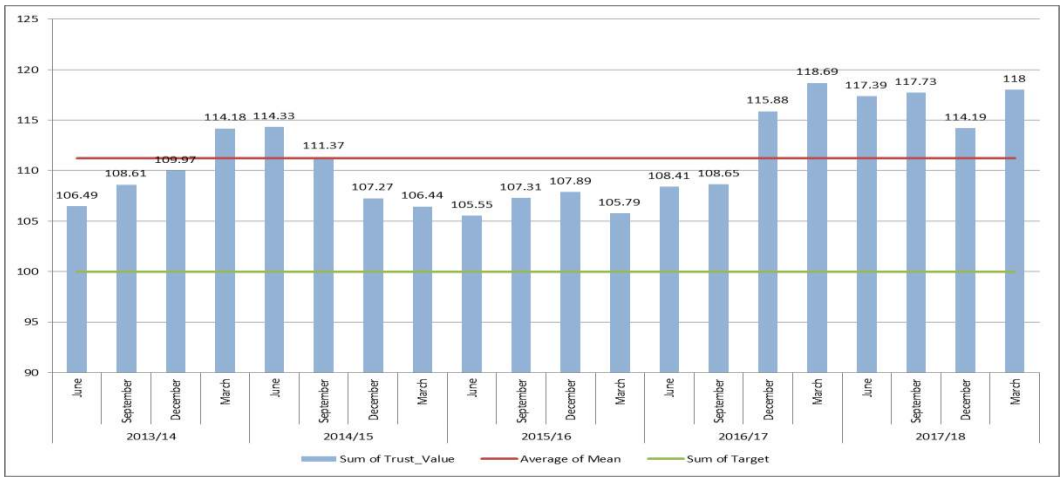
Planned Care transitioned to SJR Reviews as of Monday 1st October and Urgent Care will follow suit on Monday 5th November. All paper based mortality reviews will have ceased from this point.

3.0 Measuring Mortality

[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).'

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

The following table reports the SHMI for rolling 12 month period for Quarter 4 is 118. This ratio has been calculated from a total of 1,381 actual deaths over an expected figure of 1,170. Although higher than last quarter this was expected given the high crude death rate already reported in this period. It should be noted that this rate is actually lower than the comparable period last year and the underlying data demonstrates an actual reduction in observed deaths in the period (1,381 vs 1,392).



SHMI

The SHMI ratios for Quarter 1 2018/19 will be available in December. The graph below gives a prediction for the SHMI for the next two reportable quarters. These are based upon local data and show that quarter 1 will be similar to quarter 4 but there will be a reduction in quarter 2.

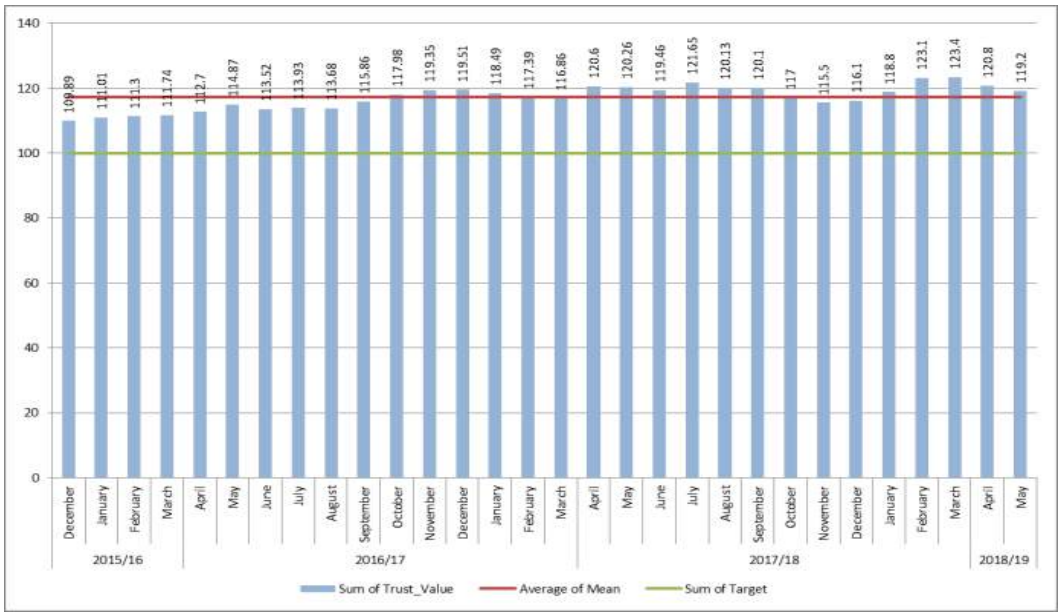
[2] The SHMI is reported quarterly and is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which 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

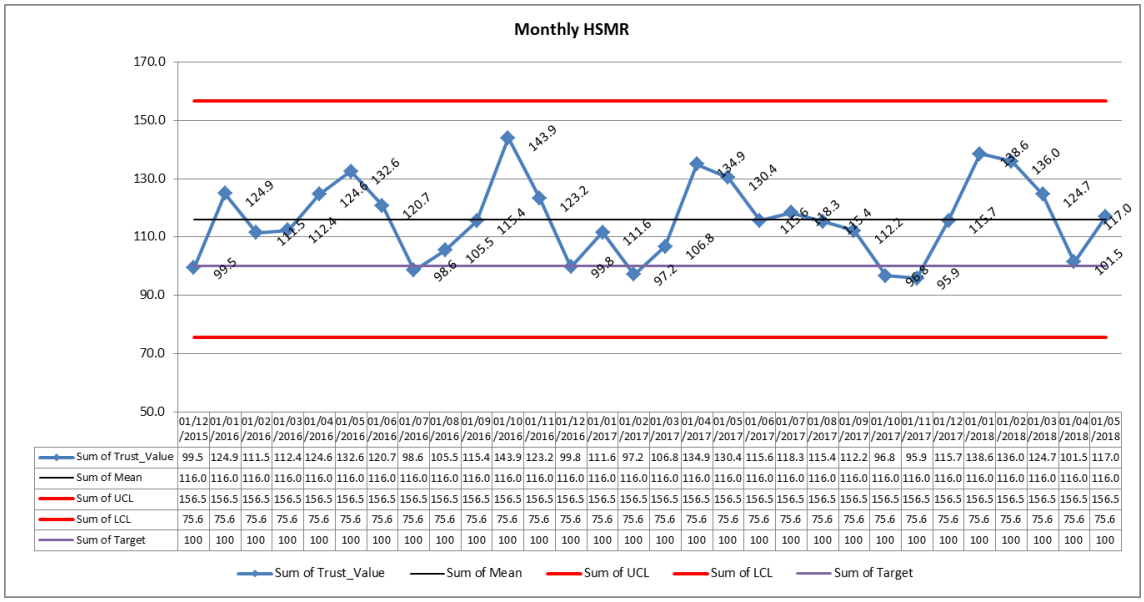
The HSMR is provided nationally by 'Dr Foster' and applies to in-hospital mortality (excluding palliative care). The 12 month rolling HSMR for May was 119.2.

The HSMR for May 2018 was slightly down on the previous month and is the second consecutive reduction in a row. This is in line with a decline in the crude death rate (from 30.37 per 1,000 discharges in April to 28.98 in May). The diagnostic areas attributable for the decline in May were: renal failure, pneumonia and Urinary tract infections.



'In Month HSMR'

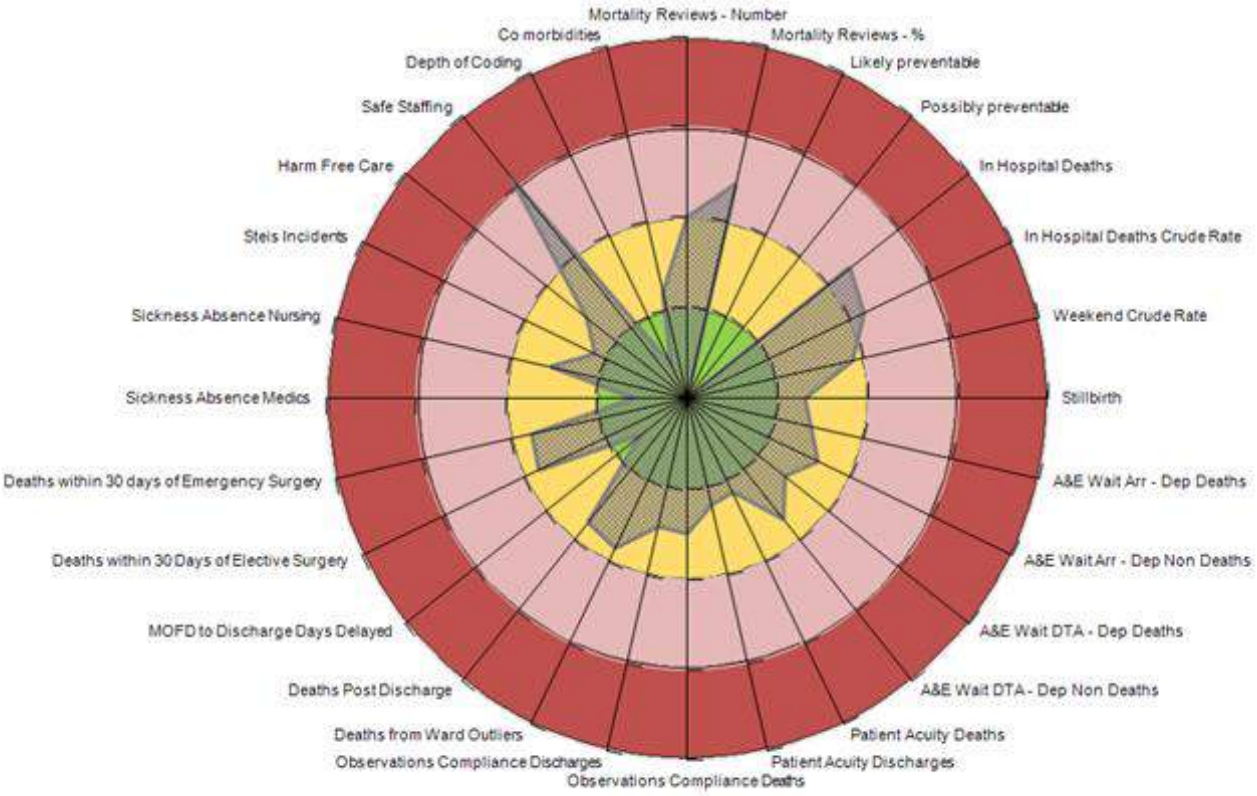
In the graph below, the 'in month' HSMR is tracked (this is the measure of in month performance only and does not take into consideration the previous 11 months). The HSMR increased from 101.5 in April to 117 in May. The performance distribution chart for May (below) highlights the key indicators (safe staffing & in hospital deaths) which are attributable to the decreased 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	01/05/2018
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	124.7	101.5	117.0
Sum of Mean	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0	116.0
Sum of UCL	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5	156.5
Sum of LCL	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6	75.6
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	100

The performance distribution chart below shows the two key areas of poor performance which contribute to the increase in HSMR in the month – staffing (fell by 1%), hospital deaths (11 more than last month. There were notable improvements in the A&E waiting times and the number of days lost to MOFD patients waiting to be discharged.

Performance Distribution for May 2018/19
HSMR Value in Month: 117



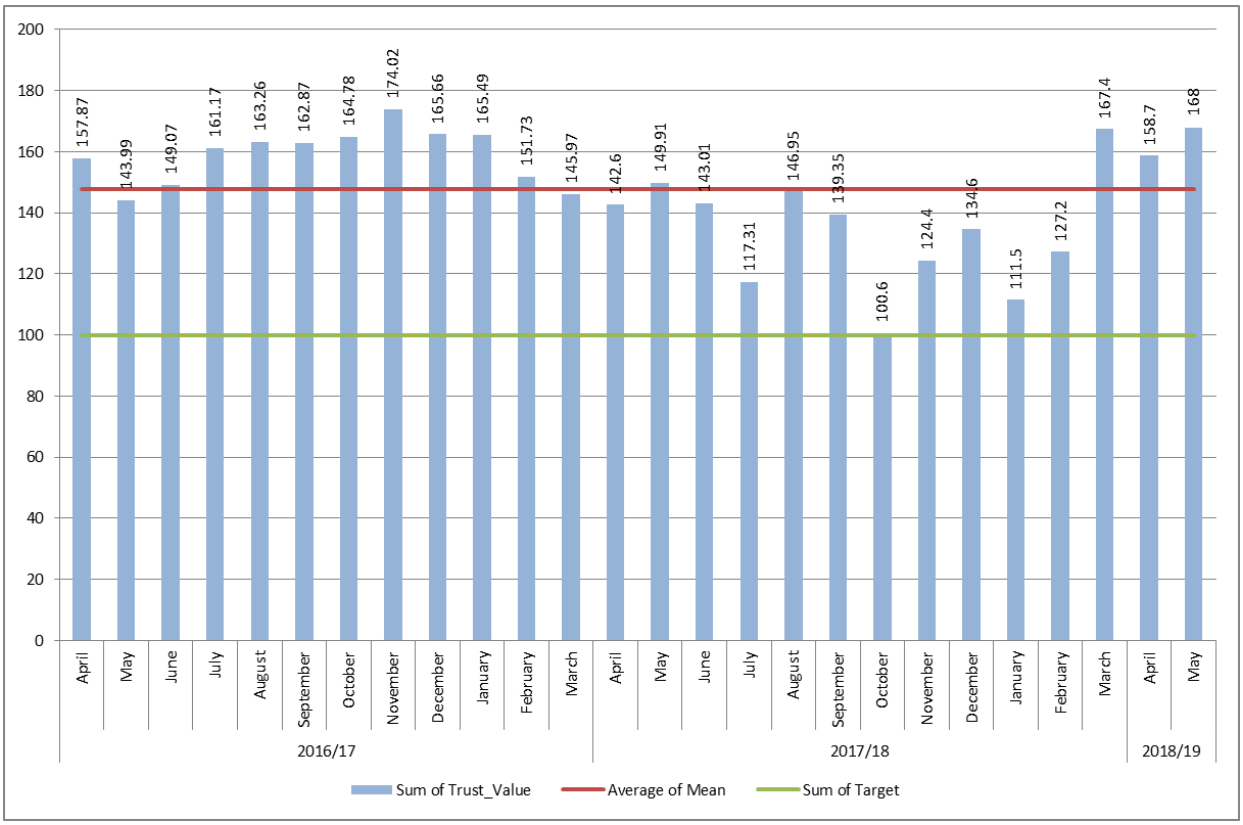
3.3 Disease-Specific Mortality – May 2018

3.3.1 Lower Respiratory Tract Infection, Acute Bronchitis & Pneumonia

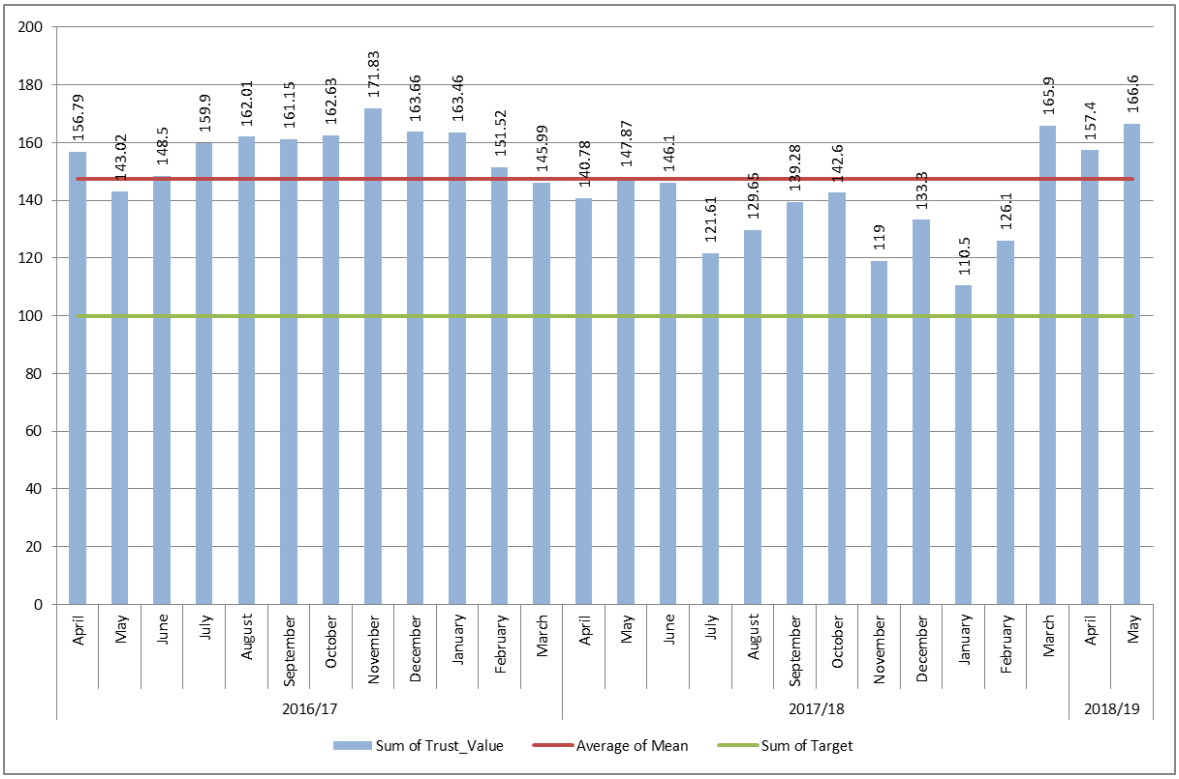
The rolling 12 month local Standardised Mortality Rate (SMR) for:

- Lower Respiratory Tract Infection (LRTI) was 168 for May.
- Acute Bronchitis was recorded at 166.6 for the same month.
- Pneumonia SMR was 135.1 for May, a reduction on April.

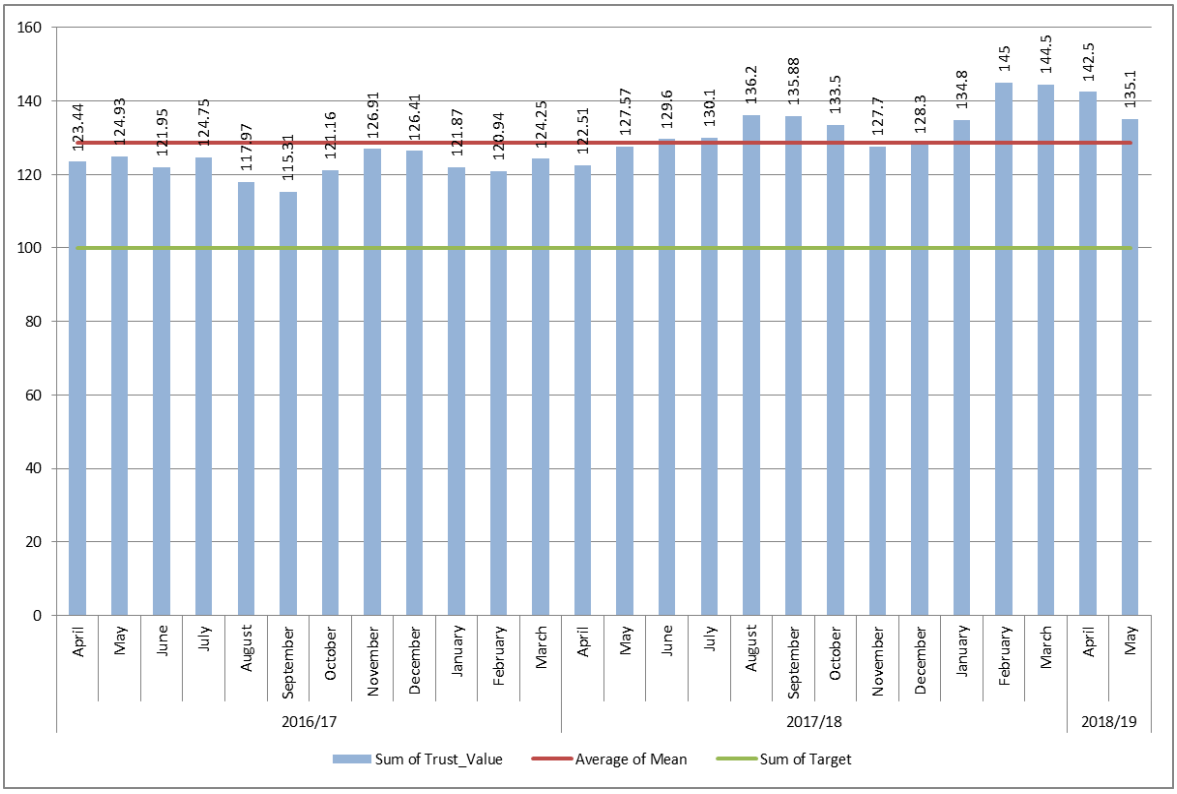
It is recognised that elderly patients with numerous comorbidities who are sedentary because of illness are particularly susceptible to lower respiratory tract infections. A revised pneumonia pathway is currently being scoped which will incorporate new processes to ensure that patients are given the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



Lower Respiratory Tract Infection



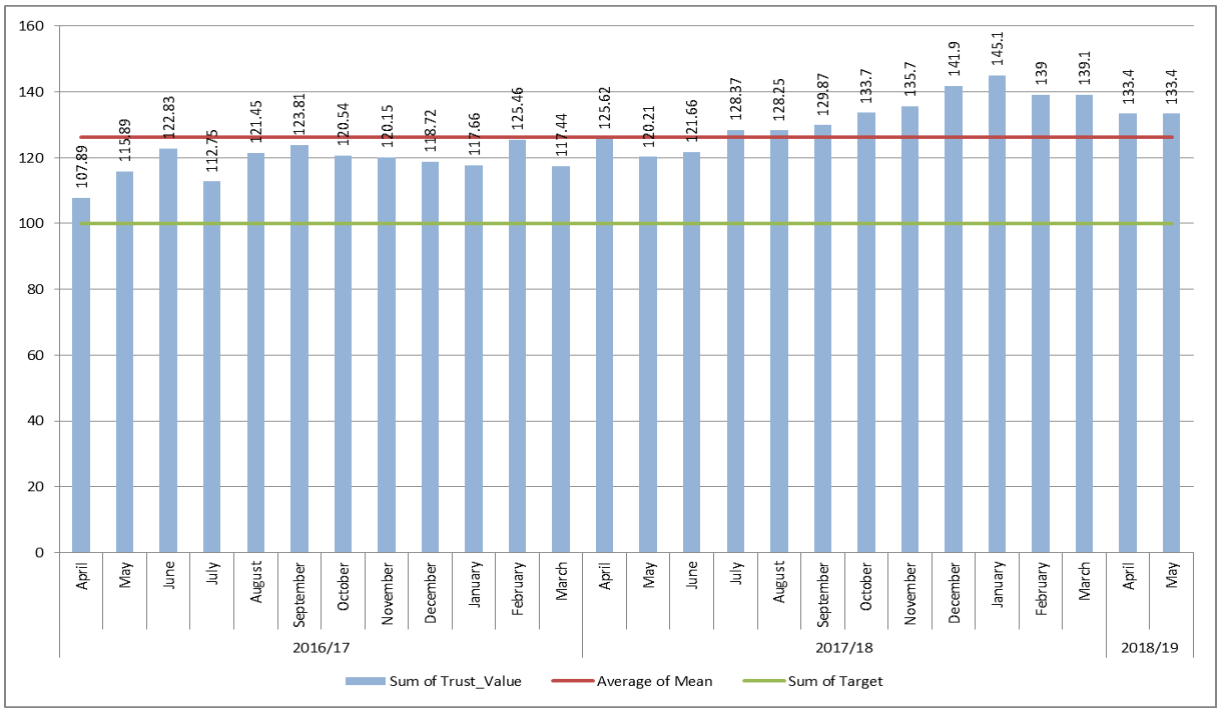
Acute Bronchitis



Pneumonia

3.3.2 Stroke

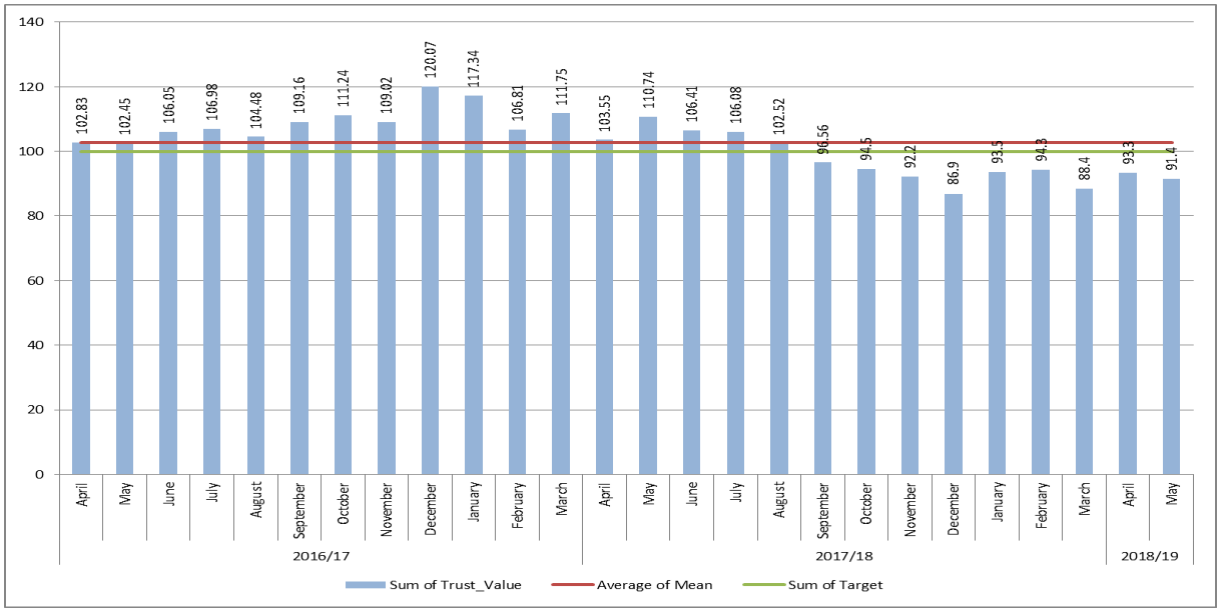
The SMR for Stroke is recorded as 133.4 for May which is the same as the previous month and the lowest ratio since November 2017.



Stroke

3.3.3 Septicemia (Except in Labour)

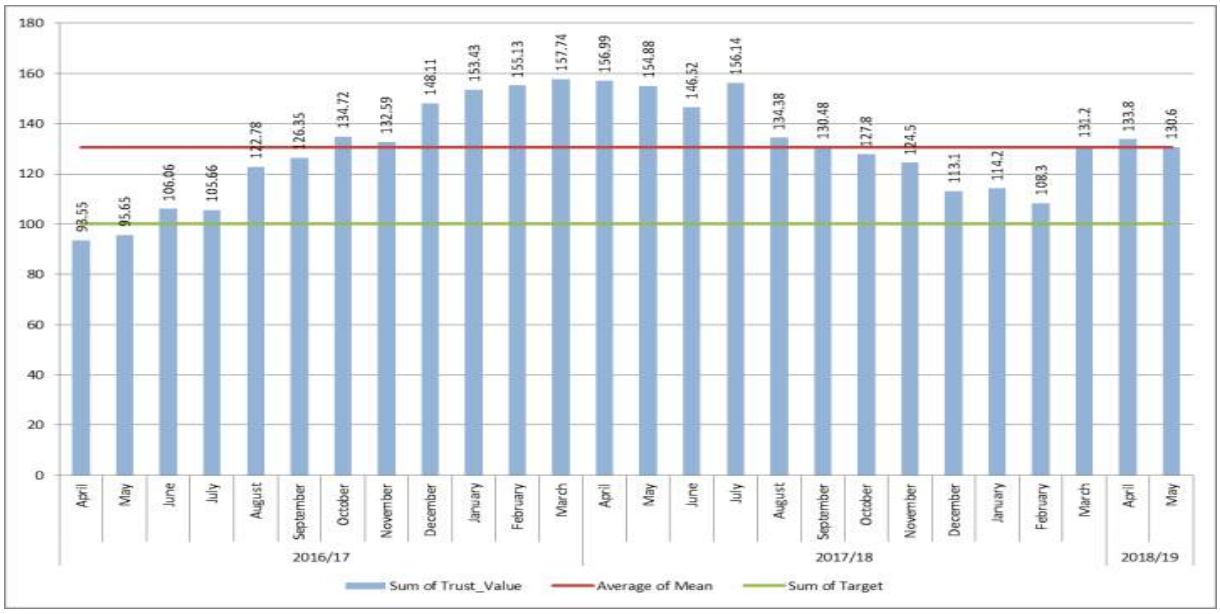
The ratio for sepsis for May remained below 100 for the eighth consecutive month at 91.4.



Septicemia

3.3.4 Urinary Tract Infection

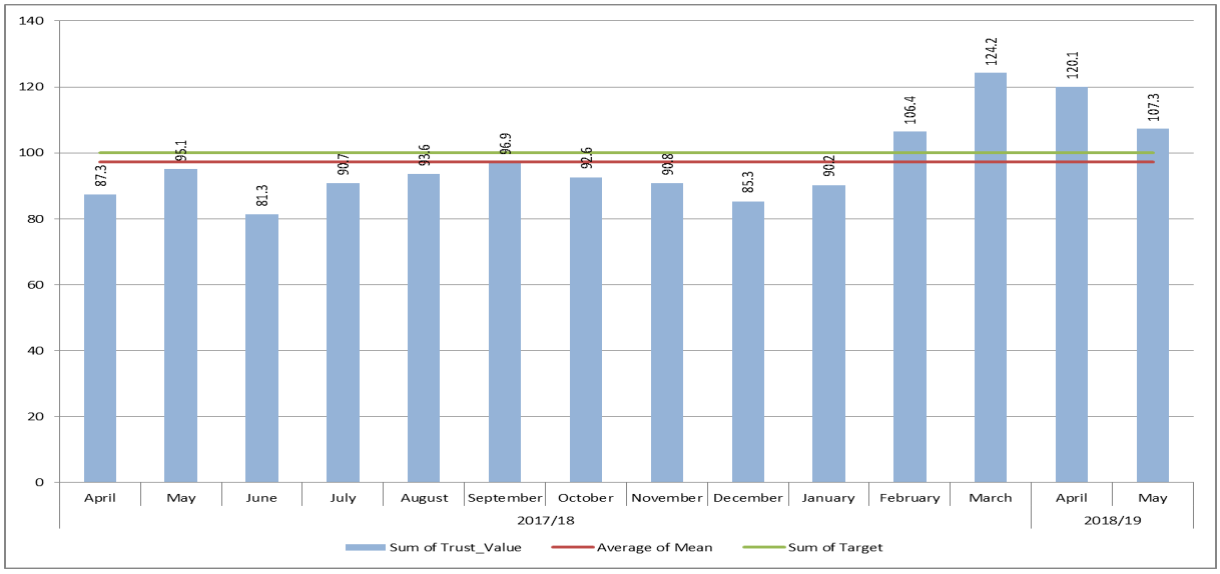
The rolling 12 month SMR for Urinary Tract Infection for May was 130.6.



Urinary Tract Infection

3.3.5 Acute Kidney Injury

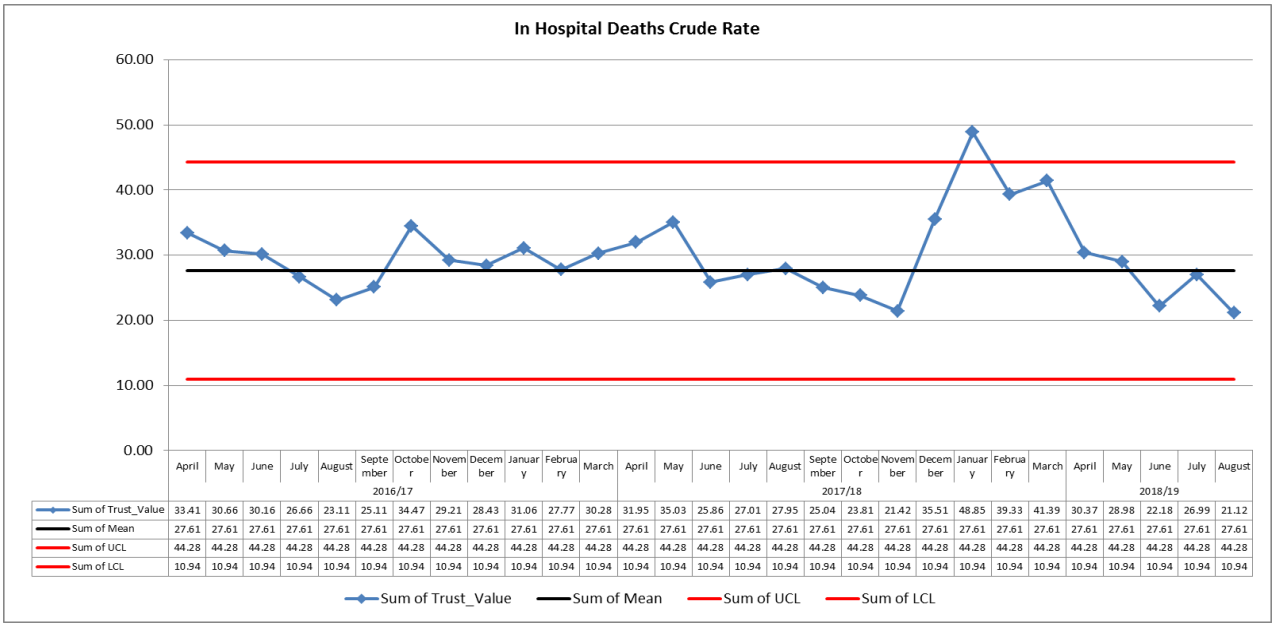
The 12 month rolling SMR for May was 107.3. The clinical pathway for Acute Kidney Injury is currently being rolled out across the Trust as part of the new Deteriorating Patient Trolleys.



Acute Kidney Injury

3.4 Crude Mortality:

The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for August was 21.12. 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	August
	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	25.04	23.81	21.42	35.51	48.85	39.33	41.39	30.37	28.98	22.18	26.99	21.12
Sum of Mean	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61	27.61
Sum of UCL	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28	44.28
Sum of LCL	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94

4.0 Mortality Dashboard Highlights – August 2018

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

4.2 There was one learning disability death for the month of August; the total for the year to date (from April 2018) totals three. 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.

4.3 The percentage of patients who received harm free care whilst staying in the Trust in August 2018 dropped to 94.4% (95.9% for Urgent Care and 93.33% for Planned Care) from 96.20% in July. (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).

4.4 Four patients whose deaths were recorded in August had been ward outliers during their in-patient stay in the Trust; this was a reduction from July when there had been 12. There has been a significant reduction since winter 2017/18 which has been in line with improvements in patient flow.

4.5 Improvement with compliance with observation has plateaued at about 60% compliance. NEWS2 implementation planned for January 2019 will provide an opportunity for redesign of the observation frequency and clinical escalation policy (Track and Trigger). Work to design this implementation programme is to be incorporated as the next stage of the Reducing Avoidable Mortality Project.

4.6 There were 21 deaths within 30 days of discharge of patients who were not on the Gold Standard Framework. This remains an important area to understand, Dr Groves has reviewed a month's worth of deaths within 30 days; in this review, 88% were considered expected deaths (GSF registered, know to Specialist Palliative Care Services or actively receiving SPCT intervention). Whilst reassuring, this leaves a 12% unexpected death rate, work is on-going with system partners to identify a mechanism of reviewing these deaths.

4.7 In August GSF patients who died within 30 days of discharge spent 209 days in hospital, waiting to be discharged after having been identified as being Medically Optimised for Discharge. (This was a significant increase from 129 hospital days in July). All patients came from Urgent Care.

(Our 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. Work is being undertaken by the STP led Integrated Frailty Pathway and the Trust Length of Stay Projects to seek to redress the issue).

4.8 The percentage of palliative care coding remains higher than the historical average at 27% with Planned Care reporting 54.5%. Overall 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. Depth of coding levels remains higher than historical levels however there has been a month on month drop.

5.0 Reducing Avoidable Mortality Project (RAM) – October 2018

A full Project Highlight report has been provided below with particular updates of note for the following areas:

- Deteriorating Patient Trolleys
- Pneumonia Pathway
- UTI Pathway
- External Mortality Review
- Safety Hub Reporting
- 24/7 Critical Care Outreach Team Recruitment
- Risks

Project Highlight Report

Project	**REDUCING AVOIDABLE MORTALITY**
Planned Project	12th February 2018
Project End Date	1st April 2019
Project Referenc	**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	22nd October 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 are now in place on the wards across the Southport site apart from Ward 10B. A Deteriorating Patient box is now in place on the Medical Day Unit.Four Trolleys are still to be rolled out at Ormskirk.	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). **The results of the audit are now required to be reported in November.**		0
	Pneumonia Pathway		The Pneumonia Pathway, written by Joanne Houghton, Respiratory Nurse and Drs. Chris McManus, Respiratory Consultant and Chris Goddard, AMD for Patient Safety has been fast tracked and is to be presented to the Clinical Effectiveness Committee 24th October. **The aim is for the pathway on the wards in time for December.**	G	50
	UTI Pathway		**Talks have commenced on 19th October Andrew Chalmers, Infection Control Lead to support the work that he has delivered under the UTI collaborative to reduce avoidable UTI and associated cases of deterioration. A further consultation is required to scope the next steps before the end of October (to look into the use of cathetar care plans, the HOUDINI method & a potential Trust pathway document).**	G	5
	AKI		RAM Project is to link into the upcoming AKI Steering Group to understand opportunities for quality improvement activity, November 2018 onwards.		0
	IV Fluid Therapy (NICE 174)		The new IV Fluid Therapy Drugs Chart went live on 10th September. IV Fluid Guidelines have been uploaded to the Intranet. This has been communicated through Trust News and by means of a Screen Saver. **Laura Gibson, Interim Deputy Chief Pharmacist has reported that more embedding is required for awareness and implementation - communications are ongoing.**	B	100
	External Mortality Review: 'Developing Trust Capacity & Approach to Learning from Deaths' to review Pneumonia & Stroke deaths from May 2017 to April 2018.		**Separate Appraisals / Discussion Forums on the External Mortality Review are being held on 7th November with both nursing staff and clinicians ahead of the presentation of the final report and Trust Action Plan after the Trust Board.**	G	60
	VitalPac Upgrades (3.5 & 3.6)		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		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.	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		IT and Information Teams met on the 18th September to confirm the plan to link Ward Boards to the screens in the Hub. There has been a delay to the follow up meeting for October due to resourcing. Two further meetings: one with clinicians and IT/ Information and one with the subgroup will scope & sign off the functionality in October/November.	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 **November** 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 and 59.7% in September.	B	100
	Communication to embed theSJR 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. **Work Rescheduled for December onwards.**	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 (Lead Consultant Geriatrician) 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 have been run by the NW Learning Collaborative Network out of Queenscourt Hospice: 8th August, 13th September and 12th October. Training sessions have been promoted to staff through Trust News.	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 monitor patients who have Anticipatory Clinical Management Plans or who are on the Gold Standard Frameworkand have been admitted.	G	10
	Rapid End of Life Transfer		Queenscourt Hospice are in dialogue with the NWAS Paramedics to find ways to facilitate ambulance transfers home for those at end of life.	A	70
	Reduce time to discharge for patients Medically Fit for Discharge for patients already on the Gold Standard Framework (GSF) Registered.		The objective to reduced time to discharge patients who are MOFD is part of the work that is currently being undertaken to improve Length of Stay with Karen McKracken and the NHS network ECIST (the Emergency care intensive support team).	A	10

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**		Recruitment for the new workforce for the 24/7 team commenced in mid October. The business case is being reviewed by the Finance Team.	R	70
	Embed Full Utilisation of Safe Staffing Tools		Improvement work to fully optimise the use of safe staffing tools will recommence once the CCOT 24/7 Team / the Ward Boards and Safety Hub Reporting is in place.	A	30
	Increase Access to & Prioritisation of Skills Training		Strategy to be developed with Training and Development and key stakeholders for access to training to support and inform a strategy to ensure managerial prioritisation and release of staff for training. Discussions have started with Training and Development	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.
Surgical Assessment Unit Opens (SAAT Project)	14th July 2018	14th July 2018	G	The SAU opened on 10th September 2018. (Output of the former Safe At All Times Project).
Go Live of Structured Judgement Review Method	3rd July 2018	3rd July 2018	B	The SJR Method went live a day early on 2nd July.
100% compliance - adoption of SJR Method	3rd July 2018	31st January 2019	A	Current levels of compliance are 59.7% - further embedding work is required.
Triangulation of Serious Incident, SJR Outputs & Mortality Data	1st June 2018	30th August 2018	R	Work has been rescheduled to commence December 2018.
Go Live Lessons Learned and Learning from Excellence	1st June 2018	29th September 2018	R	Work has been rescheduled to commence December 2018.
Joint Working Transform Palliative Care and Outreach Team	2nd July 2018	30th August 2018	B	This is nowbusiness as usual
Established 24/7 Outreach Team	1st March 2018	30th September 2018	R	Recruitment has been delayed by two months but has now commenced (October 2018).

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	Joyce Jordan to consult Carol Fowler (Workforce) and the relevant HR Manager to expedite requirements and navigate any systemic blockages encountered.	A	The recruitment process has now begun (mid-October).
The ability to provide robust reporting in the Safety Hub for Escalation / Bed / Resus and Outreach meeting based upon a deficit of information put into Medway at ward level.	A	A workstream subgroup has been set up to drive the Ward Board and Safety Hub reporting requirements and configuration. (Commenced August 2018).	G	Meetings were held in August and September, there has been a delay to the follow up meeting for October due to resourcing. Two further meetings: one with clinicians and IT/ Information and one with the subgroup will scope & sign off the functionality in November.
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.	A	This issue requires a more robust mitigation strategy, this is to be escalated to the October Mortality Operational Group. *Training funding is also an issue which is to be addressed in the same forum.*
Learning Culture Workstream	R	Levels of compliance with the SJR process and the discontinuation of the paper method of mortality screening mean that this stage of the project can now commence fully.	G	Clear recommunication of the objective, outputs, activity required and timelines to deliver. Engagement of revised and wider group to deliver the required outputs.
Timely organisation of subgroup meetings & the transfer of the project to new Smartsheets System	A	Work to be undertaken to ensure that the ownership of subgroup activity be driven by Workstream Leads. New Band 4 PMO support for CIP to assist in the transfer of RAM project to Smartsheets.	G	There has been an impact to the pace at which the RAM project is being delivered, attributable to the increased number of prioritised projects.

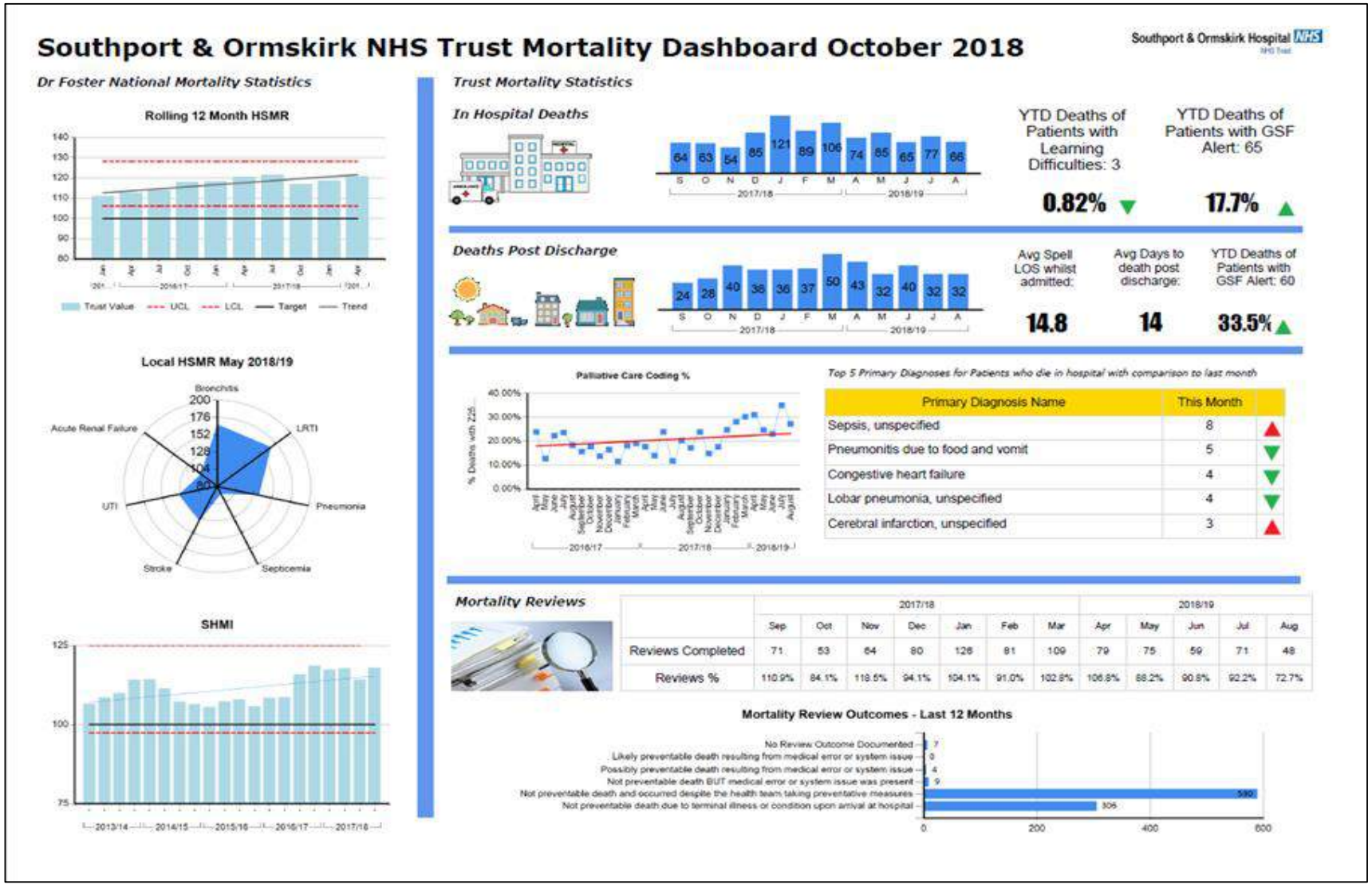
6.0 Format of Report

Following the presentation of the External Mortality Review, the format of the re the formation of this report and further activity will be mapped into the existing project plan.

7.0 Conclusion and Recommendations

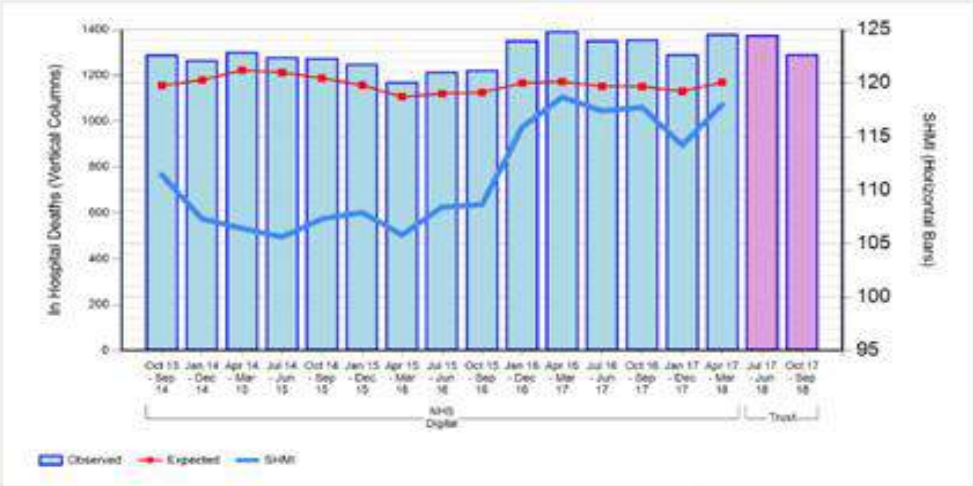
The Board is asked to note the mortality indices and also not the progress made against the Reducing Avoidable Mortality objectives.

Appendix 1– Highlights from the Trust Mortality Dashboard October 2018



SHMI Breakdown

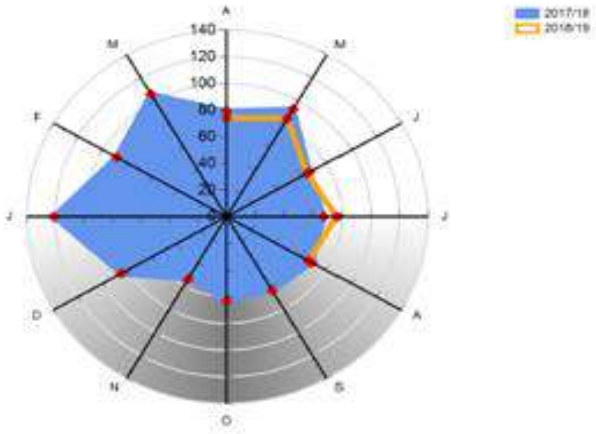
Southport & Ormskirk Hospital NHS



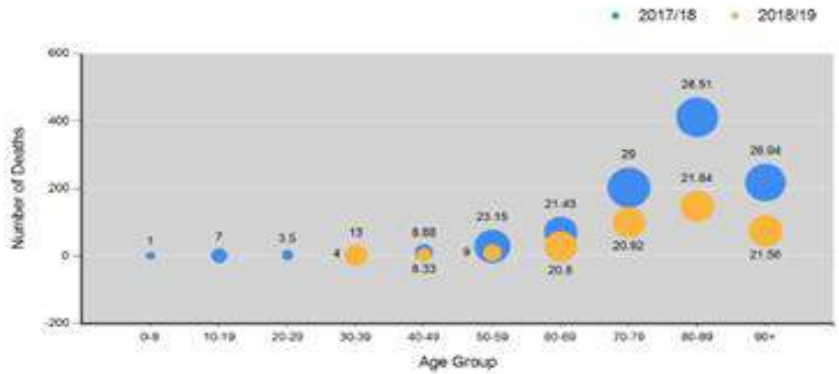
This chart shows the number of observed hospital deaths taken from NHS Digital, as well as the number of anticipated observed deaths taken from the Trust Data Warehouse for the most recent periods (vertical columns).

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 25 October 2018
Lead:	David Bricknell

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Sickness Policy – At the time of the meeting there was still no agreed Policy but it was hoped that a final meeting, the next day, would resolve it.

Publication of Policies – Despite agreement of policies they were still not being published promptly on the intranet.

Retention Consultation – This should not be confined to nursing but should be widened in due course.

Quality of Medical Training – Visit from HEENW has been brought forward to March 2019 from Autumn 2019 because of significant concerns. Key issues have been set out in a letter to the Interim Medical Director.

Attendance at Meetings – Today's Workforce Committee and Joint Negotiating Committee in September were not quorate. If these meetings are to fulfil their purpose, they must be fully or nearly fully attended, or have their ToR's and memberships reviewed.

Valuing our People / JNC – Lack of consultation and apparent lack of EIA in relation to car parking. This is not a trivial matter.

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)

ASSURE

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

Sickness Absence – The sickness absence review is now examining the positives of areas with good attendance as a learning exercise for general H&WB and its impact on sickness.

NGO/FTSU – Excellent progress has been made in a significant number of actions with only a few left outstanding.

Cheshire & Merseyside Streamlining project in relation to HR – Whilst it is a drain on resource to attend meetings there was significant assurance gained from our activities in relation to the peer group and an enhancement of our reputation regionally.

New Risk identified at the meeting	None
Review of the Risk Register	

(Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)
1783 – Failure to deliver QIPP Levels Is this within Workforce ToR and if so it requires some assurance mechanism? **1275 – Trust Website & 1274 Technical Support to maintaining Trust website** It was questioned whether these still feel within WFC

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB261/18**	**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 Fiona Barnes, Deputy Director of Nursing		
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 Board with the current position on Nurse and Midwifery Staffing in line with National Quality Board and National Institute of Health & Care Excellence (NICE) guidance.

This report presents the safe staffing position for the month of September 2018.

The Board is advised that the risk relating to current nurse staffing is rated as extreme on the risk register (ID 1862). (4 x 4 = 16) (Likelihood x Consequence)

For the month of September 2018 the Trust reported safe staffing against the national average (90%) at 91.99%.

Within the report there is an overview of the Trust compliance with National Institute Care Excellence (NICE, 2014) and National Quality Board (NQB, 2018). Recommendations are also incorporated into the gap analysis.

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. They should also ensure timely reports are sent 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 September 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 September 2018 was 91.99% compared to August 2018 that was 89.97%, compared to 90.43% in July (appendix 1).

- 86.27% Registered Nurses on days
- 94.11% Registered Nurses on nights
- 95.92% Care staff on days
- 96.40% Care staff on nights

2. September Safe Staffing

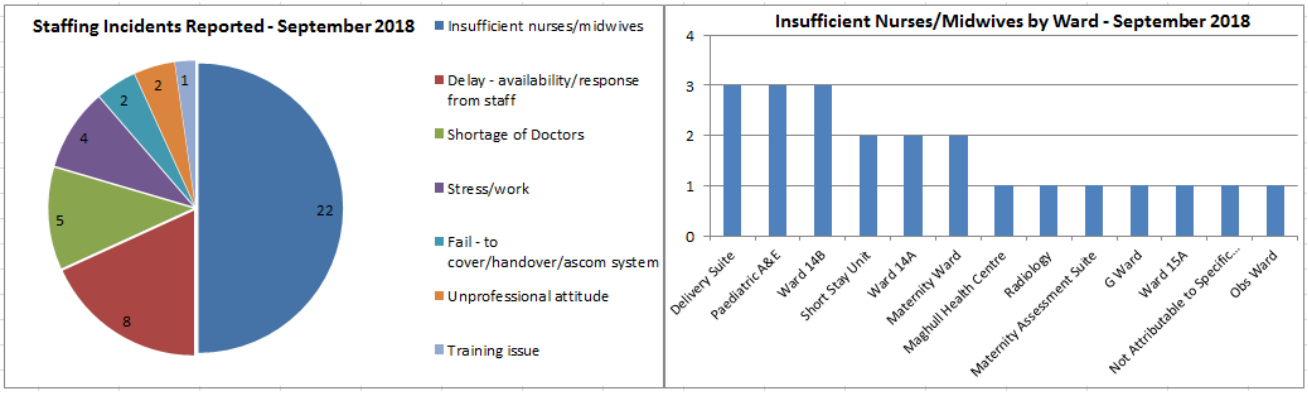
Trust whole time equivalent (wte) funded establishment versus contracted:

September 2018 data:

	Funded WTE	Contracted WTE
Registered	864.21	757.00
Non-registered	377.78	343.66
Total	1241.99	1100.66

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. The senior nursing leadership team is delivering, with supportive direction from NHSI national workforce team on trust Safer Nurse Care Tools (SNCT), acuity and dependency scoring and delivery on roster performance.

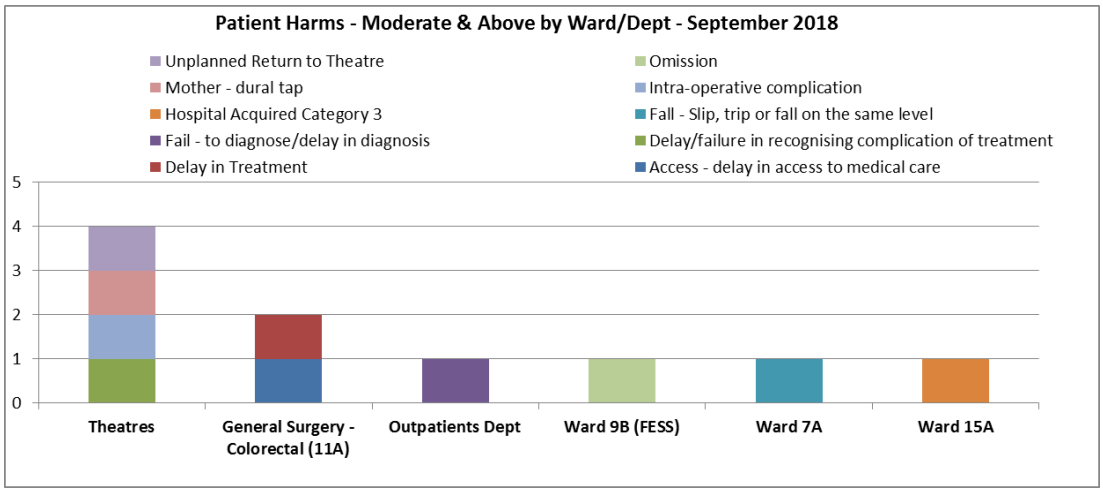
3. Staffing Related Reported Incidents September



44 staffing incidents were reported in September, an increase of 16 on the previous month. 22 of these incidents highlight insufficient nurses/midwives, 8 more than the previous month. Maternity reported 6 incidents in total impacted by cancelled shifts from flexible workers, sickness and high activity in the month. The maternity escalation policy was followed in all cases. The incidents in Paediatric A&E related to insufficient nurse

staffing to back fill for site bleep cover- this was mitigated by on call teams on the day of reporting. Urgent care highlighted insufficient nurses to meet the acuity of respiratory patients.

4. Inpatients experiencing moderate harm or above in September 2018



10 moderate or above incidents were reported in September, of which 4 were on Theatres.

5.1 Trust compliance with relevant & recent NICE & NQB guidance

5.2 Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE, July 2014):

In July 2014 the National Institute for Health and Care Excellence published guidance on safe staffing within the acute hospital. There were 38 recommendations for acute trusts to consider. A detailed gaps analysis has now been completed for the Trust (appendix 2).

There are currently 21 outstanding standards. The key areas for action are:

- Development of an Establishment Review – Standard Operating Procedure
- Implementation of the 'Red Flag' system on Data
- Review & update of the Health roster Policy
- Development of the Enhanced Levels of Care guidelines
- Development of the Clinical Metrics
- Consider ward co-ordinator SOP
- Professional Learning Communities for Wd Managers & Matrons – to include training opportunities in regard to budget setting, workforce planning
- Update SafeCare module 'criteria' in line with SNCT
- Review needs of students and any other 'trainee' posts within the clinical setting

For 7 of the recommendations the development and implementation of an Establishment Review Standard Operating procedure (SOP), will address these recommendations. This will be in place by early 2019, supported by the bi-annual Safer Nursing Care Tool (SNCT) review, as recommended by NHS England.

As part of the NICE recommendations the Trust needs to implement the recording and monitoring of 'Red Flag Events' consistently. A 'Red Flag Event' is an event that prompts an immediate response by the registered Nurse/Midwife in charge of the ward, which may be due to reduced staffing levels. The Trust will commence the recording and monitoring of

'Red Flag Event' by using the Trusts adverse incident reporting system (Datix), this will address 4 of the recommendations.

Using the Datix system the reporting of the 'Red Flag Event' will be reviewed by the Head of Nursing/Midwifery. The number of 'Red Flag Events' will also be reported on a monthly basis through this report as part of the triangulation of harm events and staffing skill mix.

Currently Nurse staffing shortfalls are escalated, discussed and resolved on a day by day basis at the Safe Staffing Huddle. Due consideration is given to the following:

- Any immediate adverse implications from staffing shortfalls
- Unexpected changes in acuity and dependency within a clinical area
- 1:1 supervision, Enhanced Levels of Care or cohorting of patients with specific nursing dependency needs is reviewed
- The mitigation of risk using professional nursing judgement for wards where nurse staffing numbers fall below planned levels

Out of hours this process is undertaken by the Site Manager, who is 'clinical'. In addition, any adverse incidents relating to nurse staffing are reported through the existing Datix system and discussed at the Daily Incident Review Meeting

5.3 Safe, sustainable and productive staffing - An improvement resource for adult inpatient wards in acute hospitals. National Quality Board, January 2018
In January 2018 the National Quality Board (NQB) published guidance on safe staffing within the acute hospital. This was based on an earlier NQB document 'Safe, sustainable and productive staffing' (2016). There are 10 recommendations for acute Trusts to consider. A gap analysis has now been completed for the Trust (appendix 3). There are 6 recommendations that the Trust is not compliant with and require further actions. There are 4 recommendations that will be addressed through the earlier action plan to be compliant with NICE 2014. The remaining actions will be addressed as identified on the gap analysis.

5.4 Developing workforce safeguards – Supporting providers to deliver high quality care through safe and effective staffing – NHS Improvement – October 2018
On 4th October 2018 a letter was sent to all Chief Executives, Directors of Nursing and Medical Directors from Ruth May, Executive Director of Nursing and Deputy CNO & National Director for Infection (NHS Improvement), announcing the publication of the 'Developing Workforce Safeguards', a framework designed for Trusts to strengthen their evidence-based approach to workforce planning.

The framework provides a set of recommendations on workforce safeguards to strengthen our commitment to safe, high quality care across all staff groups. It also includes new recommendations on governance processes and formal reporting from ward to board. NHS Improvement will be formally assessing Trusts on this issue, which will come into effect from April 2019.

A 'master-class' is being held in mid-November to provide a more detailed overview of the document which the Deputy Director of Nursing (Workforce) is planning to attend. Therefore, a gap analysis and necessary actions for the Trust will be provided in a future update to the Workforce Committee for consideration.

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

Appendix 1:

					Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
Hospital Site Details			Main 2 Specialties		Registered		Care Staff		Registered		Care Staff									
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name	Ward name	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	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
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Ward 7A-SDGH	300 - GENERAL MEDICINE		1330.25	908.92	892.75	1166.5	1055.02	996.77	702.5	640.5	68.3%	130.7%	94.5%	91.2%	801	2.4	2.3	4.6
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	A&E observation Ward	180 - ACCIDENT & EMERGENCY	300 - GENERAL MEDICINE	758.5	774	552	635.5	705	802	555	598.5	104.0%	180.5%	114.1%	112.5%	247	6.4	4.2	10.6
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	D A U	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	1638.5	1386.92	1055	901.75	1056.5	1101.5	710	710.5	84.6%	85.5%	104.3%	100.1%	486	5.1	3.3	8.4
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	FESS Ward	300 - GENERAL MEDICINE		2510.25	956.17	1501.92	1109.92	1077	838	718	752	62.0%	92.4%	77.8%	104.7%	827	2.2	2.4	4.5
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Ward 11B-SDGH	300 - GENERAL MEDICINE		1517.5	1055.25	1063.25	1037.92	1076.5	744	712	854	80.1%	140.2%	69.1%	119.9%	782	2.5	3.0	5.5
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Ward 14B-SDGH	300 - GENERAL MEDICINE		1556.75	1471	1302	1347.48	1062.5	1134.5	712.5	628.5	94.5%	103.5%	104.9%	88.2%	842	3.1	2.3	5.4
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Short Stay Unit	300 - GENERAL MEDICINE	100 - GENERAL SURGERY	2451.25	1055	1044.75	1602.5	715	1012.5	717.5	813.5	71.2%	153.4%	142.0%	114.1%	788	2.6	5.1	9.7
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	ITU/CCU	192 - CRITICAL CARE MEDICINE		6513.75	5690.25	1074.75	800.75	3939.17	5417.34	1080	923.75	81.0%	74.5%	86.5%	85.5%	322	22.1	5.4	27.6
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Ward 15a General Med	300 - GENERAL MEDICINE	410 - RHEUMATOLOGY	921.67	1044.15	860.25	1299.25	1007.25	929.75	719	1046	113.3%	151.0%	92.3%	145.5%	689	2.9	3.4	6.3
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Stroke Ward	300 - GENERAL MEDICINE		1536.67	1181.53	952.5	1195.98	1064.08	1050.58	711.5	710.5	89.1%	138.5%	98.7%	99.9%	552	4.3	3.6	7.8
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Rehab & Discharge Lounge	314 - REHABILITATION		741	1044.67	897.25	1393.92	707.75	720.75	706.5	732	141.0%	155.4%	101.8%	103.6%	649	2.7	3.3	6.0
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	Delivery Suite	501 - OBSTETRICS		2589.25	1523.58	980	403	1458	1501.08	539.5	560.5	96.0%	115.5%	96.7%	100.5%	72	40.3	10.7	51.2
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	Maternity Ward	501 - OBSTETRICS		1151.25	1084.58	704.3	591.75	825.5	790	552.5	544	94.2%	84.0%	95.7%	97.6%	297	6.3	5.2	9.5
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	MAU	501 - OBSTETRICS		1203.5	1191	348.5	389.25	718	661	356.5	321.5	99.0%	111.7%	92.1%	90.2%	93	19.9	7.6	27.6
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	Neonatal Ward - ODGH	420 - PAEDIATRIC S		1078.5	1145.25	527	240	1053	1066.25	108	72	106.2%	75.4%	101.3%	98.7%	205	10.8	1.9	12.5
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	Paediatric Unit	420 - PAEDIATRIC S		3442.25	3340	1063.25	1075.83	1880.5	1887.5	717	573	97.0%	101.2%	100.4%	79.9%	334	15.7	4.9	20.6
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Ward 14A	110 - TRAUMA & ORTHOPAEDICS	100 - GENERAL SURGERY	1916.5	1210	2139.23333	1588.23	719	844	718.5	791	92.6%	74.3%	117.4%	110.1%	939	2.5	2.8	5.3
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	Short Stay Surgical Unit	100 - GENERAL SURGERY		1837.38667	1542.25	1060.5	1089.75	710.5	713	554.5	624	73.0%	84.1%	100.4%	176.0%	449	4.8	5.8	8.5
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	Ward H	110 - TRAUMA & ORTHOPAEDICS		718	472.5	716.25	317.25	719	456.5	358	190	65.8%	44.3%	63.5%	53.1%	113	8.2	4.5	12.7
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Surgical Ward	100 - GENERAL SURGERY		1291.5	1062	1080.5	1007.5	720	684.5	716.5	404.5	83.0%	93.2%	95.1%	56.5%	509	3.5	2.8	6.2
RVY01	SOUTHPORT AND FORMBY DISTRICT GENERAL HOSPITAL - RVY01	Spinal Injuries Unit	400 - NEUROLOGY		3744.81667	3048.48	3557.25	3235.92	2749.5	2990.75	1447	1508.75	81.4%	92.0%	94.2%	90.4%	1106	3.1	4.1	9.2
RVY02	ORMSKIRK AND DISTRICT GENERAL HOSPITAL - RVY02	Ward G	101 - UROLOGY	502 - GYNAECOLOGY	1244.5	820	804	534	800	664	435	516	65.9%	65.5%	83.0%	72.6%	219	6.8	2.9	9.7

Appendix 2

Safe Staffing for Adult Inpatient Wards
National Institute Health Care Excellence, July 2014

Recommendations & Gap Analysis

Recommendations	Key Action	Compliance of S & O	Further Actions	Lead	Time frame
Organisational Strategy These recommendations are for Hospital Boards, Senior Management and Commissioners.	**Focus on Patient Care**				
	1.1.1 Ensure Patients receive the nursing care they need, including Specialist Nursing, regardless of the Ward to which they are allocated, the time of day or the day of the week. This includes planning to locate Patients where their clinical needs can be met	Specialist Nursing Care is not based in Specialist Wards, so are able to attend patients throughout the Hospital. CNS can be contacted via referral process.			
	1.1.2 Develop procedures to ensure that Ward Nursing Staff establishments (the number of Registered Nurse and Healthcare Assistant posts that are funded to work in particular Wards) are sufficient to provide safe Nursing Care to each Patient at all times	Bi-annual Staffing Review using the Safer Nursing Care Tool (S.N.C.T) to commence in October 2018. This engages the Ward Manager to share with their staff regarding the process, purpose and outcome of the audits. On a daily basis if Ward Manager believes they do not have enough of the appropriate staff for the case mix of patients based on professional judgement, then this is raised to their Matron and discussed at the Daily Safe Staffing Huddle, chaired by Head of Nursing (HoN) or Associate Director of W'force or DDoN. Any increase in staffing requests are reviewed and considered by the Matrons and HoN of the Clinical Business Unit to maintain patient safety and balance the risk across the Trust.	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018
	1.1.3 Ensure that the final Ward Nursing Staff establishments are developed with the Registered Nurses who are responsible for determining Nursing Staff requirements at a ward level and approved by the Chief Nurse (or delegated accountable staff). The Board should retain organisational responsibility. This includes when the Ward establishment and budget are set	Final establishments are agreed by reviewing a) Findings of the bi-annual SNCT Audit, b) the professional judgement of the Ward Manager, c) Professional judgement of the Senior Nursing/Midwifery Team, d) the use of Enhanced Levels of Care throughout the year. The Director of Nursing will agree the final establishment on an annual basis. This is shared with the Trust Board to be ratified as part of the Trust's Business Cycle.	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018
	1.1.4 Ensure Senior Nursing Managers are accountable for the Nursing Staff roster that is developed from the Ward Nursing Staff establishment	Using Health Roster, the Ward Managers are the first 'Manager' to agree the Off-Duty. The Matrons are then required to authorise this via the electronic system. The Heads of Nursing/Midwifery will have an overview of the rotas across their services.	There is on-going work to improve the compliance of our Healthcare roster	ADN WF	Jan 2019
	1.1.5 When agreeing the Ward Nursing Staff establishment, ensure it is sufficient to provide planned Nursing Staff requirements at all times. This should include capacity to deal with planned and predictable variations in Nursing Staff available, such as annual, maternity, paternity and study leave (commonly known as uplift). Consider adjusting the uplift for individual wards where there is evidence of variation in planned or unplanned absence at a ward level	The Trust has an agreed 'uplift' of 22.5%. It is acknowledged that the RCN recommends 25%, and this will be shared with the Trust Board when the Staffing Review is presented on a bi-annual basis as part of the Nurse Staffing Establishment Review report.			
	1.1.6 When agreeing the ward nursing staff establishment, ensure capacity to deal with fluctuations in patients' nursing needs (such as seasonal variations indicated by historical records of nursing staff requirements) and staff unplanned leave or absences	The Ward Manager takes into account the fluctuating nature of their ward speciality and seasonal variation as part of their professional judgment on an annual basis when undertaking the Staffing Review (SNCT), taking into account trust wide 'Winter planning'.			
	1.1.7 When agreeing the skill mix of the Ward Nursing Staff establishment, this should be appropriate to patient needs and take into account evidence that shows improved patient outcomes are associated with care delivered by Registered Nurses	Skill-mix is monitored as part of the bi-annual Staffing Review (S.N.C.T). Those clinical areas that do not comply with the RCN recommended 65:35 will be discussed with the clinical teams (Ward Manager, Matron & HoN) as part of their Confirm & Challenge meetings.	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018
	1.1.8 Ensure that there are procedures to identify differences between on-the-day Nursing Staff requirements and the Nursing Staff available on a ward	Each ward has a board that on a daily, shift-by-shift basis, displaying the established number of staff on a shift against the actual number of staff on a shift. This is maintained by the Ward co-ordinator.			
	1.1.9 Hospitals need to have a system in place for Nursing Red Flag Events to be reported by any Member of the Nursing Team, Patients, Relatives or Carers to the Registered Nurse-in-Charge of the Ward or Shift	The Trust does not consistently operate a 'Red Flag System', in accordance with NICE guidance.	Review Datix system (incident reporting system) to update in line with NICE requirements and implement across the Trust	DDoN	Dec 2018
	1.1.10 Ensure there are procedures for effective responses to unplanned variations in predicted Patients' Nursing needs or the availability of Nursing Staff at any time during the day and night. These procedures should include prompt action to enable an increase or decrease in Nursing Staff.	Procedures to respond to unplanned variations are through the ward co-ordinator and the Matrons and discussed at the Safe Staffing Huddle.	E roster policy to incorporate escalation processes	A.D.N. WF	Jan 2019

Recommendations	Key Action	Compliance of S & O	Further Actions	Lead	Time frame
	1.1.11 Action to respond to Nursing Staff deficits on a Ward should not compromise Staff Nursing on other Wards	The procedure to identify a staffing 'shortfall' is through the Ward Manager /Co-Ordinator and the Matrons. Every effort is made not to compromise other Ward Areas/Departments, however, the acuity, dependency and skill mix across a Directorate, CBU and Trust is reviewed and clinical risks balanced across the Organisation to maintain patient safety through the Daily Safe Staffing Huddle.			
	1.1.12 Ensure there is a separate organisational contingency plan and response for Patients who require the continuous presence of a Member of the Nursing Team (often referred to as 'Specialing' care)	Enhanced Level of Care guidelines will be developed due to the extensive use of '1-1' that may not be appropriate for all patients. A risk assessment process that will be counter-signed by the Matron, prior to authorising the shift will be part of the future guidelines.	Enhanced Level of Care guidelines	ADSG	March 2019
	1.1.13 Consider implementing approaches to support flexibility, such as adapting Nursing Shifts, Nursing skill mix, assigned location and employment contract arrangements	Flexibility of the Workforce (changes to shifts, shift patterns or skill mix) are all considered as part of the daily review of the workforce if a ward was identified as having a variation to planned levels of staff. As part of the Establishment Review the Ward Managers will, on a six-monthly basis review the skill mix, establishment and contracts of the current staff taking into account different contracts and Flexible working.			
	Monitor adequacy of Ward Nursing Establishments				
	1.1.14 Ensure that there are procedures for systematic ongoing monitoring of safe nursing indicators and formal review of nursing staff establishments of individual wards at a board level at least twice a year (and more often if there are significant changes such as ward patient characteristics). These procedures should include periodic analysis of reported nursing red flag events and the safe nursing indicators	Bi-annual review of the Safer Nursing Care Tool will be shared with the Trust Board. Incomplete portfolio of clinical metrics being shared at Board level The use of 'Red Flags' will be considered as part of this process in future.	The 'Clinical Metrics' data base is currently under review & redesign.	DDoN	Jan 2019
	1.1.15 Make appropriate changes to the ward nursing staff establishment in response to the outcome of the review	There will be professional recommendations made to the Board led by the Director of Nursing.		DoN	Feb 2019
	Promote Staff Training and Education				
	1.1.16 Enable nursing staff to have the appropriate training for the care they are required to provide	Mandatory and Role Specific Training is currently under the target of 85%. However, this is a priority for the Matrons and Ward Manager.			
	1.1.17 Ensure that there are sufficient designated registered nurses who are experienced and trained to determine on-the-day nursing staff requirements over a 24-hour period	Each shift will have a ward co-ordinator who has the competencies and experience to co-ordinate the ward and professional insight to consider whether the current staffing levels are appropriate for the case mix and acuity of the Ward. This is part of the Health Roster system and can be monitored as required.	Consider Trust wide SOP for the Ward Co-Ordinator role.	DDoN	March 2019
	1.1.18 The organisation should encourage and enable nursing staff to take part in programmes that assure the quality of nursing care and nursing standards to maximise the effectiveness of the nursing care provided and the productivity of the nursing team	• Ward Managers Meetings • Matrons Meetings • S&O Nursing Leadership programme (B6-8a) • Quality Improvement Programme	Further work to be undertaken to consider mentoring, coaching, leadership opportunities including succession planning	DDoN (all)	March 2019
	1.1.19 Involve Nursing Staff in developing and maintaining Hospital Policies and Governance about Nursing Staff requirements, such as Escalation Policies and Contingency Plans	Matrons and Ward Managers will be asked for feedback on policies and plans regarding escalation and contingency.	Professional Learning Communities & Matrons & Wd Managers Meetings	DDoN	January 2019
Principles for Determining Nursing Staff Requirements These recommendations are for Registered Nurses in Charge of individual wards or shifts, who should be responsible for assessing the various factors used to determine Nursing Staff requirements	*1.2.1* Use a systematic approach that takes into account Patient, Ward and Staffing factors to determine Nursing Staff requirements both when setting the Ward Nursing Staff Establishment and when making on-the-day assessments	Ward Establishments will be set through the review of the Safer Nursing Care Tool, professional judgement and current Establishment, by the Director of Nursing, Matron, Ward Manager and HoN once a year, in line with our Business Planning Cycle. On a daily basis the Safe Staffing Huddle utilises the SafeCare module in Health Roster to support the decision making of staff allocation.			
	1.2.2 Use a decision support toolkit endorsed by NICE to facilitate the systematic approach to determining the Nursing Staff requirements.	The Trust will be using SNCT as the audit tool during the Establishment Review. On a daily basis SafeCare is utilised.	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018

Recommendations	Key Action	Compliance of S & O	Further Actions	Lead	Time frame
	1.2.3 Use informed professional judgement to make a final assessment of Nursing Staff requirements. This should take account of the local circumstances, variability of patients' nursing needs, and previously reported Nursing Red Flag Events	Professional judgement by Ward Managers and Matrons is currently used on a daily basis to consider the appropriate levels of skill mix and number of staff required to provide care to any given case mix of patients. Training for Wd Managers & Matrons in regards to SNCT & H roster provided to support informed decision making	Development of an Establishment Review Standard Operating Procedure (SOP) Training opportunities for Wd Managers & Matrons for budget setting and Workforce planning	DDoN	Dec 2018
	1.2.4 Consider using the Nursing Care activities as a prompt to help inform professional judgement of the Nursing Staff requirements and to identify where Patients' Nursing needs are not fully accounted for by any decision support toolkit that is being used	Nursing care activities were not consistently used as part of the Safe Care Module. However, this will be reviewed following the Establishment Review using the SNCT critieria.	SNCT criteria will be used to update SafeCare.	DDoN / ADN WF	March 2019
Setting the Ward Nursing Establishment These recommendations are for Senior Registered nurses who are responsible for determining Nursing Staff requirements or those involved in setting the Nursing Staff establishment of a particular ward	*1.3.1* Set Ward Nursing Staff Establishments using the stages outlined in recommendations 1.3.2–1.3.8. This should involve the designated Senior Registered Nurses at a Ward level who are experienced and trained in determining Nursing Staff requirements. This process could be facilitated by the use of a NICE-endorsed decision support toolkit	Staff Nurses within the clinical area will be involved in the collecting of SNCT during the audit period. Ward Managers will utilise the data from the Safer Nursing Care Tool (Oct. 2018) to consider future staffing establishments. This will be reviewed as part of the Confirm & Challenge process with HoN & DDoN.	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018
	Stage 1: Calculate the average Nursing Staff requirement throughout a 24-hour period				
	1.3.2 Routinely measure the average amount of Nursing time required throughout a 24-hour period for each of the Ward's Patients. The measurement should take into account the Patient factors and Nursing Care activities outlined in *Section 1.2*. It could be expressed as Nursing hours per Patient to ensure Ward Nursing Staff Establishments are derived from individual Patient's needs. (A measurement of Nursing hours per Patient enables the Nursing needs of individual Patients and different shift durations of the Nursing Staff to be more easily taken into account than with a Nurse-to-Patient ratio)	Wards use SafeCare Module within Health-roster. Following the SNCT the SafeCare template will be reviewed to reflect the acuity & dependency of our patients.	Update the SafeCare module criteria in line with the national validated criteria	DDoN & ADN WF	Jan 2019
	1.3.3 Formally analyse the average Nursing hours required per Patient at least twice a year when reviewing the Ward Nursing Staff Establishment	This will be part of the SNCT audit			
	1.3.4 Multiply the average number of Nursing hours per patient by the average daily bed utilisation (the number of Patients that a Ward Nursing Team is responsible for during each 24-hour period). Using bed utilisation, rather than bed occupancy, will ensure that the Nursing care needs of Patients who are discharged or transferred to another Ward during a 24-hour period are also accounted for	Undertaken through the SafeCare Module.			
	1.3.5 Add an allowance for additional Nursing workload based on the relevant Ward factors such as average Patient turnover, layout and size, and Staff factors such as Nursing activities and responsibilities other than direct Patient care	This will be completed as part of the Establishment review, % occupancy will also be considered as part of the audit.	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018
	Stage 2: Determine required Nursing skill mix and shift allocation				
	1.3.6 Identify the appropriate knowledge and Nursing skill mix required in the Team to meet the Nursing needs of the Ward's Patients, with Registered Nurses remaining accountable for the overall care of Patients. Base the Nursing Staff requirements on Registered Nurse hours, and consider which activities can safely be delegated to trained and competent Healthcare Assistants. Take into account: • The level of knowledge, skill and competence of the Healthcare Assistants in relation to the care that needs to be given • The requirement for Registered Nurses to support and supervise Healthcare Assistants and other trainees • That improved Patient outcomes are associated with a higher proportion of Registered Nurses in the Ward Nursing Staff Establishment	Established skill mix is currently based on professional judgement, RCN guidance (65:35%) and any other best practice guidelines (Critical Care, Renal Network, BTS guidance for NIV & CCU guidelines).	Review needs to take account of student & any other 'trainee' posts on the ward that require supervision & support	DDoN	Dec 2018
	1.3.7 Use average Patients' Nursing needs and the estimated time of day or night when care will be required to: • Design the staffing roster • Allocate nursing staff to care for specific patients during shifts	Undertaken through SafeCare Module.			
	1.3.8 Take account of the following factors (commonly known as 'uplift' and likely to be set at an organisational level: • Planned absence (for example, for professional development, mandatory training, entitlement for annual, maternity or paternity leave) • Unplanned absence (such as sickness absence)	Uplift is currently 22.5% and is applied to all budgets.			

Recommendations	Key Action	Compliance of S & O	Further Actions	Lead	Time frame
Assessing if Nursing Staff available on the day meet Patients' Nursing needs These recommendations are for the Registered Nurses on wards who are in charge of the shifts	*1.4.1* Systematically assess that the available Nursing Staff for each shift or at least each 24-hour period is adequate to meet the actual Nursing needs of Patients currently on the Ward. The Nurse-in-Charge on individual shifts should make the on-the-day assessments of Nursing Staff requirements, which could be facilitated by using a NICE-endorsed decision support toolkit	Safer Care Module utilised on a daily basis by the ward staff to monitor acuity & dependency of patient case mix against available staffing hours.			
	1.4.2 Monitor the occurrence of the Nursing Red Flag Events throughout each 24-hour period. Monitoring of other events may be agreed locally	The Trust does not consistently operate a 'Red Flag System', in accordance with NICE guidance.	Review Datix system (incident reporting system) to update in line with NICE requirements and implement across the Trust	DDoN	Nov 2018
	1.4.3 If a Nursing Red Flag Event occurs, it should prompt an immediate escalation response by the Registered Nurse-in-Charge. An appropriate response may be to allocate additional Nursing Staff to the Ward	The Trust does not consistently operate a 'Red Flag System', in accordance with NICE guidance. Currently the Trust uses the SafeCare module to record staffing issues and the Trust generic datix system to identify any patient harms related to staffing levels.	Review Datix system (incident reporting system) to update in line with NICE requirements and implement across the Trust	DDoN	Nov 2018
	1.4.4 Keep records of the on-the-day assessments of actual Nursing Staff requirements and reported Red Flag Events so that they can be used to inform future planning of Ward Nursing Staff Establishments or other appropriate action	The Trust does not consistently operate a 'Red Flag System', in accordance with NICE guidance. As part of the Establishment Review the data from the SafeCare & Datix system will be used to triangulation with the SNCT data.	Review Datix system (incident reporting system) to update in line with NICE requirements and implement across the Trust	DDoN	Nov 2018
Monitor and Evaluate Ward Nursing Staff Establishments These recommendations are for senior management and nursing managers or matrons to support safe staffing for nursing at a ward level.	*1.5.1* Monitor whether the Ward Nursing Staff Establishment adequately meets Patients' Nursing needs using the Safe Nursing Indicators. These are indicators that evidence shows to be sensitive to the number of available Nursing Staff and skill mix. Consider continuous data collection of these Safe Nursing Indicators (using data already routinely collected locally where available) and regularly analyse the results.	Safer Care Module in place			
	1.5.2 Compare the results of the Safe Nursing Indicators with previous results from the same Ward at least every 6 Months. The comparisons should also take into account the specific Ward and Patient characteristics, such as Patient risk factors and Ward Speciality. Reported Nursing Red Flag Events should also be reviewed when undertaking this monitoring and prompt an earlier examination of the adequacy of the Ward Nursing Staff Establishment	Bi-Annual review in progress and Datix information regarding staffing and patient harm will be reviewed as part of this process.			
	1.5.3 There is no single Nursing Staff-to-Patient Ratio that can be applied across all Acute Adult Inpatient Wards. However, take into account that there is evidence of increased risk of harm associated with a Registered Nurse caring for more than 8 Patients during the day shifts. Therefore if the available Registered Nurses for a particular Ward (excluding the Nurse-in-Charge) are caring for more than 8 Patients during the day shifts, the Senior Management and Nursing Managers or Matrons should: • Closely monitor Nursing Red Flag Events • Perform early analysis of Safe Nursing Indicator Results • Take action to ensure Staffing is adequate to meet the Patients' Nursing needs if indicated by the analysis of Nursing Red Flag Events and Safe Nursing Indicators. In many cases, Patients' Nursing needs, as determined by implementing the recommendations in this guideline, will require Registered Nurses to care for fewer than 8 Patients	Current and any proposed ward establishment will be benchmarked against minimum 1:8 and shared with Trust Board on a six-monthly basis.			

Key:
DoN – Director of Nursing, Midwifery, Therapies & Governance
DDoN – Deputy Director of Nursing – Workforce & Professional Standards
ADN WF – Assistant Director of Nursing & Midwifery– Workforce
ADSG – Assistant Director of Safeguarding

Appendix 3

Safe, sustainable and productive staffing – An improvement resource for adult inpatient wards in acute hospitals – NQB January 2018

Recommendations:

In determining nurse staffing requirements for adult in patients settings:				
Recommendations	S&O Compliance	Further actions	Lead	Time frame
1. A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.	Systematic approach through the bi-annual safe staffing review, including Safer Nursing Care Tool, professional judgement and benchmarking (Model Hospital)	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018
2. A strategic staffing review must be undertaken annually or sooner if changes to services are planned.	Bi-annual safe staffing review to commence in October 2018	Development of an Establishment Review Standard Operating Procedure (SOP)	DDoN	Dec 2018
3. Staffing decisions should be taken in the context of the wider registered multi-professional team	As part of the professional judgement and 'Confirm & Challenge' process the opportunity for 'new roles' and multi-professional roles will be considerations			
4. Consideration of safer staffing requirements and workforce productively should form an integral part of the operational planning process	The development of new services or changes to services will incorporate a review of the current and required staffing , including the opportunities for new roles and included as part of business planning cycle			
5. Action plans to address local recruitment and retention priorities should be in place and subject to regular review	Retention Task & Finish Group currently in place supported by NHS Improvement. Recruitment initiatives have been combined within the Trust action plan.	To make the T&F group a permanent meeting to address Recruitment & Retention. ToR to be ratified by NMB / Workforce Committee.	DDoN / A.D.N. WF	Dec 2018
6. Flexible employment options and efficient deployment of staff should be minimised across the hospital to limit the use of temporary staff	Flexible Working policy not in place. Recruitment & Retention T & F Group in place, supported by NHS Improvement	Flexible Working Policy to be developed. Health roster policy (including re-deployment of staff based on clinical needs)	HR Team A.D.N. WF	April 2019 Jan 2019
7. A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-	CHPPD Safe Staffing data is reported to Workforce Committee monthly.	The 'Clinical Metrics' data base is currently under review & redesign. Workforce metrics will also be	DDoN	Jan 2019

making		part of this overview.		
8. Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.	Daily Safe Staffing Huddle to review immediate and next 24 hr demand on clinical hours against patient acuity & dependency through SafeCare.	Escalation process to be part of the Health roster policy. Development of the Clinical metrics and review process to be developed	A.D.N. WF DDoN	Dec 2018 Jan 2019
9. All organisations should include a process to determine additional uplift requirements based on the needs of the patients and staff.	Currently based at 22.5%. This will be reviewed as part of the bi-annual review to be commenced in October 2018.			
10. All organisations should investigate staffing –related incidents and their outcomes on patients and staff, and ensure action and feedback.	Daily Incident Review Meeting identifies any harms to patients and clarifies if this is related to staffing levels on the department at the time. Quarterly review of themes and trends of patient harms relating to staffing.			

Key: DoN – Director of Nursing, Midwifery, Therapies & Governance; DDoN – Deputy Director of Nursing – Workforce & Professional Standards, ADN WF – Assistant Director of Nursing & Midwifery– Workforce

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB262/18**	**Report Title**	**Freedom To Speak Up (FTSU) Quarter 2 Report**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery & Therapies		
Lead Officer	Martin Abrams, Freedom To Speak Up Guardian		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

This report provides an update of the concerns raised to the FTSU Guardian (FTSUG) during Quarter 2 - 2018/19 and has been uploaded to the National Guardian Office (NGO) database.

There were 11 issues in total, all managed appropriately.

There were no themes to note.

The Non-Executive Director Board Champion has now been identified as Pauline Gibson and the FTSUG has successfully recruited and trained five operational champions.

The NGO action plan summary identifies seven actions currently off plan, (an improvement from ten) all being managed by the appropriate Executive Lead to bring back on plan and manage as identified.

Following completion of the Freedom to Speak Up Self-Review Tool for NHS Trusts and Foundation Trusts, it was submitted to NHSI in August 2018 and was shared at the September Southport & Ormskirk Improvement Board (SOIB). There has been positive improvement of seven recommendations moving to 'fully met'.

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)*

To accept this report as progress against the NGO action plan and compliance to quarterly FTSU return.

Previously Presented at:

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

National Guardian
Freedom to Speak Up

NHS
Southport and
Ormskirk Hospital
NHS Trust

Freedom to Speak Up Guardian Update – Quarter 2

Report on Quarterly Submission to National Guardians Office

Quarter: Quarter 2, 1st July – 30th September 2018

Date Submitted to NGO: 08.10.18

Date National Data to be published: TBC

Number of concerns raised: 11

During quarter 2, 11 concerns were directly raised with the Freedom to Speak Up Guardian (FTSUG). This is in addition to concerns which were raised through the 'Speak Straight to Silas' initiative.

Table 1: Concerns raised during Quarter 2

No	Month	Issue	Outcome
1	July	Staff relationships within a department.	A senior member of staff met with the senior staff of the department and then with all concerned. A positive outcome was achieved.
2	August	An at risk employee felt she was being overlooked.	Significant investigation by HR and feedback given to staff member.
3	August	A member of staff had asked for an agenda for change job description review, and believed the result was being withheld.	The day the concern was raised a meeting was held with those concerned and feedback given.
4	August	A member of the public contacted the FTSUG in relation to treatment received in A & E.	In conversation with the member of the public it was agreed the issue was passed onto the complaints department. The investigation is still ongoing. (T*he person who raised the concern is happy with the progress)*
5	August	A member of a team within the hospital was feeling excluded from decision making and concerned that audit principles were not being used properly.	1) Initial meeting with the person concerned. 2) Meeting with person, executive lead and freedom to speak up guardian. 3) Meeting with above and department lead. Significant progress is being made and an investigation into audit process currently ongoing.
6	September	A lone worker felt vulnerable as she did not consider the policy was being followed properly nor the alert system understood by	Meeting with manager, concerned and change of local policy agreed. Assurance that policy was understood.

		her managers.	
7	September	A member of staff leaving the organisation wished to raise many themes, but that these themes be simply fed into "cultural change" within the hospital.	Themes will be fed into appropriate forums.
8	September	A co-worker raised a concern about a colleague's welfare.	Conversation with line manager and appropriate conversation and support to be put in place
9	September	A job had been given to a person without due process being followed, belief that a job had been created especially for someone.	HR investigation ongoing.
10	September	An anonymous concern raised that a member of staff had been convicted of aggressive behaviour and was still working within the trust.	Conversation with manager and investigation held. No evidence of any conviction, though other investigations ongoing.
11	September	A member of staff, working 20 hours a week, was concerned that having to apply again for the car park scheme meant she was facing a 50% rise in charges. She thought the wording on the form provided had changed. She was told the wording was correct and she would have to pay the full amount.	Further investigation revealed an error and the form was amended and an apology issued in trust news.

In addition to the above a number of themes have been noted in general conversations, including:

- People attitudes and behaviours towards each other is not always appropriate
- Bullying still exists
- Morale in some departments very low, especially those facing uncertainty
- People on secondment can be disadvantaged when applying for the role permanently
- People still do not feel it is safe to speak up
- Staff are really excited about the new sense of direction being given to the Trust, but also feeling that this is creating a lot of extra work which some do not feel they have the capacity to take on.

Feedback

The National Guardians Office also requires the FTSUG to ask, once a case is closed, if people would use the FTSUG again to raise a concern and if they would like to offer further comments. Feedback from Quarter 2 (in some cases abridged) is below:

Given your experience, would you speak up again?

- I would raise a concern again.
- I would raise a concern again
- Definitely, yes
- I would definitely have no hesitation in speaking up again should the need arise.
- Yes given my experience I would definitely speak up again, as I received a very sympathetic response to my concern.

- Possibly, I felt very supported by FTSUG, but told off for going to him

Any other comments you would like to make or suggestions for improving the service offered?

- I would like to say that I was very happy with the way in which my concern was dealt with and the unbiased, friendly attitude alleviated any worries I may have had with raising the matter as an issue.
- Given this is my first experience and I wasn't sure what to expect I can honestly say I have nothing but praise for the help and speed of response that was given to me regarding my concern.
- I felt confident that I was being listened to and that my concerns would be addressed in a way that I wanted. I think it is important that the trust doesn't lose this and that the people chosen to move this forward are the right type of people.
- I felt sure the concern was passed onto the appropriate person, and the response was relayed to me. However I feel the response offered to me is incorrect and part of a wider cover up.
- I was reassured that speaking up was the right thing to do and at no time did I feel that there would be negative repercussions from doing so. It was also great to get updates on the progress being made as a result of me speaking up which assured me that things were not being ignored.

Table 2: Concerns raised over last 15 months

Period	Number
1st July – 30th September 2018	11
1st April – 30th June 2018	9
1st January – 31st March 2018	5
1st October – 31st December 2017	4
1st July – 30th September 2017	4

Since the recruitment and development of the FTSUG the numbers of concerns being raised is on a steady increase which is a positive direction.

Further information

- A Freedom to Speak Up video has now been produced and will be launched as part of speaking up month in October.
- Local champions have now been trained and come from various departments across both sites and it is hoped more will be trained in the New Year.
- The FTSUG is now significantly involved in local and national networks and successfully applied for a place on the oversubscribed FTSUG development day.

National Guardians Office – Update on action plan following recommendations from visit in September 2017.

The organisational wide action plan (attached) has been reviewed and updated by on 9th October 2018.

Table 3: NGO action plan - Progress to Date

Rating	Number	Comment
Delivered and Sustained	1	
Action Completed	38	
On track to deliver	33	
No progress / Not progressing to Plan	7	Of the actions where the target date has passed: 2 – Audit of policy and procedures by MIAA, was planned for Quarter 1 escalated to lead 1 – Training review of current provision of vision and values training 3 – Policy reviews and update in partnership with STHK 1 – Sharing of cultural review report delayed due to ongoing HR issue

Freedom to Speak Up Self-assessment Tool for NHS Trusts and Foundation Trusts

Following completion of the tool and incorporating actions into the NGO action plan, the position in August 2018 was presented to NHSI, CQC and CCGs through the Southport and Ormskirk Improvement Board (SOIB) in September. The SOIB were supportive of progress in implementing National FTSU recommendations, NGO recommendations and completion of NHSI FTSU self-assessment tool.

Progress continues to complete actions identified with movement of 7 recommendations to 'fully met' since reporting in September 2018.

Current position is detailed below:

Table 4: self-assessment tool current position

Self-review indicator	Expectation being met	
	Partial	Full
Leaders are knowledgeable about FTSU	4	
Leaders have a structured approach to FTSU	1	3
Leaders actively shape the speaking up culture	5	1
Leaders are clear about their role and responsibilities		3
Leaders are confident that wider concerns are identified and managed		2
Leaders receive assurance in varying forms	4	4
Leaders engage with all relevant stakeholders		8
Leaders are focused on learning and continual improvement	6	2
Individual responsibilities CEO and Chair		5
Individual responsibilities Executive lead(s)	5	4
Individual responsibilities Non-executive lead(s)		6
Individual responsibilities HR and OD directors	2	1
Individual responsibilities medical and nursing directors	1	2

Recommendation:

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

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Finance, Performance & Investment Committee 29 October 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)

- A review of cancer waiting times has concluded that the Trust will not meet the 62 day national cancer standards until the end of quarter 4.
- Discussions on the winter plan are continuing, particularly around the scale and type of additional capacity needed to cope with the anticipated extra demand.
- At month 6 the Trust is overspent by £15.8m but is still aiming to meet the outturn target of a £28.8m deficit.
- The increased volume of non-elective activity has generated some commissioner challenges and these are being dealt with in the regular contract monitoring meetings.

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)

- Single sex accommodation breaches will be reviewed with the aim of improving compliance with the national standard.
- Given the high level of sickness absence, it was agreed that as a matter of urgency a wide-ranging review would be undertaken of the potential ways in which the Trust could bring the position into line with neighbouring organisations.
- The practice of admitting patients on the day before their surgery will be examined with a view to moving further towards same day admission.
- The information contained within the Service Level Reporting system (PLICs) remains unvalidated so work to complete the exercise is continuing.

ASSURE

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

The detailed daily analysis of blocked beds has been significantly enhanced, which will facilitate much greater oversight and intervention as necessary.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Audit Committee 17 October 2018
Lead:	Ged Clarke, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- There are elements in the Audit Handbook that should be included in the Annual Business Cycle (Work Plan) of the Committee. This includes Clinical Audit Strategy and periodical reports. An example of a business cycle including those elements to be shared by Mazars, the External Auditors.
- Mandatory training across all sectors remains a concern and the relevant leads have been alerted as to their responsibilities in this matter
- The Anti-Fraud Specialist alerted the Committee on a fraud scheme which was targeting the NHS and its suppliers. Decision makers have been warned to be on the alert.
- The apparent non-disclosure of Gifts and Hospitality by staff needs an urgent awareness programme.

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)

- All staff, including medical, need to be reminded of their responsibilities to declare outside work to their line manager and the Company Secretary as set out in the Standard of Business Conduct and Managing Conflict of Interests Policy

- All staff to be informed of new rules relating to the need for Privacy Notices in relation to their payroll information

ASSURE

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

The following are assurances received:

- MIAA-Internal Audit gave a fair assurance on Anti-Fraud in the Trust. There had been significant progress when benchmarked against other Trusts
- The Company Secretary had arranged meetings with key staff groups to refresh their knowledge and awareness around declaration of interests, outside work and gifts and hospitality. He was making arrangements for staff to make their declarations using Smart Sheets- an online tool from which reports/registers can be generated.

New Risks identified at the meeting

No new risks were identified as areas included in Alerts were already on the Risk Register.

Review of the Risk Register

No

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PUBLIC TRUST BOARD

7 November 2018

Agenda Item	TB265/18	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 performance management framework and are discussed with the relevant teams in monthly performance forum meetings.

The report contained the following components:

- Performance Dashboard
- KPI Highlight Report
- Executive Assurance
- Vision 2020 Workstream Progress
- KPI Graphs and Narrative

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	*Failure to meet key performance targets leading*

services	*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)*

This is a dynamic document and its structure and content may be updated as necessary.

Previously Presented at:

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

NHS
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NHS Trust

Integrated Performance Report

Trust Board November 2018

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Report - September 2018

Safe	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
MRSA	1	0	0	0			
C-Diff	3	0	6	0			
VTE Prophylaxis Assessments	95%	95.9%		178			
Never Events	0	0	2	0			
Harm Free (Safety Thermometer)	95%	99.2%	96.7%	3			
Falls - Moderate/Severe/Death	1	1	0	1			
Safe Staffing	90%	92%		N/A			
Patient Safety Incidents - Low, Near Miss or No Harm		582	3308	582			
Fractured Neck of Femur	90%	59.3%	75.9%	16			

Effective	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
SHMI (Summary Hospital-level Mortality Indicator)	100.1	118		N/A			
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100.1	119.2	119.2	N/A			
Stroke - 90% Stay	80%	64.3%	59.8%	5			
WHO Checklist	99.9%	100%		1			
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	12	64	12			
Written Complaints	44	17	135	17			
Friends and Family Test - % That Would Recommend - Trust Overall	90%	91%		62			

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%	91%	91%	910			
Accident & Emergency - 12+ Hour trolley waits	1	1	7	1			
Ambulance Handovers <=15 Mins	99%	50.5%	41%	708			
Diagnostic waits	1%	4%		140			
14 day GP referral to Outpatients	93%	94.7%	94.4%	46			
31 day treatment	96%	96.6%	98.1%	2			
31 day treatment (Surgery)	94%	100%	95.2%	0			
31 day treatment (Anti-cancer drugs)	98%	100%	100%	0			
62 day GP referral to treatment	85%	79%	80.4%	8.5			
62 day pathway Analysis	85%	79%	77.9%	8.5			
Referral to treatment: on-going	92%	95.3%	95.3%	464			

Well-Led	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
Duty of Candour - Evidence of Discussion	100%	44.4%	71.2%	5			
Duty of Candour - Evidence of Letter	100%	22.2%	78.8%	7			
I&E surplus or deficit/total revenue	-1%	-19.1%	-19%	N/A			
Liquidity	-23	-42	-42	N/A			
Distance from Control Total	0%	0.5%	-7.9%	N/A			
Capital Service Capacity	-2.423	-3.251	-3.559	N/A			
% Agency Staff (cost)	5.6%	6.4%		N/A			
Use of Resources (Finance) Score		3	3	N/A			
Distance from Agency Spend Cap	0%	16.1%	-5.6%	N/A			
Staff Turnover	0.8%	0.8%	5.7%	N/A			
Vacancy Rate - Medical		12.5%	12.5%	N/A			
Vacancy Rate - Nursing		11.4%	11.4%	N/A			
Sickness Rate	3.9%	5.4%	5.5%	N/A			
Personal Development Review	85%	69.3%	69.3%	N/A			
Mandatory Training	85%	84%	84%	N/A			
Care Hours Per Patient Day (CHPPD)	7.5	8.2		N/A			

Efficiency	Target	Actual	YTD Actual	Patients	RAG	Trend	1-mth F'Cast
DTOC - Number of Beds lost per month		6		5.65			
Post MOFD (Medically Optimised for Discharge) - Number of Beds lost per month		27		27.37			
Length Of Stay		6.6		N/A			
Bed Occupancy	85%	70.3%		N/A			
DNA (Did Not Attend) rate	8%	7.3%	7.4%	1583			
New:Follow Up	2.64	2.4	2.4	N/A			
Cancelled Ops	0.6%	0.3%	0.3%	7			
Theatre Utilisation	90%	74.3%	75.3%	N/A			

Reporting Frequency is monthly except for SHMI which is quarterly.

KPI Highlight Report

Safe	
Never Events	There were 0 Never Events in September. However it was identified that a never event occurred in July but was not identified as a never event until October The Never Event relates to a retained guide wire after insertion of a PICC line. There was 1 incident reported to Steis in September. The external review report will go to private board November.
Falls – Moderate/Severe/Death	Falls have reduced in number over the last three months
Fractured Neck of Femur	Performance has failed target for the fifth consecutive month and for the eleventh time in the last 12 months. New KPI on report – action plans included in future reports
Safe Staffing	Performance improving following the collaborative workforce streams inclusive of NHSI pilots - Performance reporting against the national target of 90% achieved in month.
MRSA	The Trust continues to achieve target. There have been no MRSA bacteraemia since September 2017.
C.Diff	There was no Hospital Acquired C diff in September and the Trust remains under its trajectory.
VTE Prophylaxis Assessments	Performance remains positive consistently achieving over the target of 95% compliance, and achieved 97.03% compliance in August which is the most recent available data
Harm Free (Safety Thermometer)	Performance compliance has improved and now exceeds the national benchmark
Effective	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio) - HSMR 12 Month Rolling Total for the Trust for May 2018	The HSMR for May 2018 was slightly down on the previous month and is the second consecutive reduction in a row. This is in line with a decline in the crude death rate (from 30.37 per 1,000 discharges in April to 28.98 in May).
SHMI (Summary Hospital-level Mortality Indicator) - SHMI for rolling 12 month period for Quarter 4	The SHMI for rolling 12 month period for Quarter 4 is 118. Although higher than last quarter this was expected given the high crude death rate already reported in this period.
Stroke - 90% Stay	Stroke performance shows a failure to meet the target. This is partly due to a data quality issue. Current indications are that we are very close to meeting the stroke target. This will be validated for the next report.
WHO Checklist	Compliant in September. Audit identified some non-compliance in August.
Sepsis Screening & Antibiotic Administration	The Trust continues to achieve target
Caring	
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	There is no improvement in compliance due to the consistent demand for acute inpatient beds. Patient flow management is ongoing
Friends and Family Test - % That Would Recommend - Trust Overall	Performance remains below the target of 95% but is within normal variation.
Written Complaints	The complaint numbers are 17 for the month of September. This is 5 less than the previous month and the lowest since February 2018.

Responsive	
Accident & Emergency - 4 Hour compliance	September performance saw some improvement, narrowly missing the 91% that had been set as part of the trajectory. Notable improvement was seen in performance on the Southport site - performance was 81% in comparison to 67.1% the previous year. This was despite an 11.5% increase in attendances compared to September 2017
Accident & Emergency - 12+ Hour trolley waits	There was one 12+ hour trolley breach in September where a patient required a side room and elevated bed that only 14b could provide.
Ambulance Handovers <=15 Mins	Performance against this target remains significantly below target, although performance for September 2018 was the highest performance seen for over 18 months.
Diagnostic waits	Performance continues to fail the target. Improvements are focused on Endoscopy, Non-obstetric ultrasound and the diagnostic element of the 62 day cancer pathway.
62 day GP referral to treatment	Compliance has improved, but is still below target - The cancer services team has initiated the 7 day pathway project to facilitate Trust wide changes which should lead to improvements in performance.
62 day pathway Analysis	There were 8.5 breaches of the 62 day standard in August (1.5 colorectal, 1.5 Haematology, 0.5 head & neck, 1 upper GI, 4 urology)
14 day GP referral to Outpatients	The Trust continues to achieve target
31 day treatment	The Trust continues to achieve target
31 day treatment (Anti-cancer drugs)	The Trust continues to achieve target. The last breach was in April 2018.
31 day treatment (Surgery)	The Trust continues to achieve target
Referral to treatment: on-going	The Trust continues to achieve target
Well-Led	
Duty of Candour – Evidence of Discussion & Evidence of Letter	The Integrated Governance Team continues to monitor and escalate to the CBUs areas of non-compliance
Care Hours Per Patient Day	Performance continues to achieve target for the sixth concurrent month.
Finance – please refer to the DoF Report for the detail	
I&E surplus or deficit/total revenue	A slight improvement in month resulting in a 19.1% year to date deficit.
Liquidity	Performance is relatively static although there is a minor improvement in September
Capital Service Capacity	Slight improvement in this metric as the Trust is achieving its financial plan.
% Agency Staff (cost)	Performance continues to deteriorate against the 4.4% monthly target. The majority of the agency spend is in nursing and medical staff (in month £639k of total agency spend of £704k)
Distance from Agency Spend Cap	Performance is deteriorating as agency spend continues to increase as the monthly plan educes. Performance against this metric is expected to deteriorate in the second half of the year and the NHSI cap of £5.67m will not be achieved.
Distance from Control Total	The Trust is ahead of its financial plan
HR	
Mandatory Training	The Trust's overall mandatory training compliance has seen a 0.49% rise in month. Performance is now just 0.9% short of the target of 85% at 84.01%
Sickness Rate	Sickness absence is reducing month on month however still remains high and is not significant to achieve target
Personal Development Review	PDR compliance has improved for the 5th consecutive month

Staff Turnover	Staff turnover has increased slightly in month but remains on target
Efficient	
OP Slot Utilisation	There is an increasing trend in utilisation although performance fell slightly last month - Further validation is required to ensure appropriate clinic data is being captured. Patient access team struggled over summer period with staffing due to sickness and vacancies.
Theatre Utilisation	Performance remains consistent, but is still failing target. Data cleansing exercise underway to validate data
Bed Occupancy	Bed occupancy remains on target across both sites.
DNA (Did Not Attend) rate	The DNA Rate for the Trust is 7.25% and remains within threshold
New:Follow Up	The New:FU Rate for the Trust is 2.43% and is within threshold.

NHS
Southport and Ormskirk Hospital
NHS Trust

Executive Assurance of Operational Performance

Director's Assessment Of Overall Position	Director: Chief Operating Officer	Amber

Director's Overview

4 Hour Performance: The Trust has failed to meet the 4 hour standard for Accident & Emergency waits since August 2015. Trust performance improved again in September to 90.9% which is mainly driven by improvements at the Southport site. The Trust was 0.1% short of the trajectory target for September 2018. Performance was 5.2% better than September 2017. For September the Trust ranked 27th in region (out of 44) and 80th nationally (out of 134). Trust performance was 4th best in the Cheshire & Mersey STP (out of 10).

Winter planning: The Trust continues to progress the internal winter plan schemes to drive efficiency & improvement with a prime focus in reducing Length of Stay. Capacity and demand modelling work was delivered by Ernst Young (EY) in June 2018 for Winter 2018/19. The work demonstrated that the Southport & Ormskirk (S&O) health and care system would have a gap of 40 beds in winter 2018-19 (November – February). This was based on the current capacity in the system (as at June 2018) and the projected demand for winter 2018 – 19. Southport & Ormskirk Hospitals NHS Trust has formally expressed concerns to the NM LAEDB and regulators in the inability for the S&O health and care system to manage the overall deficit gap. The Ormskirk Divisional General Hospital (ODGH) site has physical capacity available however due to workforce constraints the Trust is unable to open independently. The Trust wants to avoid having a greater number of patients in beds than capacity (e.g. medics and nurses) to treat them as this will reduce efficiency, create harm and halts flow. The commissioners have opted for alternative winter initiatives which currently have not been quantified in terms of impact on reducing Length of Stay. The Trust therefore cannot offer assurance that the system can maintain occupancy levels at 88% or below at the Trust.

62 day cancer waiting time: The standard has been achieved for achieved for 6 months (across the last 18 month period of reporting) and performance has been variable month on month with no statistical pattern. At the request of the Chief Operating Officer the Cancer services team has now developed an improvement plan with clear improvement actions and confirmed a trajectory G9against performance). This will be monitored at weekly Senior Operational Leadership Team meetings chaired by the Chief Operating Officer. The improvement plan focuses on a number of interventions which cover the following work streams: 1) Internal Pathway Design; 2) Training strategy; 3) Proactive cancer tracking; 4) Clinical engagement.

Assured/Most Improved

18 week RTT: The Trust is performing against the ongoing RTT target of 92%. There are only 3 services failing however controls are in place to support improvement (see below).

- Optometry where there is only 1 patient breeching
- Oral surgery which is at 91%. There has been issues with clinicians within this service. However, approval has been agreed and clinicians recruited to address the 41 outstanding patients.
- Community paeds where there are 42 patients breeching. Funding for clinicians has been sought from the West lancs CCG to address the issues within this service.

Ambulance Handovers <=15 Mins: The ED is increasing the physical capacity to support the 8% increase in demand into the ED. The reconfiguration of the build will be delivered by 31st October 2018. The completed work will introduce 4 dedicated assessment cubicles in ED for ambulance patients, in addition to the extension and relocation of triage. The improvement will enable crews to hand over patients timely in an appropriate area whilst improving privacy and dignity.

Not Assured/Most Deteriorated

Length of Stay: The Trust has reset the internal Patient Flow Improvement Board to primarily focus on reductions in LoS and continues to work with partners of the Southport & Ormskirk Local A&E Delivery Group to improve whole system patient flow for those patients classed as stranded that no longer need hospital care. Whilst average length of stay decreased again to 8.12 days this is not being delivered at the required rate. The Chief Operating Officer has introduced weekly monitoring of the delivery plan to ensure interventions are completed timely and robustly. The current project outputs and implementation do not provide assurance in offering sustainable delivery that offers good practice and reduces the known unwanted variations in process & practices.

Overdue Follow Up position: Trust position for overdue reviews is currently 2575. This has seen an improvement on the positon earlier in the year (May 3237). Of these patients 118 are more than 12 weeks overdue. Ophthalmology currently has 1337 overdue patients with 34 of these over 12 weeks overdue. Ophthalmology is currently tipping over 400 patients a month due to demand exceeding capacity. The issues are exacerbated by a number of factors. Workforce, both nursing and clinician; estate, which is shared with ENT and eRS position where it has been possible to book a NP appt in 3 weeks, hence attracting out of area patients from neighbouring trusts. To address these issues we have converted NP slots to FU. Following risk stratification of the 12 week+ patients, the patients are given appts in these slots. This has enabled us to reduce the overall position down from 1900 earlier in Oct. We gave also progressed discussions with the clinicians and an external resource, Eyecare. The clinicians have commenced risk stratification of the remaining overdue patients against an agreed exclusion criteria to identify patients that can be outsourced.

62 day cancer waiting time: Due to the complexity of the Cancer pathways it is essential interdependencies improve at the same rate / time The below areas have been identified as work streams that support overall efficiency and will contribute to overall improved performance against the Cancer waiting time standards. The key areas being: Successful delivery of Electronic Referral Service; Radiology; Medway to SCR link; and Endoscopy.

Diagnostic waits (Endoscopy): The current Endoscopy improvement is not formally recorded and concerns have been raised by the Chief Operating Officer on accountability and visibility. This will be addressed through the “Theatre & Endoscopy Improvement Programme” led by a dedicated Programme Director (Jenny Farley) and supported by the PMO. A project plan has been developed (October 2019) which covers 8 high impact actions (derived from a number of recommendations from external visits from nationally acclaimed experts). The trajectory for improvement is being developed however the overall aim should be to offer patients the 3-week Reasonable Notice Rule whilst trying to maintain the 14 day Target.

Director's Assessment Of Overall Position	Director: Dr Jugnu Mahajan	Red

Director's Overview

SHMI & HSMR : Trust is actively working to reduce both HSMR and SHMI values to bring them within acceptable parameters by 2020.Clincal pathways to improve quality of care are being developed and rolled out. Structured Judgement reviews methodology for Learning from deaths is now being used and compliance is improving.. Work streams under Reducing Avoidable Mortality project are being progressed.

Assured/Most Improved

High SHMI and HSMR remains a risk for the trust. Action plans are in place to improve care and reduce SHMI & HSMR . The actions are being monitored at the board level via the Quality Safety Committee and monthly Reducing Avoidable Mortality report to the board..

Not Assured/Most Deteriorated

Director's Assessment Of Overall Position	Director: Director of Nursing, Midwifery & Therapies, completed by Deputy Director	Amber

Director's Overview

Performance in Harm Free Care, VTE, sepsis screening, Care Hours Per Patient Day is positive.

Work continues to improve the response rate for FFT, with systems now in place to ensure collection of feedback in the Discharge lounge. Paediatric teams are introducing the use of an IPad, to collect data, and if successful will be rolled out across other areas. This will be supported as we recruit volunteers to support clinical teams in the collection of real time feedback.

The number of complaints received continue to reduce although the response time to relatives is still longer than the 40 day target.

Assured/Most Improved

Harm Free care data is now collected on the same day across the trust to prevent duplication of data

Not Assured/Most Deteriorated

The process and data collection in relation to Duty of Candor is under review. Currently the data is conflicting and does not give assurance that all patients who have been part of an incident which has caused moderate harm or above have been informed either face to face or by letter.

The identification of a 'Never Event' related to a guide wire being left in situ is under investigation, with immediate discussion with anaesthetic teams and release of a 'safety notice' to clinical staff.

Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward remains a challenge. The review of data collection has been completed and the recruitment of a stroke nurse to increase cover to 24/7 is ongoing.

Director's Assessment of overall position	Director: Director of Finance	Red

Director's Overview

Month 6 financial performance remains consistent with previous months, however there are a number of risks that will impact on whether the Trust will deliver the planned deficit of £28.8M as follows:

- Delivery of £7.5million CIP is at risk although additional schemes are continually being identified.
- The Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) tariffs proposed in the draft independent report will need to be paid in full by CCG's; this is estimated at £1.6 million for the year.
- It is likely that commissioners will apply sanctions as the Trust could not sign up to its control total; the value of sanctions that could be applied for the first six month's performance is £1.2 million although performance in recent months has improved.
- Pressures from vacancies, sickness and rota gaps are resulting in increased agency usage.
- CQUIN underperformance could result in reduced income of up to £500,000 for the full year.
- The Trust has been successful in receiving additional capital funding.

Assured/Most Improved

- Deficit for first six months of £15.750 million against a £15.788 million deficit plan; favourable variance of £39,000 against plan.
- Income ahead of plan; accrual of £800,000 included in income for outcome of Expert Determination on ACU CDU tariff.
- Total underlying expenditure levels (both pay and non-pay) remain consistent compared to last year.
- The Trust continues to receive cash support from DHSC on a monthly basis to support the planned deficit.
- Income for CQUIN schemes forecast to improve following increased focus.

Not Assured/Most Deteriorated

- CIP plan has not been delivered for the first half of the year. Although further CIP schemes have been identified the CIP target of £7.5 million has a projected shortfall of £1.8 million at the year end. £1.797 million was achieved to end of September against a plan of £2.899 million which is a shortfall of £1.102 million; the in-month plan shortfall was £424,000.
- Agency spend has risen over the last four months and is at the highest level (£705,000 in September) in over a year; the year to date agency spend of £3.7 million will result in the Trust breaching the year end agency cap set by NHS Improvement.
- Half Year deficit of £15.750 million represents a run rate that will deliver a year end deficit exceeding £31 million unless improvements can be made to both income and expenditure levels in the second half of the year.
- CCG have challenged the ACU/CDU tariffs as well as predicted income levels for non elective activity.
- Risk of sanctions being applied by CCG's for performance against operational standards such as A&E 4 hour wait and ambulance handovers.

Director's Assessment of overall position	Director: Director of Human Resources	Red

Director's Overview

HR continues to provide full support to CBUs and Corporate services to improve their current position regarding sickness, mandatory training, appraisal rates etc. This includes HR Essential Skills training.

I hope to see a sustained improvement in all areas highlighted in the Board Report.

Assured/Most Improved

Personal Development Reviews rates remain just below the target of 85%, however, there is continued improvement and the current overall Trust position is 84.01%. I am particularly pleased to see the improvement in Corporate and Specialist Services who have made a huge effort to improve and both areas are now over 85%. Review at PBR meetings will continue to ensure trajectories are met and/or exceeded.

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In order to support managers with PDRs, the Training and Education team have reviewed the documentation to make it more “user friendly” for staff and managers to have a meaningful conversation. Hospital Management Board has had the opportunity to comment on the documentation and they will be circulated across the Trust shortly.

Work continues to build the Trust Bank and reduce agency usage. AHP’s have been included in TempRE bank resourcing system from September 2018, with plans to grow the number of staff on the bank in this staff group. The People and Activity Group, which meets weekly, ensures there is an action plan and trajectory to remove all temporary/interim posts across the Trust.

Not Assured/Most Deteriorated

Whilst sickness absence rates are still higher than the Trust target, the HR team remains focused on supporting managers to address high levels of sickness across the Trust and to improve attendance.

The reviewed Supporting Attendance Policy has not been agreed in the timeframe originally planned with ongoing discussions with Staff Side Colleagues in October. The policy must be presented at November Workforce Committee. Whilst a new policy will not address all issues with sickness absence rates, it will help to manage absence in a consistent and meaningful way.

HR continues to support CBUs to reduce sickness rates and support staff who need support and assistance to maintain regular attendance at work. Sickness is a standing item at monthly CBU Meetings, IPR meetings and HR Metrics are discussed at Workforce Committee.

HR, Nursing Colleagues and NHSI continue to work together on the Health and Wellbeing pilot Action Plan with the ultimate aim of improving attendance at work. The Flu campaign has been launched and a Health and Wellbeing Day is planned at the end of November 2018.

Vision 2020 Progress Report

October 2018

Board Leadership	RAG Rating

Key Achievements/Progress

BOARD LEADERSHIP & DEVELOPMENT & FITNESS TO GOVERN

A robust Board Development Plan has been developed using the Four (4) Well Led Domains of:

- Strategy & Planning
- Capability & Culture
- Process & Structures
- Measurement

Elements of the programme to involve Senior Leaders and will be delivered by Aqua, MIAA and specialists in their fields

A meeting to finalise the details of the Development Programme was held with the Chair and separately with the CEO. The CEO has had talks with Aqua to discuss ways in which they can input into the been planned for 12 September with the Chair, The Head of Learning & Development, after discussions with the Company Secretary, has finalised talks with Aqua and confirmed that they will deliver three (3) sessions on Well Led: 5/12/18; Jan 2019 and 6/3/19. These sessions will involve not only the Board but Senior Leaders. In addition there are development programmes planned on:

- Good governance
- Objective setting/ Strategic Planning-9/1/19 and 6/2/19
- Leadership Masterclass (topic to be firmed up) by Professor Michael West of Lancaster University-invitation to be extended to LA Colleagues and NHS Executives and Senior Leaders. This will mean zero cost for securing the services of the Professor.
- “How increased ownership of inclusive behaviour will reduce discrimination, unfairness, bullying and harassment and how it’s everyone’s responsibility”- by Tracie Joliff, Head of Inclusion, Systems Leadership(NHS Leadership Academy)

We have already had workshops on: GDPR and Effective Use of Integrated Performance Management and Reporting

Key Achievements/Progress in Month

Delivery of the Well Led Review as part of the SOSH priorities is on track
Significant developments include:

- Chair recruitment-on the way with interviews scheduled for 29 October 2018
- Conditional offer made to substantive Medical Director in September 2018

Key Risks/Issues	Mitigating Actions	RAG
If the Board Development programme does not demonstrate Well Led the CQC could impose harsh measures given the recommendations made in their March Inspection Report. The Well Led Action Plan although not completed has been updated in key areas.	Ensure that the Well Led Programmes/Sessions within the Board Development Programme are rolled out as planned. This being progressed hence a rating of GREEN as per our BRAG system	G

BOARD GOVERNANCE

JM1

QUALITY & SAFETY

RAG Rating

Key Achievements/Progress

QUALITY & SAFETY PLAN

See separate paper for detail
22 should and must do actions are green , 1 is blue
24/7 critical care outreach service approved
Reducing Avoidable Mortality

QI METHODOLOGY

Programme to deliver QI training agreed and to commence in December
Recruited to PMO posts
SJR's commenced

SAFE STAFFING

Review of all ward based establishments planned for Q3, position paper presented to Trust Board. Training commenced with support from NHS Improvement, with further sessions planned in October 2018.
Continue to use temporary workforce to bridge gaps in nursing and medical staffing. Daily review of nurse staffing through Staff Safety Huddle.
Recruited into consultant and nursing vacancies

MEDICAL WORKFORCE ENGAEMENT

Senior doctor's engagement session held on 27.9.18. with CEO ,MD and members of Exec Team. Well received with positive feedback. Regular meeting to be held Quarterly
Engagement with Senior clinicians via existing forums
Approval for 5 SAS posts to improve clinical supervision and patient safety on Medical wards.
Appointment of three A&E consultants, 4 T & O consultants,2 COE consultants. Further approval of 8 clinical fellow posts in Medicine to improve safety . Approval for 5 AICU Medical consultant posts to improve Patient flows and safety.
Improved Doctors Mess facilities.

Key Achievements/Progress in Month

2 Deputy Don posts and Head of Care for Older People commenced
Buddy agreed in principle with Leeds
Preparations for CQC inspection agreed at Trust Board

Key Risks/Issues	Mitigating Actions	RAG
Capacity and capability to deliver multiple quality improvement projects	Recruited into PMO and Deputy DoN posts, adopt a project management approach to oversight	A
Preparation for CQC inspection	DoN, Turnaround Director and Improvement Director to commence planning	A

WORKFORCE — AMBER

Key Achievements/Progress

WORKFORCE EFFICIENCY

Establish a Trust wide People and Activity Group
Reduce Agency Spend to comply with NHS cap of £5.6 Million
Extend utilisation of TempRE bank resourcing system to include AHPs, A&C, Estates/Facility staff
Improve Productivity through robust Job Planning
New Supporting Attendance Policy (sickness absence) still in negotiation

CLINICAL WORKFORCE PLAN

This programme is due to commence March 2019 – Initial scoping document to be presented to Executive Team in October 2018

RECRUITMENT AND RETENTION

Develop Action Plan in concert with NHSI Retention pilot
Reviewed Exit Interview process to ensure meaningful data is captured
Positive meeting with NHS Improvement. Engagement events planned in October 2018 with nursing w'force to prioritise our 'Retention' actions as advised by NHS Improvement. Final actions plan for NHS I to be submitted to NHSI w/c 29th October 2018

LEARNING AND DEVELOPMENT

Establish CBU trajectories to increase mandatory training rates to 95%
Establish CBU trajectories to increase appraisal rates to 95%
Deliver HR Essential Skills training to Trust managers on an ongoing basis

HEALTH AND WELLBEING

Planning for the Flu campaign 2018 has commenced.
A programme of communication and events which will highlight the Health and Well Being support available to staff will be circulated widely in October 2018.

OD AND STAFF ENGAGEMENT STRATEGY

Workforce and OD Strategy (including associated plan) agreed and ready for circulation to wider organisation.

HR IMPROVEMENT PRIORITIES

This programme is due to be completed by April 2019 – Temporary HR resource secured to develop a transfer strategy and action plan. Postholder to commence in November 2018.

2018/19 FINANCIAL PLAN

RAG Rating

Key Achievements/Progress

IMPROVE THE SHORT TERM FINANCIAL POSITION – CONTROL & USE OF RESOURCES

Current performance

Month 5 year to date (YTD) deficit (£13.5M) worse than plan (£13.3M). Income reduction of £0.3M actioned in month 5 for CQUIN underperformance YTD. Excluding CQUIN deduction there has been an improvement in the deficit run rate compared to previous months which is mainly driven by income.

Progress re plan

Discretionary spend policy – policy has now been implemented and number of requests have been rejected.
People and Activity group, CQUIN review group, CIP check and Challenge group and Business, Development and Investment Sub Committee have all been established as planned.
List of locums now in place and exit plans are being reviewed and challenged. Substantial number of clinicians recruited but the Trust is waiting for Visas and therefore currently unable to confirm exit date for locums.

Key action

Further work to be done on "No PO, No Pay" policies, supplier and product rationalisation and stock levels to drive further savings.
Additional control measures will continue to be added into the system until such time the run rate reduces.

COST IMPROVEMENT PROGRAMME

Current performance

Month 5 YTD CIP delivery of £1.5M against plan of £2.2M. Projected delivery of £4.1M against £7.5M CIP plan resulting in shortfall of £3.4M

Progress re plan

CIP workshops held with each CBU to drive additional CIP's; in total 180+ ideas have been generated and now being developed.
Line by line budget review is yielding additional tactical savings and CIP ideas.
Focus is on development of transformational schemes such as theatres, LoS and outpatients to drive recovery of lost planned activity and to improve efficiencies.
Further focus is on workforce linked CIPs and run rate reductions, including reduction in use of bank and agency, recruitment, improvements to rostering and further efficiencies driven via job plans.
Efficiency opportunities linked to Model Hospital has commenced following the additional PMO resource secured in August. Meetings with Model Hospital teams are being organised to maximise the impact.
Further work done on looking at the most loss making contracts and plans are being formed to confirm what the next actions are.

Key action

All newly identified opportunities must be either developed and implemented making immediate impact on run rate or added to pipeline for 19/20.
Create week by week plan for the large transformational schemes to allow clear tracking of benefits.
Start conversations in respect of loss making contracts.

FINANCIAL GOVERNANCE

Current performance

Grip & control governance changes proposed and implemented (see above).
Further work to be done around changes to procurement (see above).

2018/19 FINANCIAL PLAN(2)	RAG Rating

Key Achievements/Progress

FINANCIAL GOVERNANCE (cont.)

Progress re plan
Meetings with all budget holders (and their Divisional Finance Managers (DFM)) have been set up for September/October to enable TD review and starting to yield results.
Proposal for reducing current authorisation limits outlined in Scheme of Delegation has been drafted.
Board approval given to reduce authorisation levels; this is to be implemented by the end of October.

Key action
Further work to be done around procurement grip & controls.
Development of Internal Improvement Board required.

FINANCIAL STRATEGY

Current performance
MBI held conference call with CCG's and SOHT DoF on 26 September to discuss scenario outputs from the MBI economic modelling.

Progress re plan
On target.

FINANCIAL PLANNING CYCLE

Current performance
Coding and Counting – SOHT sent letter to CCG colleagues on 28/9/2018 as required by the guidance. The Trust also included other items to be considered as part of the contract negotiations. West Lancashire CCG have sent their Coding, Counting and Commissioning intentions to the Trust.

Progress re plan
Exchange of letters compliant with guidance.

Key action
Trust to establish activity forecasts alongside commissioning intentions for 2019/20 onwards
Finance team to formalise and communicate financial planning requirements alongside the Business Planning process.

Key Risks/Issues	Mitigating Actions	RAG
Month 6 deficit run rate does not reduce	*Further work on CIP, governance and "grip and control" led by TD should impact from month 6 onwards and enable the delivery of the Trust's financial plan.*	R
CIP target for month 6 (both "in year" and year to date) and future months is not achieved	*Work led by TD is more likely to impact in future months rather than mitigate the expected month 5 CIP performance; The use of reserves may partially mitigate.*	R
Sanctions are applied by commissioners which are forecast to be £2.7M for the full financial year.	*Trust and commissioner colleagues to agree regarding application of sanctions and the cost of winter pressures*	R

ACUTE SUSTAINABILITY

RAG Rating

Key Achievements/Progress

SERVICE CHANGE PROPOSAL

Service change proposal (Case for Change and emergering Clinical Scenarios) completed by KMPG/TU July 18
Governance and Decision Making Framework agreed at Sefton Transformation Board and core membership agreed at Clinical Leaders Group Aug 18
Staff engagement meetings continue led by CEO and other members of the Executive Team, meetings with local MPs continue led by CEO
Clinical patient reference group meetings scheduled in October

CLINICAL SCENARIOS

Work on other clinical work streams is slow but has been the focus of concentrated work during Sept in preparation for the Senate visit
Yorkshire and Humber Clinical Senate visit 2 Oct to test robustness of emerging models
Provider Alliance relaunched , provision models differ across the patch and concerns remain about capacity and capability to deliver

ESTATES SOLUTIONS

Work progresses on hot/cold site split with Prof Briggs returning to Trust 17 Oct to launch the programme
WWL has presented first thoughts on use of Ormskirk to be discussed in detail with DOF and DOS 24 Oct
Time in diary end of October to map out 2 year timeline for Ormskirk estates development

FINANCE SOLUTIONS

Further stress testing completed on financial options however the Provider Alliance keen to test OOH assumptions quickly
Capital bid £600k for digital enabling, EPR and telehealth progressed from C&MHCP through regional to national panel

OPERATING MODEL

Potential operating models being explored through financial modelling to better understand viable options
Contact made with external colleagues about digital opportunities and developing plan to investigate further

Key Achievements/Progress in Month

Presentation to NHS England and NHS Improvement strategic sense check 14 Sept
Preparation for Clinical Senate visit and meeting with Matthew Swindells

Key Risks/Issues	Mitigating Actions	RAG
Maturity of Out of Hospital solutions to inform acute demand modelling	Develop a MoU with each neighbourhood and advance the Integrated Delivery Framework in West Lancs	A
Capital bid for PACU (Post Anaesthetic Care Unit) declined	Further development of funding application to support future opportunities	A
Capital bid for new hospital of £100k must include OOH requirements	Additional diverse funding sources to be investigated	A

OPERATIONAL PERFORMANCE

RAG Rating

Key Achievements/Progress

HIGH IMPACT IMPROVEMENT PLAN FOR IMPROVING FLOW (INCLUDING WINTER PLAN)

Current performance – key issues and actions

The Trust had a 4 hour access target of 91% for September and came in at 90.08 % . The Trust was above trajectory until the 28th September and then the weekend saw higher level of attendance with some increase in admissions however the biggest issues was delay in discharges causing the position to drop. The Trust continues to work with partners to expedite delays and there are significant issues with Sefton Local Authority's ability to support community capacity which they are trying to address.

Progress on Red to Green

Roll out is on trajectory , additional resource is being sourced to support the roll out . Some wards are showing and improvement in processes which is supporting ward teams more effecitgly manage discharges in a timely manner.

Operational resilience

Ambulatory Care continues to be ring fenced which is supporting flow . SAU function continues to increase which is also having a positive impact on flow for surgical patients.

System and Trust inputs to Winter plan

The Winter Plan was approved . Southport and Formby CCG however have confirmed they are not in a position to support the system wide plan of Transitional Beds . They have 5 schemes which they have outlined to the Trust's Chief Executive and further detail is required to understand and mitigate against the capacity gap.

OPERATIONAL EFFICIENCIES

Plan to reduce LOS

A LoS programme Board is now well established with by weekly meetings covering Winter Planning and Flow monitors progress against plan .

Cancer

the Trust continues to fail against this target , re alignment of breaches in accordance with new national policy say the Trust's position deteriorate further. The project management of the Cancer Recovery Plan is established and work on the various work streams to support delivery has commenced.

RTT

The Trust Delivers against this 92% target coming in above trajectory at 95.3 % Ophthalmology remains the greatest number of over due follow ups. The CCG, lead clinicians and management teams have met to agree the process for minimising the risks

CIP

The Programme Boards for OP and Theatre have been drawn up and support from the PMO agreed. Theatre's workforce work stream has commenced . Out Patients is on track for October.

Key Achievements/Progress in Month

RTT continues to deliver against the trajectory . Red to green continues to be progressed . The 4 hour access target was above trajectory until the last weekend in the month. The Trust approved additional therapy support and recruited a therapy lead to support the frailty pathway. Additional funding for ACPs was also agreed to support flow/

Key Risks	Mitigating Actions	RAG
4 hour access target Over due Follow-ups – ophthalmology Delivery of CIP by CBUs	Weekly meeting now established chaired by Interim Deputy COO Planning to out-source, review of GIRFT actions and clinical meeting with MD Project plans draw up with details including KPIS and Accountability	R
		R

NHS
Southport and Ormskirk Hospital
NHS Trust

KPI Graphs and Update

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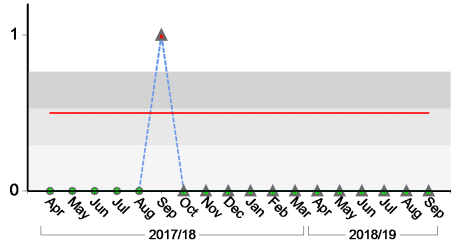
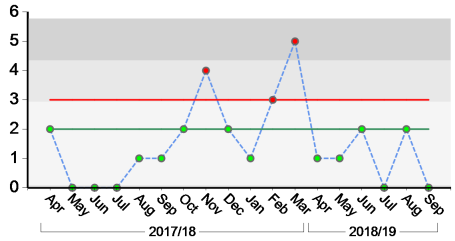
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0.	NO MRSA bacteraemia since September 2017 - There is a zero tolerance for MRSA blood stream infection - it is now more than a year since the last MRSA bacteraemia.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Adherence to Trust Cannula Care Plan	80	IPC team have conducted a cannula audit and reported this through Trust meetings; the team has also updated the cannula care plan and will do a further audit in September 2018. The CBUs have determined that cannula care plans need to be assessed by senior nurses on the wards and that this will be monitored by the respective CBU Matrons, however the CBUs haven't as yet determined how the monitoring will be accomplished and recorded. August update - the CBUs are due to report on further prgress in the IPC Assurance meeting in September. September update - no further progress by the CBUs, IPC team to conduct a point prevalence survey in October	Off Target

Indicator Name	Description	Narrative	Month Trend
C-Diff	Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 36 for the year. Good performance is fewer than 36 for the year.	No Hospital Acquired C diff in September - This year the target set by NHSI is for the Trust to have no more than 35 hospital acquired C diff infections; the Trust also has an internal stretch target of no more than 20 infections (this is because in 2017/18 our actual cases were 21). The above targets allow for 2.9 cases per month if using the NHSI target or 1.7 if using the stretch target, hence the Trust is under trajectory by either 14 cases (based on NHSI target) or 6 (based on Trust stretch target).	

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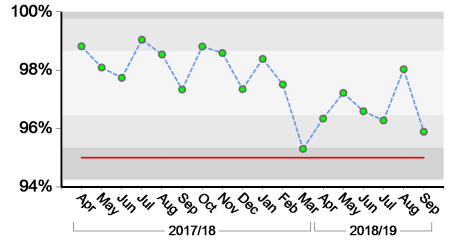
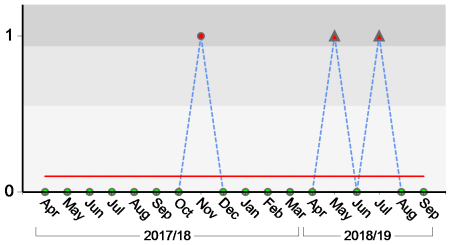
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
VTE Prophylaxis Assessments	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher.	Performance remains positive consistently achieving over the target of 95% compliance, and achieved 97.03% compliance in August which is the most recent available data -	
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death.	There were 0 Never Events in September. However it was identified that a never event occurred in July but was not identified as a never event until October The Never Event relates to a retained guide wire after insertion of a PICC line. -	

Action Description	Action Progress (%)	Action Narrative	Action Status
Checklist Task & Finish Group to be implemented for WHO etc.	50	AMD to implement T & F for Trust wide amendments to WHO checklist	Off Target

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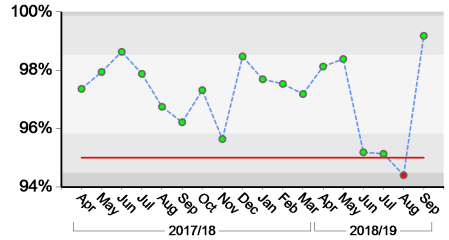
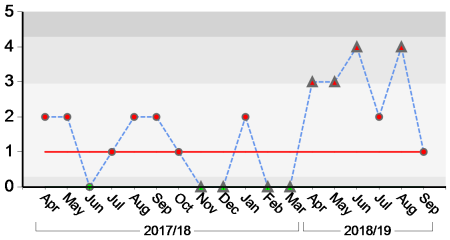
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Harm Free (Safety Thermometer)	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better.	Performance compliance has improved and now exceeds the national benchmark - National benchmark of 95% reached for month of September. During the census period of data collection (n=368the Trust reported 3 new patient harms which were made up of: 1 new HAPU (Grade 2 or above) – 9b (1 x Grade 3) 2 new VTE – Critical Care (1 x DVT) 7a (1 x PE) Actions are responsibility of respective CBU or identified individuals as below	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review UTIs	20	Review UTI to understand Root Causes and formulate action plans AC now part of NHSi Urinary Tract Infection Collaborative looking at a number of issues, which catheter related urinary tract infections is part of. Progress reports into Infection Control Committee	On Target

Indicator Name	Description	Narrative	Month Trend
Falls - Moderate/Severe/Death	The total number of falls within the Trust were the severity of the harm was either moderate, severe or resulted in death. Threshold:0	falls per 1000 bed days - September Data per/1000 bed days Planned care 3.07 falls shows a slight increase in falls on last months data and 1.65 with harm is an increase from 0.75 falls Specialist services 0.43 falls down from 0.46 and 0 falls with harm reported in September Urgent Care 4.56 falls in September down from 5.2 this is the third month that has shown a reduction in falls 2.39 falls were reported with harm again this is a reduction from 2.6	

Action Description	Action Progress (%)	Action Narrative	Action Status

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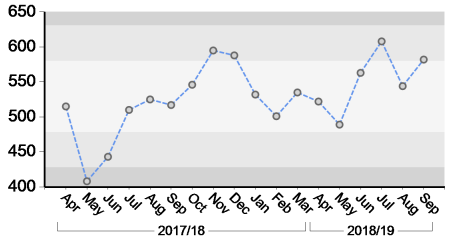
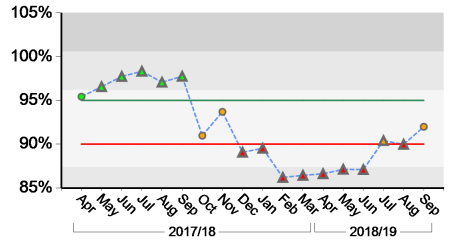
NHS Southport and Ormskirk Hospital NHS Trust

Safe

Indicator Name	Description	Narrative	Month Trend
Patient Safety Incidents - Low, Near Miss or No Harm	The number of incidents relating to patients where the severity was Low, Near Miss or No Harm caused. A lower number is good.	There were 588 lower level incidents reported in September - There has been an increase in the reporting of lower level incidents during September for the Trust, 588 reported compared to 544 last month; for September there were 31 Near Miss Incidents , 451 no harm and 106 low harm incidents , the catergories with the top 3 highest reported incidents relate to safeguarding (non pressure ulcer), Accidents and communication/consent/information	
Safe Staffing	The ratio between the proposed number of nursing staff to ensure a safe staffing level and the actual number of nurses working those shifts. Threshold: 95%, Fail 90%.	Performance improving following the collaborative workforce streams inclusive of NHSI pilots - Performance reporting against the national target of 90% achieved in month. This is supported through data cleansing activities inclusive of all shift cover outside of healthroster (agency fill) now being captured to facilitate clarity on actual shift fill across all inpatient areas. Nursing and Midwifery now has a substantive HealthRoster lead to facilitate work ongoing and provide much needed direct & support to ward leaders.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Acuity and dependency scoring of patients against Safer Nursing Care Tool (SNCT)	80	NHSI national workforce leads have completed training programme to Trust Leads. Ongoing delivery of training by CF/FB by end of Oct 18	On Target
Establishment reviews for nursing and midwifery	70	Establishment reviews planned during Nov 2018	On Target
E-roster Performance reviews for Nursing and Midwifery	70	Trust involved in NHSI nursing workforce productivity improvement lead inclusive of work against auto Rostering and personal patterns	On Target

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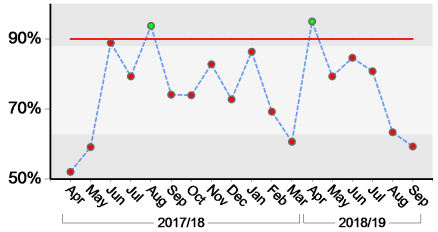
Safe

Indicator Name	Description	Narrative	Month Trend
Fractured Neck of Femur	Percentage of FNOF operated on within 36 hours of admission. Threshold: 90%.	Performance remains below target for the fifth consecutive month and for the eleventh time in the last 12 months -	

Action Description	Action Progress (%)	Action Narrative	Action Status
Report on remedial action plan	0		On Target

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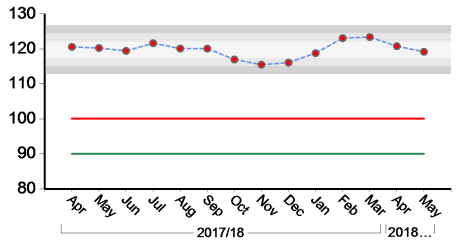
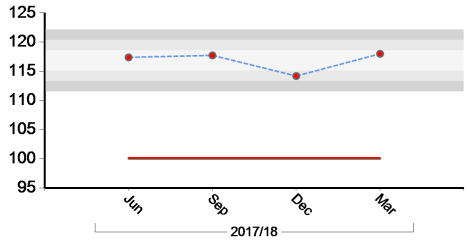
NHS Southport and Ormskirk Hospital NHS Trust

Effective

Indicator Name	Description	Narrative	Month Trend
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100. At Trust level, good performance is 100 or less. Source = Dr. Foster. Please note: This indicator is reported monthly and is 3 months behind due to when Dr Foster publish the data.	HSMR 12 Month Rolling Total for the Trust for May 2018 - The HSMR for May 2018 was slightly down on the previous month and is the second consecutive reduction in a row. This is in line with a decline in the crude death rate (from 30.37 per 1,000 discharges in April to 28.98 in May). The diagnostic areas attributable for the decline in May were: renal failure, pneumonia and Urinary tract infections.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Best Practice Care Pathways	50	Revised and updated AKI, sepsis and pneumonia pathways. Best practice pathway for GI Bleed and revised, well publicised drugs charts	On Target
Communication and Escalation of the Deteriorating Patient	30	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	On Target
Future Care Planning	40	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 ,	On Target
Learning Culture	60	Roll out and embedding of the Structured Judgement Review	On Target
Information	80	Continuous assessment for opportunities for improvement. Collaborative Working with AQUA and Dr Foster.	On Target

SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly and is 6 months behind due to when Dr Foster publish the data. Good performance is 100 or less.	SHMI for rolling 12 month period for Quarter 4 - The SHMI for rolling 12 month period for Quarter 4 is 118. This ratio has been calculated from a total of 1,381 actual deaths over an expected figure of 1,170. Although higher than last quarter this was expected given the high crude death rate already reported in this period. It should be noted that this rate is actually lower than the comparable period last year and the underlying data demonstrates an actual reduction in observed deaths in the period (1,381 vs 1,392).	

Action Description	Action Progress (%)	Action Narrative	Action Status
Best Practice Care Pathways	50	Improvement and revision of AKI, sepsis and pneumonia pathways. Best practice pathway for GI Bleed and revised, well publicised drugs charts	On Target
Commmunication and Escalation of the Deteriorating Patient	30	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	On Target
Future Care Planning	40	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	On Target
Learning Culture	60	Roll out and embedding of the Structured Judgement Review	On Target
Information	70	Continuous assessment for opportunities for improvement. Collaborative Working with AQUA and Dr Foster.	On Target

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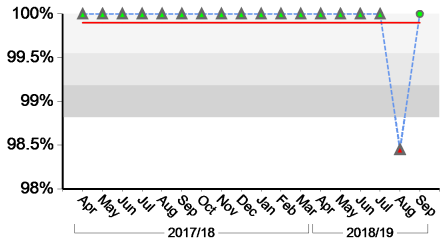
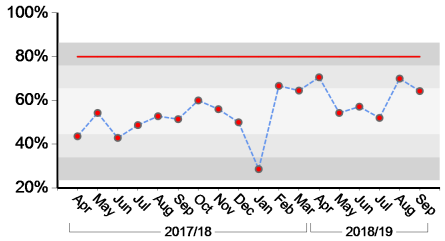
Effective

Indicator Name	Description	Narrative	Month Trend
WHO Checklist	WHO Checklist.	Compliant in September. Audit identified some non-compliance in August. -	

Action Description	Action Progress (%)	Action Narrative	Action Status
WHO Checklist Report	0	Discussed in clinical governance. Report required from audit team to include WHO checklist compliance in 2018-2019 audits	Off Target

Indicator Name	Description	Narrative	Month Trend
Stroke - 90% Stay	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Please note: Indicator may change as a result of delayed validation.	Stroke performance shows a failure to meet the target. This is partly due to a data quality issue. The timeframe for 'lockdown' of data has been revised to enable timely and accurate reports. -	

Action Description	Action Progress (%)	Action Narrative	Action Status
Protected stroke bed	80	due to bed pressures and patient flow this is not always possible	On Target
Additional stroke nurse to provide 7day 24hr cover	50	Awaiting Vacancy approval	On Target

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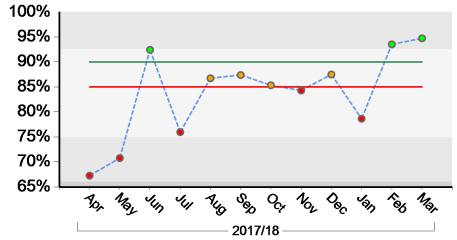
Effective

Indicator Name	Description	Narrative	Month Trend
Sepsis Screening & Antibiotic Administration	Sepsis Screening & Antibiotic Administration.	The Trust continues to achieve target -	

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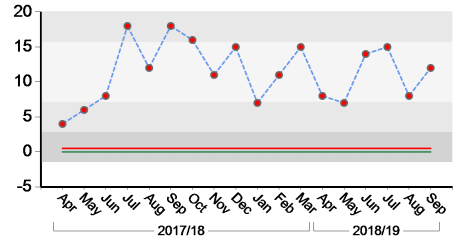
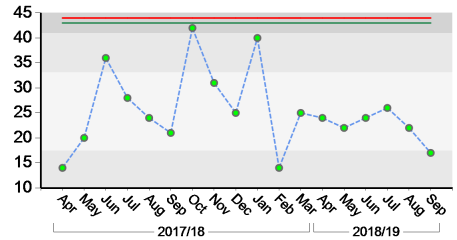
NHS Southport and Ormskirk Hospital NHS Trust

Caring

Indicator Name	Description	Narrative	Month Trend
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours.	No improvement in compliance - DSSA breaches occur when a patient is deemed fit to be transferred out of critical care into an acute bed within the hospital. With the consistent demand for acute inpatient beds this compliance is regularly breached. Meeting held with EMS to discuss current triggers within EMS that do not identify delayed transfers from critical care. awaiting system wide response	

Action Description	Action Progress (%)	Action Narrative	Action Status
Ongoing patient flow management	100	Ongoing	On Target
review of data collection from Critical care to monitor time delays	30	new template being developed	On Target
review of EMS plus to monitor delayed transfers from critical care	40	risk identified to EMS and request for altered triggers to be discussed with other acute trusts by EMS	On Target

Written Complaints	The total number of complaints recieved. A lower number is good.	The complaint numbers are 17 for the month of September, this is 5 less than than the previous month and the lowest since February 2018. - The complaints will be reported in the Qualityand Safety reports for each Clinical Business Unit. The Clinical Business Units continue to work through the complaints within the required timescales, and the adherence to these timescales is monitored through the monthly Quality and Safety reports.	

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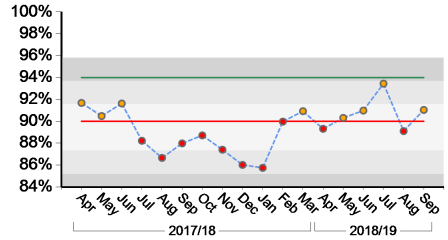
Caring

Indicator Name	Description	Narrative	Month Trend
Friends and Family Test - % That Would Recommend - Trust Overall	The proportion of patients overall who responded that they would be likely or extremely likely to recommend the Trust to Friends and Family.	Performance improved on previous months data. - Performance slightly improved on previous months data, however remains below the target of 95%. Implementation of the Trust patient experience strategy continues. Other positive developments are ongoing in the Trust such as A+E redesign, Red to Green and Home First Campaigns which should all have a positive on the patient, family and carer experience.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Patient Experience Strategy - Pledge Groups.	50	Pledge groups ongoing.	On Target

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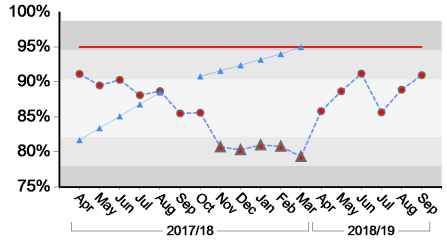
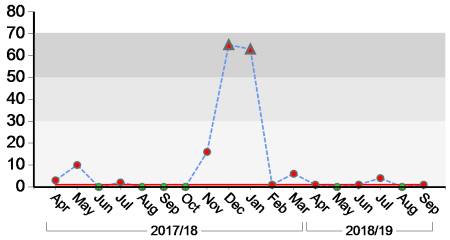
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher.	September performance saw some improvement, narrowly missing the 91% that had been set as part of the trajectory - September saw some improvement against the 4--hour standard, however fell just below that trajectory position of 91%. Notable improvement was seen in performance on the Southport site - performance was 81% in comparison to 67.1% the previous year. This was despite an 11.5% increase in attendances compared to September 2017 (an additional 523 patients; 450 of which were majors category). The conversion rate for patients admitted via A&E was 30.71% compared to 34.04% for the previous year, as clinical teams continue to drive alternative pathways to admission. The ED estates work due for completion by Christmas 2018 will provide much needed clinical space. The approval to expand the acute physician team to develop a 7 day ambulatory service will further support ED flow.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Phase 3 Rebuild	50	Regular project meetings continue. Works commenced 12/9/18 with completion due Christmas 2018 but clinical rooms due for completion mid November	On Target
Medical Staffing Workforce	50	x2 new substantive consultants now in post. 3 applications received for SAS posts-shortlisting underway.	On Target
Increase in ambulatory streaming	20	Business case approved at HMB. KPI meeting held 9/10/18. Recruitment commencing	On Target

Indicator Name	Description	Narrative	Month Trend
Accident & Emergency - 12+ Hour trolley waits	The number of patients waiting more than 12 hours,for an emergency admission via A&E, from the point when the decision is made to admit to the time when the patient is admitted. The threshold is 0.	There was one 12+ hour trolley breach in September where a patient required a side room and elevated bed that only 14b could provide. -	

Action Description	Action Progress (%)	Action Narrative	Action Status
Roll out of redtogreen	50	To enable early flow	On Target
Continued liaison with IP&C to ensure that side room utilisation is appropriate	80	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	On Target
Aim for 4hr not 12hr target		Ongoing	

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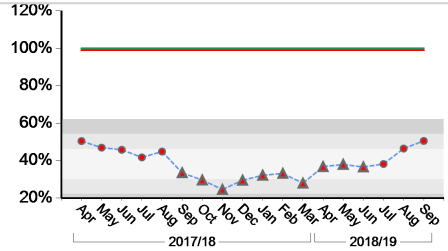
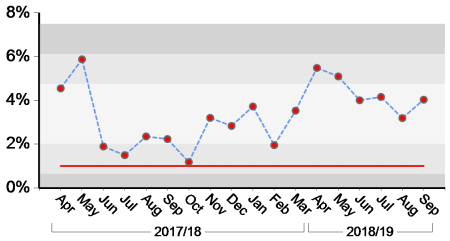
Responsive

Indicator Name	Description	Narrative	Month Trend
Ambulance Handovers <=15 Mins	All handovers between ambulance and A&E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes.	Achievement against this indicator remains a challenge - Whilst performance against this target remains significantly below target, performance for September 2018 was the highest performance seen for over 18 months. September saw over 500 additional patients, however this increase was with patients who self presented, rather than brought in by ambulance. The ED estates work will provide dedicated cubicle capacity for ambulance and triage capacity; this phase of work is expected to be available by the end of October 2018. The ED team continues to work with NWAS	

Action Description	Action Progress (%)	Action Narrative	Action Status
Phase 3 Rebuild	40	Building works commenced 12/9/18 and due for overall completion by Christmas 2018; ambulance cubicles will be available from the end of October 2018	On Target

Indicator Name	Description	Narrative	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower.	Performance remains consistently failing target - Diagnostics Improvement workstreams are Endoscopy, Non-obstetric ultrasound and Cancer 62 Day Target. For Non-obstetric ultrasound, the full time Sonographer is now in post, slight delay in starting and commenced in post on the 10th October. Pending locum Consultant Radiologist commencing. To review in 6 weeks.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Colonoscopy/Cystoscopy/Flexi Sigmoidoscopy - open up room 4 once trained staff available	50	Opening of additional room in endoscopy, once nurse training has been completed. Agreement to be reached over safe staffing levels	Off Target
Endoscopy WLIs	50	For all scopes there are WLIs On Saturdays. Demand and capacity work underway - completion end September	On Target
Cystoscopy capacity	50	Reviewing OPD and IP lists for capacity	On Target
Non Obs Ultrasound - increased activity	50	Remedial plan being drafted. Demand and Capacity work underway - completion September	On Target

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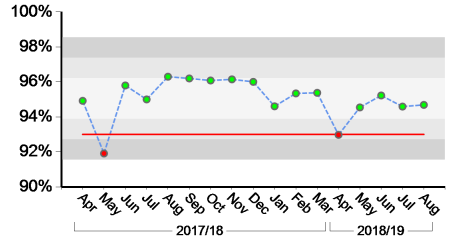
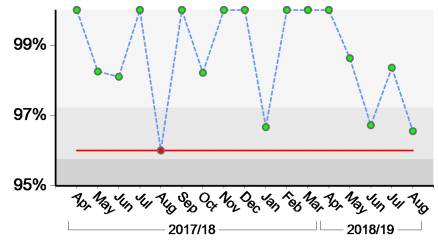
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
14 day GP referral to Outpatients	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. Target 93%. Good performance is higher.	Work continuing to ensure compliance following move to ESR - Breaches of this target are still primarily for reasons of patient choice. Several issues have arisen as a result of the move to ESR which are addressed in the ESR improvement project. One element of the 7 day ways of working project is an eventual move to all first appointments being offered at day 7	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review of all cancer pathways for the need to implement RAS into ERS	40	PID written. Clair Gahan to start conversations with directorates	On Target
Move to all first appointments at day 7	10	Part of the 7 day ways of working project	On Target

31 day treatment	Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Target 96%. Good performance is higher.	Performance compliant - Performance is still compliant, but downward trend reflects capacity issues in Dermatology. The MFU department have gone to PAG to provide two extra sessions in dermatology per week. It is anticipated that this should clear the backlog of patient in the system in the next couple of months.	

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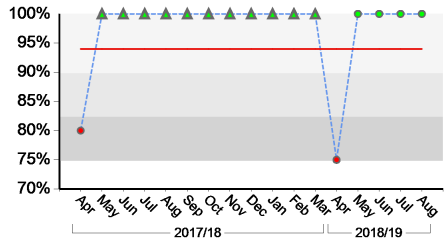
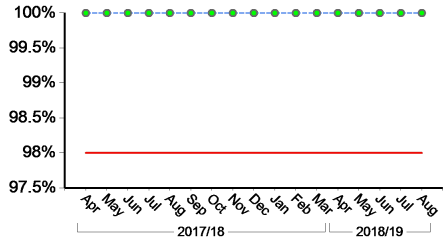
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
31 day treatment (Surgery)	Percentage of patients receiving first definitive surgical treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	Performance maintained at 100% - Trust continues to maintain performance against this target.	
31 day treatment (Anti-cancer drugs)	Percentage of patients receiving first definitive anti-cancer drug treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat').	Compliance maintainted - trust continues to meet this target 100%	

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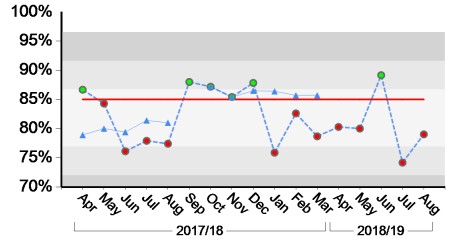
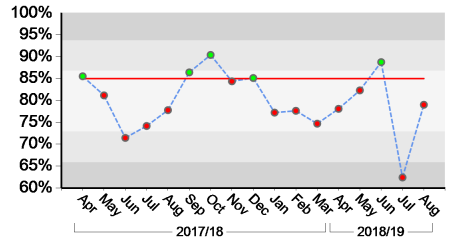
NHS Southport and Ormskirk Hospital NHS Trust

Responsive

Indicator Name	Description	Narrative	Month Trend
62 day GP referral to treatment	Percentage of Patients receiving first definitive treatment for cancer within two months (62 days) of urgent GP referral for suspected cancer. Target 85%. Good performance is higher.	Compliance has improved, but is still below target - The cancer services team has initiated the 7 day pathway project to facilitate Trust wide changes which should lead to improvements in performance.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Changes to internal cancer pathway	10	Collection of baseline data underway and action plan created.	On Target

62 day pathway Analysis	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment.	Gradual improvement in performance, but still non-compliant - There were 8.5 breaches of the 62 day standard in August (1.5 colorectal, 1.5 Haematology, 0.5 head & neck, 1 upper GI, 4 urology)	

Action Description	Action Progress (%)	Action Narrative	Action Status
IT link from Medway to Somerset Cancer Registry	30	Infrastructure has been updated. Testing to commence w/c 17.09.18	Off Target
Introduction of daily Cancer pathway huddles	20	Pilot commenced and another site to start next week	On Target

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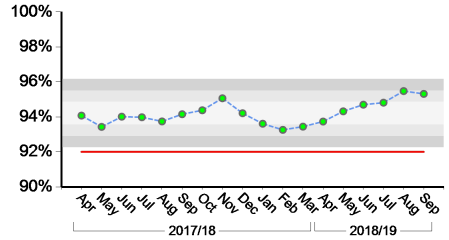
Responsive

Indicator Name	Description	Narrative	Month Trend
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher.	RTT Performance compliant at 95.32% - Trust Performance has again met the 92% threshold for September 2018 which was recorded at 95.32%. Patients are still being booked in chronological order. This overall Trust figure does not reflect the challenges faced in some sub-speciality areas i.e. Oral Surgery 90.2% and Paediatric Endocrinology 87.5%.	

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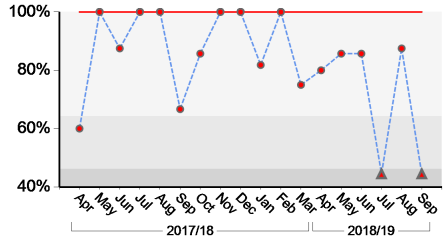
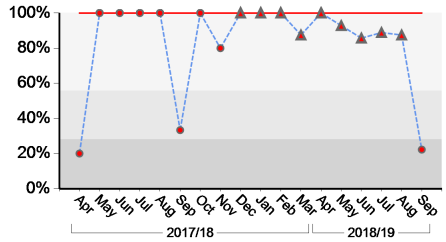
Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
Duty of Candour - Evidence of Discussion	The proportion of patients who have had a discussion with healthcare professionals about something that has gone wrong with their treatment or care.	Evidence of Discussion - The Integrated Governance Team continues to monitor Duty of Candour compliance and alerts the CBU's re areas of non compliance	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review at SIRG DOC process		72 hour review form includes DOC	On Target
The Integrated Governance Team continues to monitor Duty of Candour compliance and alerts the CBU's re areas of non compliance		Monitoring / Escalating	On Target
The Trust has developed a Duty of Candour Staff Leaflet alongside the information Video on the Intranet		Staff have further guidance	On Target

Indicator Name	Description	Narrative	Month Trend
Duty of Candour - Evidence of Letter	The proportion of patients who have received a letter of apology when something that has gone wrong with their treatment or care.	Duty of Candour letter - The IGT continues to monitor and escalate to the CBU's areas of non compliance. A staff leaflet has been developed so staff are further aware of this statutory duty	

Action Description	Action Progress (%)	Action Narrative	Action Status
The IGT continues to monitor and escalate to the CBU's areas of non compliance. A staff leaflet has been developed so staff are further aware of this statutory duty		DOC Leaflet. Escalation	On Target
Duty of Candour is monitored at the SIRG		The SIRG continues to monitor compliance	On Target

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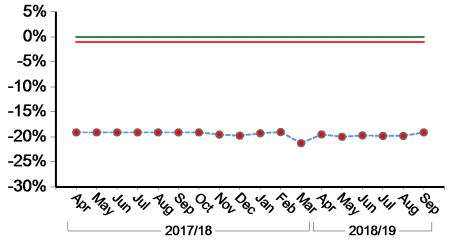
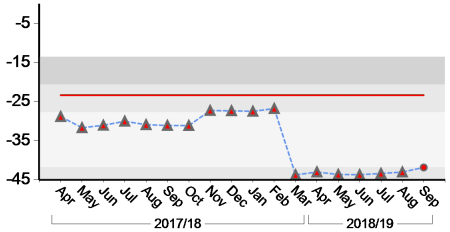
NHS Southport and Ormskirk Hospital NHS Trust

Well-Led

Indicator Name	Description	Narrative	Month Trend
I&E surplus or deficit/total revenue	The proportion of Income & Expenditure surplus/deficit of the total revenue generated by the Trust.	A slight improvement in month resulting in a 19.1% year to date deficit. - Performance has been consistently at 19%/20% over the last year. If the Trust achieves the financial plan of £-28.8m deficit then this will result in circa 17% deficit compared to turnover. This represents the best case scenario for 2018/19. Financial performance needs to continue to improve in the second half of the year to achieve this and is dependant on CIP delivery, control of expenditure and a satisfactory outcome to contract issues with commissioners.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review current CIP schemes	80	Interviews held with those involved in the CIP process to establish deliverability in 2018/19	On Target
Detailed review of budgets to identify where furher savings can be made to mitigate current CIP underperformance	20	Scheduled for end August/September	On Target

Indicator Name	Description	Narrative	Month Trend
Liquidity	Liquidity indicates whether the provider can meet its operational cash obligations.	Metric is relatively static although there is a minor improvement in September - There was a step-change in the metric with the re-classification of one of the loans as a current liability which worsened the metric by 17 days. Whilst there maybe some scope for a reclassification of loans it will still mean that the Trust is significantly away from meeting its liquidity target (0 days or better). The only solution is for the Trust to become financially sustainable and for DH to convert the loans into public dividend capital.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Reclassification of DH loans	0	If DH agree to defer payment of the loan due to be repaid in February 2019 to a future financial years, this will reclassify it as non-current and improve the metric by 11 days.	On Target

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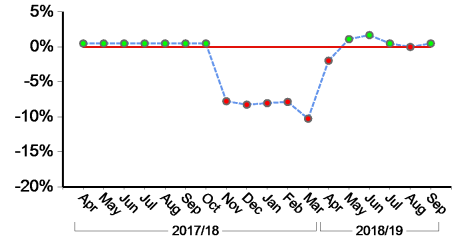
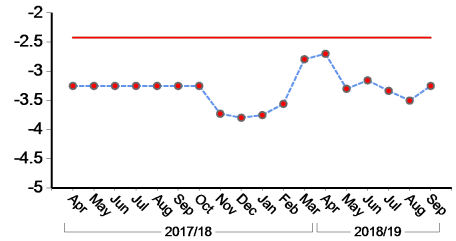
Indicator Name	Description	Narrative	Month Trend
Distance from Control Total	Distance from Control Total.	The Trust is ahead of its financial plan - At the end of month 6, the planned deficit was £15.788m. The Trust has underspent against this plan with an actual deficit of £15.750m. The main reason for moving ahead of plan at the month 6 YTD position is the £0.8m accrual for ACU/CDU income following the MIAA draft report.	
Capital Service Capacity	The level of debt the Trust is required to service. This indicator is 1 of 5 used to derive the 'Use of Resources (Finance)' score.	Slight improvement in this metric as the Trust is achieving its financial plan. - This month the Trust is £52k ahead of its financial plan (after technical adjustments). In order to improve this metric, the Trust needs to be making an operating surplus. This requires the delivery of a long-term strategic plan to make the Trust financially sustainable.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Develop a plan to move the Trust into a surplus position	0	Reconfiguration of hospital services in medium to long term to address the structural deficit	On Target

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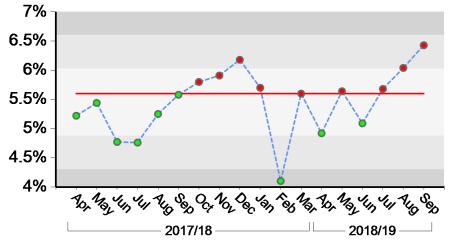
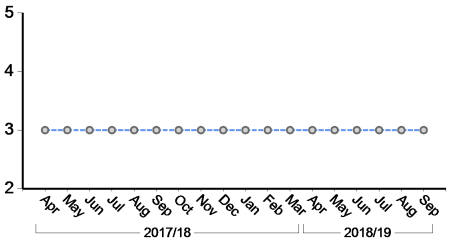
Indicator Name	Description	Narrative	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system.	Performance continues to deteriorate against the 4.4% monthly target. - The majority of the agency spend is in nursing and medical staff (in month £639k of total agency spend of £704k) Nurse agency continues to rise. Ongoing daily monitoring of spend and escalated rates in place. External market conditions are leading to challenging agency rate environment with increasing pressure to pay escalated rates (both medical and nursing staff). Exit plans for agency staff have been shared with Turnaround Director so that agency spend can be reduced sensibly and can be monitored and challenged.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Nurse recruitment	50	Despite the number of recruitment events and nursing vacancies advertise there has been no noteable reduction in nurse agency spend over the last 12 months and increasing usage over the last two months.	On Target
Non medical/non clinical	70	List of all agency staff produced with an action plan for replacement	On Target
Medical recruitment	70	Each CBU has been tasked with establishing action plans to recruit substantively to posts or utilise bank/short term contracts on payroll in order to avoid premium rate agency spend.	Off Target
TempRE platform to be utilised for AHP staff	100	meeting 16.8.18 to discuss next steps including pay rates which need further review following recent pay award	Complete

Use of Resources (Finance) Score	A Financial performance score derived from the NHS Improvement 'Use of Resources' assessment framework.	Overall score remains static at 3 (A score of 1 is best and 4 is the worst) - The unrounded rating is 3.0 and this is the same as last month. The scale of improvement required to improve the overall rating is too great for the short-term and therefore the Trust should focus on maintaining delivering the financial plan (on target rated at 1) and achieving the agency cap target (adversely away from plan with a rating of 2).	

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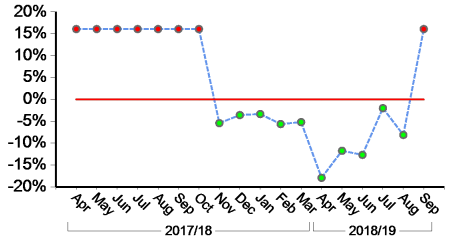
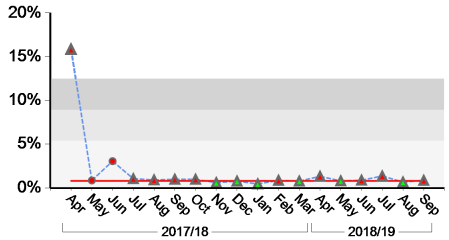
Indicator Name	Description	Narrative	Month Trend
Distance from Agency Spend Cap	Distance from Agency Spend Cap.	Performance deteriorating as agency spend continues to increase as the monthly plan reduces - Up to month 5 agency spend was below the monthly trajectory. The monthly plan has reduced and September's spend is the highest so far this financial year. This has resulted in an adverse variance against the agency cap at month 6 YTD (£3.7m against £3.2m cap) The Trust has introduced improved governance arrangements around the recruitment of staff but this has enabled substantive appointments to be made and reduce the reliance on agency. Work continues on continuing to recruit to key posts. Performance against this metric is expected to deteriorate in the second half of the year and the NHSI cap of £5.67m will not be achieved.	

Action Description	Action Progress (%)	Action Narrative	Action Status

Indicator Name	Description	Narrative	Month Trend
Staff Turnover	Staff Turnover is calculated by taking the number of leavers divided by the average headcount from the start and end of the month.	Staff turnover has increased slightly in month but remains on target. YTD turnover is 5.7%. Rolling 12 month turnover is 10.88% - The Trust is participating in the NHSI Nursing Workforce Retention Pilot, in order to increase the Trust's nursing retention. This is a 90 day pilot.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review of exit questionnaire	90	The exit questionnaire has been reviewed by the retention task and finished group. The new process will going live from November 2018.	On Target
Stability Indicator to reported on at CBU peformance review boards	100	The stability indicator is now being reported on the CBU HR performance reports on a monthly basis.	Complete
Establishment of NHSi Nursing Workforce Retention Pilot Task and Finish	80	The Trust has developed a Retention Action plan for which progress against will be monitroed by a task and finish group.	On Target

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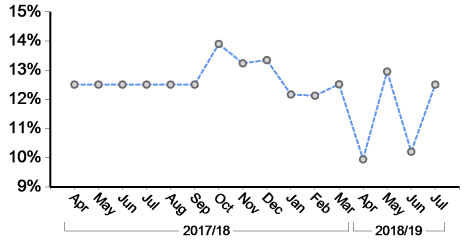
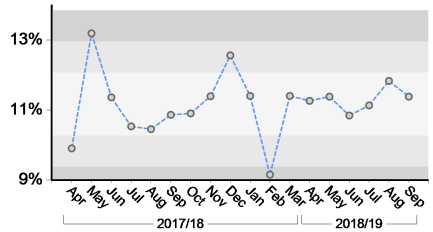
Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Medical	The proportion of planned medical establishment that is currently vacant.	-	

Action Description	Action Progress (%)	Action Narrative	Action Status
Pull together a comprehensive medical workforce strategy	10	Meeting currently being arranged.	On Target

Indicator Name	Description	Narrative	Month Trend
Vacancy Rate - Nursing	The proportion of planned nursing establishment that is currently vacant.	Performance improving against target and plan - Performance against fill rate shows an improvement. Further improvements will be realised for supportive actions following position review of all Nursing posts/offers of employment inclusive of review of current TRAC activity/actions required. Planned local recruitment events in place, and considered recruitment to overseas under review.	

Action Description	Action Progress (%)	Action Narrative	Action Status
HCA recruitment campaign	70	Recruitment and selection process has taken place, currently undertaking pre-employment checks.	On Target
NHSi retention pilot	70	Action plan submitted and task and finish group set up to commence from 22/08/18	On Target
Review of trust recruitment tools/process.	70	Collation of vacancy position from trust ledger v TRAC actions/adverts to monitor & assure fill to vacant posts by 01/12/18	On Target
Planned RN Recruitment events/Advertising campaigns	80	Supported through trust engagement with NHSI pilot.	On Target

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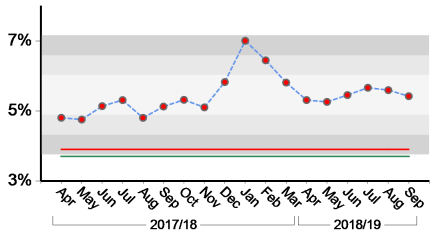
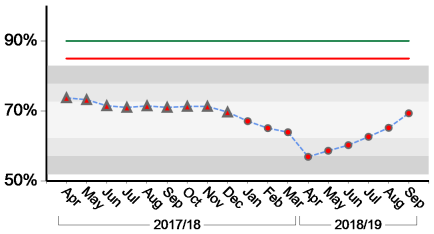
Indicator Name	Description	Narrative	Month Trend
Sickness Rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better.	Sickness absence is reducing month on month however still remains high above target. - Sickness absence continues to be a concern for the Trust. The monthly trend at the moment is a month on month reduction in sickness absence however it is not significant enough to achieve the Trust's target of 4.2%. There are a number of ongoing action plans that link into reducing sickness absence, there is the Health and Wellbeing Action Plan supported by NHSI; Nursing Retention Workforce Pilot with NHSI; Trust and CBU staff survey action plans. All action plans performance will be monitored at Workforce Committee to ensure progress.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Review of sickness absence policy	80	A further meeting is scheduled with staff side 26/10/18 to finalise the final amendments to the policy with the revised policy to go to November's Workforce committee for approval.	Off Target
Integrate Health and Wellbing, Sickness absence and self assessment action plans	100	Draft integrated action plan submitted to NHSi.	On Target
Health and Wellbeing Action Plan	50	Feedback received from NHS 18/10/18 re HWB action plan. Plan to be reviewed and measurable data to be utilised to monitor progress.	On Target
Health and Wellbeing Task and Finish group to be set up	50	Task and finish group to be set up once feedback on the submitted action plan has been received from NHSi on 24/09/18. Feedback delayed from NHSi not received until 18/10/18.	Off Target
Launch of Health and Wellbeing Brand, 'For You, With You'	50	Launch date set for the 30th October 2018	On Target

Indicator Name	Description	Narrative	Month Trend
Personal Development Review	Percentage of staff with an up to date Personal Development Review (PDR).	PDR compliance has improved for the 5th consecutive month. - PDR compliance is now at 69.33% which is a 5th month consecutive improvement. All CBU's PDR improvement plans report to meet 85% improvement target by November, to meet this trajectory there would need to be a 15.67% overall improvement this month. Consequently all CBU's have been asked to review and if applicable revise their improvement trajectories to ensure that they have a realistic plan to deliver the improvement.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Report ran to establish staff who had not had a PDR for 3 or more years	100	Report ran and shared with CBU's all CBU's mandated to complete outstanding PDR's by 17/08/18. Improvement should be seen in August's figures.	On Target
Monthly monitoring to continue at all operational and strategic meetings	80	Workforce dashboards to be provided monthly focusing on progress	Off Target
Review and revise improvement trajectories	50	CBU Improvement trajectories to be reviewed and revised to ensure that they have a realistic plan to deliver the improvement.	Off Target
Quality Appraisal Conversations Training	100	Quality Appraisal Conversations Training to be delivered to improve the quality of appraisals being delivered by the organisation. Training will be available from Oct 18 – Jan 19.	Complete

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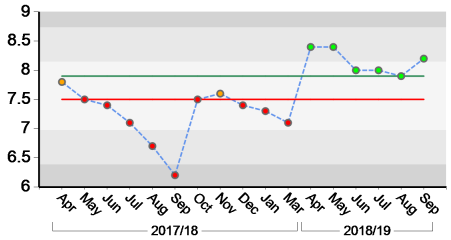
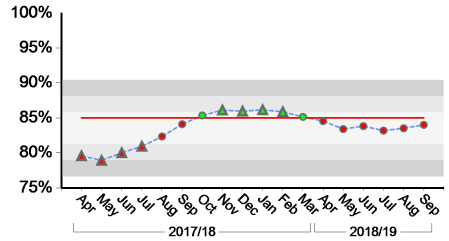
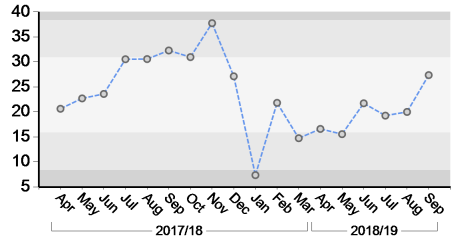
Indicator Name	Description	Narrative	Month Trend
Care Hours Per Patient Day (CHPPD)	Number of nursing care hours worked per patient day. This indicator is used to measure nurse staffing levels.	Performance continues to achieve target for the sixth concurrent month. -	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%.	Performance is 0.9% short of the target of 85% at 84.01% - The Trust's overall mandatory training compliance has seen a 0.49% rise in month. The training department continues to circulate monthly reports, drawing attention to the areas where compliance can significantly be improved - this month was local fire safety and hand hygiene training. Face to face training and eLearning modules are available throughout the year for staff to access with ESR Manager and Self Service readily available for monitoring purposes.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Consultant mandatory days	90	Reinstated to support our Doctors in meeting their compliance requirements	On Target
Monthly compliance reports	100		On Target

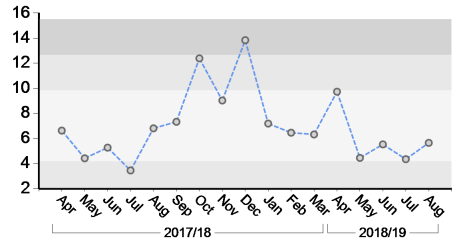
Board Report - September 2018

NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Post MOFD (Medically Optimised for Discharge) - Number of Beds lost per month	Number of beds lost from inpatients who have passed their medically optimised for discharge date. It is taken as a snapshot on the last working day of the month. Lower is better.	continued increase in MOFD - improvements in data quality may account for limited change in MOFD. implementation of SAFER- Red2Green has seen significant improvements within the primary roll-out wards.all discharge facilitators now in post working through competency framework completed in conjunction with community teams, review of processes planned with ECIST for October on hold pending outcome of community bed review.	

Action Description	Action Progress (%)	Action Narrative	Action Status
Appointment of discharge facilitators	90	ALL IN POST- competencies being worked throu	On Target
Improvement data accuracy	80	part of the discharge facilitators compency framework	On Target
Implimentation of SAFER as part of the 10 high impact actions	50	From PFIB 10 high impact actions have been identified, the implementation of SAFER is one of these	On Target
Review weekly system leaders MOFD meeting	20	meeting held to review community bed base and criteria for admission	On Target

Indicator Name	Description	Narrative	Month Trend
DTOC - Number of Beds lost per month	The number of beds lost per month from patients who have experienced a Delayed Transfer of Care (DTOC).	-	

Action Description	Action Progress (%)	Action Narrative	Action Status
improvements with IT to support data	50	meetings held with HOPF to develop IT	On Target
discharge facilitators	70	4 in post, remainder in post by 1/10/18	On Target
review of process to support DTOC	10	review with social workers required to review current and future process	On Target

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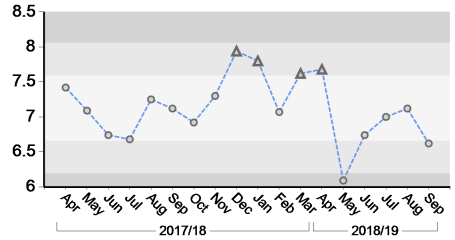
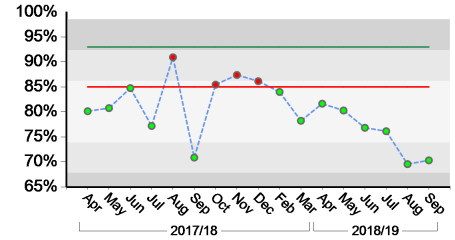
NHS Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Length Of Stay	The average amount of time in days that patients spent as an inpatient from an emergency admission. Excludes ZERO Length of Stay.	All discharge facilitators in post, competencies being worked through - The introduction of the discharge facilitators will assist the wards in delivery of red2green, support with complex discharges and check, challenge and chase internal and external delays. the LOS meeting were put on hold pending review of process- an extraordinary meeting was held due to pressure within the Acute trust; red2 green continues it's roll out and now has covered 5 wards; unfortunately due to pressures ACU was bedded for part of the week to maintain patient safety within ED	

Action Description	Action Progress (%)	Action Narrative	Action Status
Appointment of discharge facilitators	90	all in post, competencies being worked through	On Target
weekly LOS meetings	20	review of meetings in progress with support from ECIST	On Target
Vacancies within bed management	50	2 started and 2 date set- period of supervised practice	On Target
Introduction of SAFER	30	commenced in August with support from NHSi- 5 wards completed	On Target
safeguarding assessment areas	80	SAU opened 10/9/18; metric being developed to capture data on assessment beds	On Target

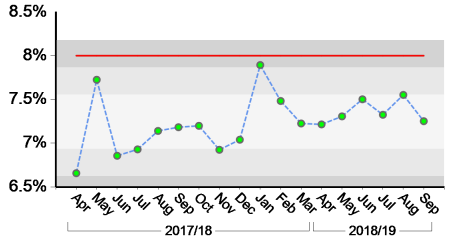
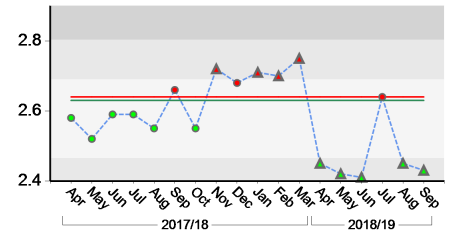
Bed Occupancy	The proportion of Inpatient beds occupied of the total bed stock. Beds at both Southport and Ormskirk are included.	Bed occupancy remains on target Trustwide -	

Action Description	Action Progress (%)	Action Narrative	Action Status
bed right size	60	meetings in place with appropriate clinicans to review bed useage at ODGH	On Target
SAFER	30	3rd ward commenced, roll out plan developed	On Target
Assessment areas	80	use of ACU- never event, SAU opened	On Target

Board Report - September 2018

Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better.	The DNA Rate for the Trust is 7.25% and remains within threshold. - A deep dive is required by the OPD Project Board once commenced to develop an action plan to address the current DNA rates.	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor.	The New:Fu Rate for the Trust is 2.43% and is within threshold. -	

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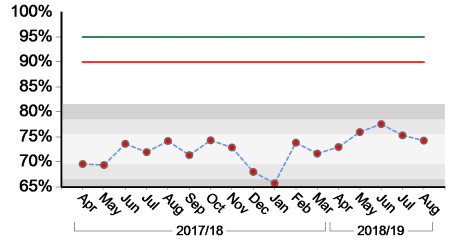
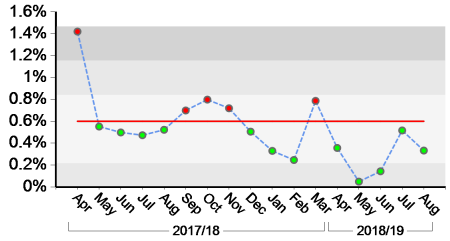
Southport and Ormskirk Hospital NHS Trust

Efficiency

Indicator Name	Description	Narrative	Month Trend
Theatre Utilisation	The proportion of elective Theatre slots used over the total elective planned capacity.	Performance remains consistent, but is still failing target -	

Action Description	Action Progress (%)	Action Narrative	Action Status
Data cleanse required.	10	request sent to Operational and BI teams	On Target

Cancelled Ops	Percentage of Operations Cancelled.	Performance remains consistently achieving target. -	

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
7 November 2018

Agenda Item	TB266/18	Report Title	Director of Finance Report - September 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 6 the Trust's financial performance is a deficit of £15.75 million against a deficit plan of £15.788 million which is £39,000 better than plan.
- The Trust is better than plan after the inclusion of £800,000 income for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU) activity.
- Agency spend is rising, particularly in nursing
- There are a number of other risks which, if not addressed, will lead to the Trust not achieving the planned deficit of £28.8 million.
- The main risks are CIP, agency spend and agreeing a satisfactory contract outcome with our commissioners.
- Based on the current run rate the outturn will be in the region of £30-32 million deficit.
- There is no plan at this stage to amend the forecast outturn from £28.8 million deficit.

The Board is asked to receive the month 6 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)*

Trust senior team to meet with commissioners on 1st November to determine the system wide financial position. This will be followed by a joint meeting with both NHS Improvement and NHS England later in November.

Following the above the December Trust Board will be updated on the level of risk of delivering the Trust's financial plan.

Previously Presented at:

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

Purpose

1.1. This report provides the Board with the financial position of the Trust for Month 6 (the financial period ending 30th September 2018).

2. Executive Summary

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

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

2.3. At month 6 the Trust's financial performance is a deficit of £15.75 million against a deficit plan of £15.788 million which is £39,000 better than plan.

2.4. An income accrual of £800,000 has been made this month in relating to the report from Mersey Internal Audit Agency (MIAA). This was following the Expert Determination recommendation to establish tariffs for Ambulatory Care Unit (ACU) and Clinical Decision Unit (CDU).

2.5. Discussions with commissioners took place on 15th October but no agreement has been reached regarding the tariffs to be applied.

2.6. A provision of £326,000 has been made for non achievement of CQUIN at month 6.

2.7. Income from clinical activity is in line with plan before the application of the MIAA recommendations regarding ACU and CDU activity.

2.8. A&E activity is up by 4.2%; resulting in a financial impact of £219,000

2.9. Elective activity is down by 11.0%; resulting in a financial impact of -£685,000

2.10. Non elective activity is up by 20.4%; resulting in a favourable financial impact of £2.049 million when the recommendation of the MIAA report has been applied.

2.11. 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; a reduction of £597,000 has been applied resulting in a favourable impact of £1.452 million.

2.12. Outpatient activity is down by 2.86%; resulting in an favourable financial impact of £72,000.

2.13. Total expenditure now exceeds plan at month 6 YTD, mainly driven by CIP underperformance against a high monthly profile.

2.14. Underlying pay expenditure is up on previous months reflecting the increased nurse agency usage in September and the higher rates from Thornbury.

2.15. Non pay spend has increased in September.

2.16. Agency spend has increased again to £708K in month which leads to a YTD spend of £3.7M; the NHSI cap of £5.6M will not be achieved.

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

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	148,918	74,032	74,760	729	12,197	12,999	802
PP, Overseas & RTA	1,380	690	553	(136)	114	57	(57)
Other Income	14,247	7,105	7,295	190	1,212	1,219	7
Total Income	**164,545**	**81,827**	**82,609**	**783**	**13,523**	**14,275**	**752**
Operating Expenditure							
Pay	(129,049)	(65,258)	(65,626)	(368)	(10,607)	(10,942)	(335)
Non-Pay	(53,129)	(26,780)	(27,029)	(249)	(4,497)	(4,603)	(106)
Total Expenditure	**(182,178)**	**(92,038)**	**(92,655)**	**(617)**	**(15,104)**	**(15,545)**	**(441)**
EBITDA	**(17,633)**	**(10,211)**	**(10,046)**	**166**	**(1,581)**	**(1,270)**	**311**
Non-Operating Expenditure	(11,217)	(5,609)	(5,633)	(24)	(935)	(954)	(19)
Retained Surplus/(Deficit)	**(28,850)**	**(15,820)**	**(15,679)**	**142**	**(2,516)**	**(2,224)**	**292**
Technical Adjustments	63	32	(71)	(103)	5	(8)	(13)
Break Even Surplus/(Deficit)	**(28,787)**	**(15,788)**	**(15,750)**	**39**	**(2,511)**	**(2,232)**	**279**

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 £28.8 million.

2.20..1. CIP delivery of £7.5 million.

2.20..2. Agency costs are rising which is creating overspends in nursing and medical budgets.

2.20..3. Contract sanctions have not been deducted from the income position and commissioners have recently indicated they will apply in full.

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

2.20..5. Potential further business cases or pressures (including winter) may not be fully covered by reserves.

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 £30-32 million deficit.

2.22. There is no plan at this stage to amend the forecast outturn from £28.8 million 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 £326,000 for non achievement of antibiotic review and advice & guidance for Quarters 1 and 2.

3.2. Non elective activity continued to overperform even regarding the average price for non elective activity. The Trust has rejected this challenge. The marginal rate reduction (30%) is being applied for activity exceeding the baseline.

3.3. A meeting took place with both Southport & Formby CCG and West Lancashire CCG on 15th October to share respective assumptions regarding financial plans. This is in readiness for a meeting with both regulators in November to ascertain the system risk in delivery of the year end position.

3.4. Elective activity continues to underperform with an in month activity shortfall of 15%. Please refer to the detail within the appendices but theatre staffing continues to be a major issue with many lists being cancelled. The Trust's forecast outturn assumes the elective shortfall is brought back to plan and, therefore, it is vital that a significant improvement is delivered in the second half of the year.

3.5. The issue regarding the tariffs for ACU and CDU has still not been agreed. MIAA have issued their draft report and proposed two options for charging. Either option delivers circa £800,000 to the Trust for month 6 YTD and, therefore, this has been accrued. The commissioners are disputing the outcome of the MIAA report and challenging whether MIAA have delivered on the agreed scope.

3.6. In summary, non elective activity is generating a favourable variance against plan of £652,000 after deductions for ACU, CDU and marginal rate. This increases to £1,452,000 once the £800,000 has been accrued.

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 appendices to this report highlight the performance levels to date and the associated financial risk. The YTD income position does not include any reduction for sanctions. It is now expected that commissioners will apply sanctions in full in order to negate the impact of any overperformance against their contract values.

4. Expenditure

4.1. Underlying expenditure levels for both pay and non-pay have increased compared to previous months with agency expenditure still increasing due to the increased use of Thornbury and their price increase (13%) from September.

4.2. Pay expenditure in September has increased compared to previous month's performance (after negating the pay review back pay in August) with the biggest increase in nurse agency (£291,000 in month of which £132,000 relates to Thornbury).

4.3. The Department of Health has notified all Trusts of additional funding following an exercise to determine the unfunded element of the Agenda for Change pay award. The Trust will receive an additional £59,000. The DoH will now pay a monthly amount of £169,000 for the remainder of the year.

4.4. Non consultant medical staff and nursing staff have overspent in month which is a reflection of the high level of vacancies and the necessity to fill shifts at premium rates.

4.5. The key areas of nurse overspend are A&E, medical wards and theatres.

4.6. The key areas of non consultant medical staff overspend are medicine, surgery and theatres

5. Non pay spend has increased again in September with a YTD overspent of 1.4% (before reserves and CIP).The Turnaround Director is holding budget reviews with all budget holders

to bring back into balance.

6. Agency spend

6.1. The Trust has spent £705,000 on agency staff in September (7.5% 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, holidays and sickness.

6.2. The reduction in agency spend required in the second half of the year in order to achieve the NHSI agency cap is no longer possible.

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

6.4. Nurse agency spend is £291,000 in September which continues on an upward trend as reported at last month's Board.

6.5. As in previous months high agency levels are experienced in A&E but there has been a large increase in agency within both general medicine and general surgery in September.

6.6. Bank fill remains constant; the focus continues to be recruiting to substantive posts.

6.7. Vacancy levels have reduced in month to 11.3% (11.8% August) without any improvement on nurse bank and agency spend.

6.8. The cost of providing cover for nurse sickness in September was £99,000 (bank £82,000; agency £17,000) based on the information provided by NHSP.

6.9. Thornbury nurse agency spend has increased month on month: June £24,000; July £45,000; August £122,000; September £132,000.

6.10. With regard to medical staff a revised escalation procedure has been discussed and agreed at the Executive Team Meeting.

6.11. 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.

6.12. 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.

6.13. The Trust is coming under continued pressure to breach its own bank rates when shifts require filling at short notice and there are quality/safety concerns

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

6.15. The cost of providing cover for medical sickness in September was £1k bank only based on the information provided by TempRE.

7. Cost Improvement Plan (CIP)

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

7.2. This figure rises to £7.5 million 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.

7.3. 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	2,631	1,529	(1,102)	673	249	(424)
17/18/ balance to FYE	535	268	268	0	45	45	0
Total	7,541	2,899	1,797	(1,102)	718	294	(424)

7.4. Once again the CIP has underachieved and is contributing materially to the adverse expenditure budget performance in month.

7.5. The Turnaround Director reviewed the CIP plans and revised the CIP forecast down. Additional schemes have been identified and £1.5 million has been added in September for the additional income expected for ACU and CDU. This along with the revision of other schemes has increased the CIP forecast to £5.7 million, a shortfall of £1.8 million.

8. Cash

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

8.2. 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 (September's cash flow was sent on 9th August).

8.3. The Trust borrowed £2.142 million in September. This 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%).

8.4. Performance against the cash target in September was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	2,109	Brought forward balance.
Cash inflows	15,997	16,622	Sefton Council catch up payments of £674k. Public Dividend capital of £127k received not in the original plan.
Cash outflows	-15,997	-17,698	PAYE, NI and superannuation relating to back pay not in the original plan (£418k). Quarterly GE contract £428k not built into original plan. Non NHS payment runs £761k higher than plan.
Closing balance	**1,000**	**1,033**	

8.5. 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 £1million bank balance at the end of the month.

8.6. The Trust identified there were some anomalies in the original September plan, however, the cash position was maintained by achieving an improved opening position and flexing payments during in September as necessary.

8.7. October's loan request of £2.618 million was approved at the Private Board on 3rd October.

8.8. Following discussions with the CCGs regarding settlement of prior year invoices it has been agreed to start paying these in mid-November subject to DH agreeing the loan.

8.9. The borrowing request for November is £5.196 million and of this £3.128 million is to support the settlement of prior year invoices.

9. Capital

9.1. 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.

9.2. Overall spend was very low in month at £156,000. Cumulative spend stands at £1.751million against a target of £3.439 million.

9.3. Commitments and orders not received amount to £2.278 million at the end of September.

9.4. The plan has been altered to reflect the decision to defer the fire precaution works as follows:

Scheme Deferred	**£'000s**
Fire compartmentation	-153
Fire Precautions - Fire Doors	-38
	-191
Reallocated to	
Southport A&E Redesign	91
UPS Theatre	40
Sexual Health Accommodation	60
	191

9.5. A further revision to the plan will be made when the Trust has received the allocated £280,000 and £455,000 of 2018/19 capital support for winter from DHSC.

9.6. £280,000 is for new Surgical Assessment Unit and the Trust Board will need to confirm agreement to the Memorandum of Understanding in November and then the funds can be drawn down.

9.7. £455,000 is capital to support increased capacity and improved emergency care performance this winter with a real time patient access and flow system to community health and social care. This will be delivered through a fully integrated cloud based platform *Strata Pathways.*

9.8. This will be a three phase project with the first milestone date 24 December 2018 by which time *Strata Pathways* will be deployed for specific care pathways at the front-end of the Trust, in order to reduce unscheduled care admissions and ease the strain on ED waiting times.

9.9. Due to its focused nature, there will be minimal staff disruption and an implementation timeline of 10-12 weeks.

9.10. Phase 2 -Expand and Embed: based on Trust and community data, further care pathways will be deployed to further reduce unscheduled care admissions. Strata Pathways will also be deployed in the community, including mental health teams, and social care teams for specific healthcare professionals in order to divert patients away from the ED, thus reducing unscheduled care admissions.

9.11. Phase 3- System Wide Flow: Pathways will be deployed for discharge, thus reducing delayed

transfers of care, stranded and super-stranded patients. Care pathways will be chosen based on the needs of the local population and Trust data. The architecture of this deployment can include 'any to any' whole system flow including health, social care and third sector stakeholders

9.12. In light of additional funding being realised and a number of projects yet to be started there is a risk that the Trust may not be able to spend its full capital allocation. The Capital Investment Group will be monitoring this closely and may bring forward deliverable schemes into 2018/19 so that the CRL is achieved.

10. Commissioning for Quality and Innovation payments (CQUINS)

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

10.2. The Trust has recognised the likely non achievement in September's position and reduced CCG income by £326,000.

10.3. This is an area of focus for the Turnaround Director and governance has been recently strngthened in this area..

11. Risks

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

11.2. Agency spend is rising each month caused by high sickness levels and vacancies.

11.3. No provision for contract sanctions has been accrued into September's financial position. Commissioners have indicated sanctions will be applied in full in order to balance back to their contract value.

11.4. Current activity performance will lead to CCG payments exceeding their contract value. The risk is that contract challenges and will lead to lower income levels that Trust needs in order to deliver its year end forecast.

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

12. Forecast Outturn 2018/19

12.1. The Trust forecast outturn with NHSI. This is covered in more detail later in the agenda

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

13. Recommendations

13.1. The Board is asked to receive the month 6 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	148,918	74,032	74,760	729	12,197	12,999	802
PP, Overseas & RTA	1,380	690	553	(136)	114	57	(57)
Other Income	14,247	7,105	7,295	190	1,212	1,219	7
Total Income	**164,545**	**81,827**	**82,609**	**783**	**13,523**	**14,275**	**752**
Operating Expenditure							
Pay	(129,049)	(65,258)	(65,626)	(368)	(10,607)	(10,942)	(335)
Non-Pay	(53,129)	(26,780)	(27,029)	(249)	(4,497)	(4,603)	(106)
Total Expenditure	**(182,178)**	**(92,038)**	**(92,655)**	**(617)**	**(15,104)**	**(15,545)**	**(441)**
EBITDA	**(17,633)**	**(10,211)**	**(10,046)**	**166**	**(1,581)**	**(1,270)**	**311**
Non-Operating Expenditure	(11,217)	(5,609)	(5,633)	(24)	(935)	(954)	(19)
Retained Surplus/(Deficit)	**(28,850)**	**(15,820)**	**(15,679)**	**142**	**(2,516)**	**(2,224)**	**292**
Technical Adjustments	63	32	(71)	(103)	5	(8)	(13)
Break Even Surplus/(Deficit)	**(28,787)**	**(15,788)**	**(15,750)**	**39**	**(2,511)**	**(2,232)**	**279**

see further appendices for explanation of variances

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2018	30/09/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	126,790	125,402	(1,388)	(367)
Other assets	1,382	1,384	2	(142)
TOTAL NON CURRENT ASSETS	**128,172**	**126,786**	**(1,386)**	**(509)**
CURRENT ASSETS				
Inventories	2,454	2,548	94	(19)
Trade and other receivables	9,591	8,357	(1,234)	803
Cash and cash equivalents	1,079	1,033	(46)	(1,076)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**13,124**	**11,938**	**(1,186)**	**(292)**
CURRENT LIABILITIES				
Trade and other payables	(25,231)	(23,891)	1,340	764
Provisions	(131)	(155)	(24)	3
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)	(179)	292	9
TOTAL CURRENT LIABILITIES	**(32,199)**	**(30,591)**	**1,608**	**776**
NET CURRENT ASSETS/(LIABILITIES)	(19,075)	(18,653)	422	**484**
TOTAL ASSETS LESS CURRENT LIABILITIES	**109,097**	**108,133**	**(964)**	**(25)**
NON CURRENT LIABILITIES				
Provisions	(278)	(266)	12	0
DH revenue loans	(66,615)	(81,444)	(14,829)	(2,142)
PFI/Finance lease liabilities	(13,807)	(13,774)	33	71
DH Capital loan	(1,400)	(1,200)	200	0
TOTAL NON CURRENT LIABILITIES	**(82,100)**	**(96,684)**	**(14,584)**	(2,071)
TOTAL ASSETS EMPLOYED	**26,997**	**11,449**	**(15,548)**	**(2,096)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	97,241	97,368	127	127
Retained earnings	(83,484)	(99,159)	(15,675)	(2,223)
Revaluation reserve	13,240	13,240	0	0
TOTAL TAXPAYERS EQUITY	**26,997**	**11,449**	**(15,548)**	**(2,096)**

In month material movements are as follows:

Trade and other receivalbles increased by £803k, the majority of this was associated with income accruals together with August's VAT return where the monies were not received until October.

Cash reduced by just over £1m but still remained above the minimum level set by DH. This was consistent with the internal cash flow plan and monies were utilised to reduce the level of trade payables.

The loan received in September was £2.142m.

It should also be noted that the Trust received DH capital investment of £127k for wifi and this is reflected in the public dividend capital line.

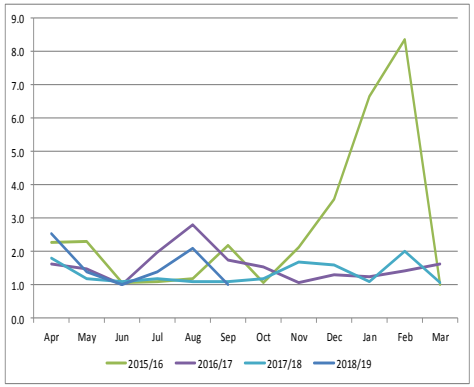
Statement of cash flows

Southport and Ormskirk Hospital NHS Trust

The Trust held enough cash to cover 1.97 days of operating expenditure at the end of September 2018 (August = 4.05 days).

	Actual Apr-18 £'000s	Actual May-18 £'000s	Actual Jun-18 £'000s	Actual Jul-18 £'000s	Actual Aug-18 £'000s	Actual Sep-18 £'000s	Plan Oct-18 £'000s	Plan Nov-18 £'000s	Plan Dec-18 £'000s	Plan Jan-19 £'000s	Plan Feb-19 £'000s	Plan Mar-19 £'000s	Total £'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,217)	(2,330)	(2,192)	(2,274)	(2,376)	(1,792)	(1,406)	(1,491)	(2,287)	(1,545)	(2,138)	(1,739)	(23,787)
Income recognised in respect of capital donations (cash and non-cash)	(5)	(52)	(30)	(18)	(20)	(20)	(15)						(160)
Depreciation and Amortisation	523	524	523	524	523	524	517	517	517	509	509	509	6,219
Impairments and Reversals	0	0	0	0	0	0							0
(Increase) in Inventories	(50)	59	(83)	0	(39)	19					39	55	0
(Increase) in Trade and Other Receivables	976	153	(468)	558	818	(805)					(818)	(414)	0
Increase in Trade and Other Payables	135	(859)	261	(514)	(371)	(144)	101	(3,528)	1,344	(101)	2,204	70	(1,402)
Increase in Provisions	(3)	(3)	(61)	82	0	(3)		(30)	(27)		(28)	33	(40)
Net Cash Inflow/(Outflow) from Operating Activities	(641)	(2,508)	(2,050)	(1,642)	(1,465)	(2,221)	(803)	(4,532)	(453)	(1,137)	(232)	(1,486)	(19,170)
Cash Flows from Investing Activities													
Interest Received	1	3	3	3	2	5	3	2	2	3	2	3	32
(Payments) for Intangible Assets	(36)	(65)	(53)	(24)	(31)	(8)	(50)	(80)	(57)	(56)	(47)	(39)	(546)
(Payments) for PPE and investment property	(215)	(606)	(259)	(441)	(198)	(214)	(513)	(502)	(704)	(1,006)	(794)	(437)	(5,889)
Receipts from disposal of fixed assets	0	0	1	2	0	0							3
Receipt of cash donations to purchase capital assets	5	52	30	18	20	20	15						160
Net Cash Inflow/(Outflow) from Investing Activities	(245)	(616)	(278)	(442)	(207)	(197)	(545)	(580)	(759)	(1,059)	(839)	(473)	(6,240)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	127		280					407
Public dividend capital repaid	0	0	0	0	0	0							0
Loans received from DH	2,739	2,178	2,479	2,718	2,573	2,142	2,618	5,196	1,764	2,451	1,764	3,378	32,000
Loans repaid to DH	(200)	0	0	0	0	0	(200)						(400)
Capital element of finance leases	(8)	(8)	(8)	(8)	(8)	(8)	(554)	(122)	(8)	(8)	(243)	(7)	(990)
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)	(193)	(143)	(186)	(153)	(184)	(1,024)	(2,957)
Interest element of finance lease	0	0	0	0	0	0	(262)	(5)			(172)		(439)
Interest element of PFI, LIFT	(80)	(80)	(196)	(80)	(80)	(197)	(80)	(80)	(197)	(80)	(80)	(195)	(1,425)
PDC dividend (paid)/refunded	0	0	0	0	0	(77)						(32)	(109)
Net Cash Inflow/(Outflow) from Financing Activities	2,338	1,973	1,966	2,512	2,335	1,342	1,315	5,112	1,212	2,196	1,071	1,959	25,331
NET INCREASE/(DECREASE) IN CASH	**1,452**	**(1,151)**	**(362)**	**428**	**663**	**(1,076)**	**(33)**	**0**	**0**	**0**	**0**	**0**	**(79)**
Cash - Beginning of the Period	1,079	2,531	1,380	1,018	1,446	2,109	1,033	1,000	1,000	1,000	1,000	1,000	1,079
Cash - End of the Period	**2,531**	**1,380**	**1,018**	**1,446**	**2,109**	**1,033**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

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	250	229	21	36	39	735	304	431
	Beds / Trolleys	G0060	50	50	51	(1)	0		50	51	(1)
	Sub total MEDICAL DEVICES		**785**	**300**	**280**	**20**	**36**	**39**	**785**	**355**	**430**
IM&T	Electronic Patient Record	F6409	190	95	56	39	6		190	62	128
	Vitalpac	G0007	30	15	1	14	2		30	3	27
	eDMS	F6447	160	80	0	80	0		160	0	160
	Wireless network upgrade	G0073	302	175	174	1	146		302	320	(18)
	Server warehouse infrastructure incl. storage	G0078	75	75	25	50	0		75	25	50
	Telephony system replacement	G0059	95	95	0	95	0		95	0	95
	Cyber security	G0071	50	26	0	26	7		50	7	43
	Fixed network infrastructure	F6498	100	50	9	41	12		100	21	79
	Datacentre	G0075	50	50	5	45	0		50	5	45
	Virtual desktop infrastructure	G0076	25	13	2	11	0		25	2	23
	Equipment refresh	G0077	50	26	4	22	0		50	4	46
	Sub total IM&T		**1,127**	**700**	**277**	**423**	**174**	**0**	**1,127**	**450**	**677**
ESTATES	GE Turnkey works for Radiology equipment replacement programme	G0061	200	50	1	49	125		200	126	74
	Southport A&E Redesign	G0068	576	391	208	183	54	508	576	770	(194)
	Ward reconfigurations	G0064	140	140	134	6	0		140	134	6
	Medical gasses	G0067	30	30	25	5	11		30	36	(6)
	UPS Theatre	G0053	140	90	0	90	0	142	140	142	(2)
	Waste management storage facilities		100	100	0	100	0		100	0	100
	Theatre airplant controls		45	45	0	45	0		45	0	45
	Generator connectors		65	65	0	65	0		65	0	65
	Fire compartmentation	G0052	12	12	12	(0)	0		12	12	(0)
	Fire Precautions - Fire Doors	G0019	7	7	7	0	0		7	7	0
	Discharge lounge	G0074	134	134	127	7	0		134	127	7
	Spinal isolation works		200	125	0	125	0		200	0	200
	Additional Car Parking		50	0	0	0	0		50	0	50
	Sexual Health Accomodation		260	30	2	28	0		260	2	258
	Capital team	F6305	155	83	93	(10)	0	93	155	186	(31)
	Aseptic isolator		30	30	0	30	0		30	0	30
	Sub total ESTATE IMPROVEMENT SCHEMES		**2,144**	**1,332**	**609**	**723**	**190**	**743**	**2,144**	**1,542**	**602**
FACILITIES	Catering equipment	G0026	100	100	0	100	0		100	0	100
	Sub total FACILITIES		**100**	**100**	**0**	**100**	**0**	**0**	**100**	**0**	**100**
	CONTINGENCY	**F6301**	**155**	**155**	**48**	**107**	**0**		**155**	**48**	**107**
	Capital plan excluding donations and IFRIC 12		**4,311**	**2,587**	**1,214**	**1,373**	**400**	**782**	**4,311**	**2,395**	**1,916**
OTHER	Donated assets	000000	120	60	145	(85)			120	145	(25)
	GE Radiology equipment replacement programme (IFRIC 12)	F6420	1,488	792	392	400		1,096	1,488	1,488	0
	Sub total Donations and IFRIC 12		**1,608**	**852**	**537**	**315**	**0**	**1,096**	**1,608**	**1,633**	**(25)**
	TOTAL CAPITAL SPEND		**5,919**	**3,439**	**1,751**	**1,688**	**400**	**1,878**	**5,919**	**4,028**	**1,891**

Actual year to date spend is £1,751k with a further £2,278k committed.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB267/18**	**Report Title**	**Statement of Compliance 2018/2019 Core Standards Self-Assessment- Emergency Preparedness, Resilience and Response (EPRR)**
Executive Lead	Steve Christian, Chief Operating Officer		
Lead Officer	Chris Pilkington, Emergency Preparedness Manager		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

NHS England (NHS E) has a statutory requirement to formally assure both itself and NHS organisations in England are in a state of EPRR readiness. This is provided through the NHS England Core Standards for EPRR Annual Assurance Process.

There is a requirement that a Statement of Compliance is approved annually by the Board. This year's Statement of Compliance had to be submitted to NHS England before 11 October 2018. NHS England was informed that the Board would not be able to formally approve the Statement as its next meeting was scheduled for 7 November 2018. NHS E agreed that the Trust's Accountable Emergency Officer, namely the Chief Operating Officer could sign the submission subject to approval by the Board at its next meeting.

There is an action plan supporting further improvement with timescales. This is attached at **Appendix 1**

Following self-assessment, and in line with the definitions of compliance, the organisation declares itself as demonstrating **Substantial** compliance against the EPRR Core Standards. The Compliance Statement was signed and submitted on 9 October 2018. This attached at **Appendix 2**

Recommendation:
The Board is asked to **approve** the Statement of Compliance

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 Board is asked to take assurance that the Trust is prepared for an emergency and approve the Statement of Compliance.

Previously Presented at:

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

APPENDIX 1

Overall assessment:			Substantially compliant						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG Amber = Not compliant, the Organisations EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months**	**Action to be taken**	**Lead**	**Timescale**	**Comments**
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	• Minutes of meetings	Partially compliant	Newly appointed COO from 1st October, therefore we are more confident in achieving the required target attandance of 75%	COO	Immediately	The AEO has attended 1 out of 3 meetings to date. The meeting in October will be attended by the AEO or their nominated deputy so this will be 50% of meetings per annum. We have had a change in leadership so going forward we are planning to increase the attendance to 100%.
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Partially compliant	Currently the departmental Business Continuity Plans are updated every 2 years however, to improve resilience we will review the documents on an annual basis as suggested in this process	COO	Immediately	Departmental BCPs contain the following categories:- Staff Shortages, Equipment Failure, Utilities Failure, Communications Failure, IT Failure, Supplies/Transport Failure, External Major Incident, Fire, Security Situations, Healtha nd Safety Issues. The Departmental BCPs are updated every 2 years or following new guidance or organisational change. We have experienced a number of incidents where our business continuity has been tested and plans have been updated to reflect learning from these
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	Maintenance of CPD records	Partially compliant	We require PRPS Instructor training courses for hospital traininers but at present the National Ambulance Resilience Unit (NARU) are the only accredited training facility for PRPS instructor training for the NHS and unfortunately there aren't any PRPS instructor course running at the moment and haven't been since November 2016. This is outside our scope of influence however, we have highlighted this to NHS England to requst they address this on our behalf.	COO	When courses become available from NARU	Once PRPS Instructor course are available we will ensure A&E staff are given protected time to attend
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Maintenance of CPD records	Partially compliant	We require PRPS Instructor training courses for hospital traininers but at present the National Ambulance Resilience Unit (NARU) are the only accredited training facility for PRPS instructor training for the NHS and unfortunately there aren't any PRPS instructor course running at the moment and haven't been since November 2016. This is outside our scope of influence however, we have highlighted this to NHS England to requst they address this on our behalf.	COO	When courses become available from NARU	Once PRPS Instructor course are available we will ensure A&E staff are given protected time to attend

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019

STATEMENT OF COMPLIANCE

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

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

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

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as Red	Standards rated as Amber	Standards rated as Green
xx	xx	xx	xx
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43**	**0**	**4**	**60**

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

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

Sign Name

Steve Christian

Print Name

The organisation's Accountable Emergency Officer

7th November 2018

Date of board/governing body meeting

9 Oct 2018

Date signed

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB268/18**	**Report Title**	**Risk Register**
Executive Lead	Juliette Cosgrove, Director of Nursing, Midwifery and Therapies		
Lead Officer	Katharine Martin, Senior Information Analyst & Datix Lead Mandy Power, Assistant Director of Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

There are currently 8 risks on the High Level Risk register. These are:

- **1688** - Inadequate Staffing Levels in Anaesthetic Department
- **1902** - Failure to comply & improve governance of services in relation to the areas of non-compliance identified by CQC
- **1917** - Quality of Older Peoples Care
- **1901** - Cancellation of elective activity in theatres
- **1314** - Management of mental health pathways
- **1862** - Maintaining safe quality nursing care with current level of nursing & HCA vacancies
- **1367** - Failure to have a motivated and engaged workforce (culture)
- **1329** - Returning to financial balance by 2021

Recommendation:

The Board is asked to **receive** the Risk Register.

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 ☐ 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)*

This is a dynamic document and its structure and content may be updated as necessary.

Previously Presented at:

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

Risk Register – as at 31 October 2018

Southport and Ormskirk Hospital NHS Trust

Strategic Objective	SO1 - Agree with partners a long term acute services strategy. SO2 - Improve clinical outcomes and patient safety. SO3 - Provide care within agreed financial limit. SO4 - Deliver high quality, well-performing services	Link to Board Assurance Framework (BAF)	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
13/11/2017	1688	Chief Operating Officer	Mandy Marsh	Inadequate Staffing Levels in Anaesthetic Department

Description	Staffing Levels of anaesthetic department affecting capacity and safety of emergency/ Intensive Care Unit /Maternity cover. Lack of emergency cover for on call / Intensive Care Unit / maternity both sites. This would result in the closure of high risk patients presenting to Accident & Emergency (A&E) for both adult and children and the inability to staff Intensive Therapy Unit.
Controls	Internal/external Locums anesthetists' to cover shortfall caused by vacancies People to work additional hours to fill extra sessions Elective lists cancelled to ensure cover when needed Change to on-call system to ensure full coverage; 1st on call onsite & 2nd on call supporting within core hours Interim support from staff pain management shortfall
Gaps in Controls	Availability of staff to cover vacant shifts at a minimum due to burn out/sickness/annual leave Lack of agency staff within capped rate 2.88 vacancies remain in service 1 consultant taken out of core theatre sessions to run pain activity; back filling those sessions with Waiting List Initiative (WLI) which has been approved to the end of the year by Director of Finance (DoF)

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	5	Moderate risk	09/10/2018	09/11/2018

Assurance	Monthly Planned Care governance meetings	**Gaps in Assurance**	
Action Plan	Reviewing job descriptions to be in line with national requirements.	**Action Plan Due Date**	18/12/2017
Action Plan Rating	Completed		

Strategic Objective		SO1 - Agree with partners a long term acute services strategy. SO2 - Improve clinical outcomes and patient safety. SO3 - Provide care within agreed financial limit. SO4 - Deliver high quality, well-performing services. SO5 - Ensure staff feel valued in a culture of open and honest communication. SO6 - Establish a stable, compassionate leadership team			Link to BAF	
Opened	**ID**	**Assistant Director of Operations (ADO)/Exec Lead**	**Risk Lead**	**Title**		
19/09/2018	1902	Director of Nursing & Quality	Paul Jebb	Failure to comply & improve governance of services in relation to the areas of non-compliance identified by Care Quality Commission (CQC)		
Description	If we fail to comply with regulatory framework then this will result in breach of the Trust regulation and potential legal action, poor patient experience, unsafe and poor quality of care, and lack of public confidence in the Trust					
Controls	Enhanced team to support Director of Nursing (DoN) deliver expectations Improvement plans developed and agreed with Trust Board Improvement groups developed across Trusts, including Clinical Business Unit (CBU) Commitment to run a shadow CQC process over 12 weeks Identified Executive and management leads for Performance, quality, people and use of resources Development of a shared drive to enable evidence to be uploaded Development of awareness raising and preparation for key leaders at Board and CBU level Identified support from Programme Management Office (PMO) with project management				**Gaps in Controls**	CQC identified 97 MUST AND SHOULD DO actions following November and December 2017 inspection Lack of pace and assurance regarding progress of action plan

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Likely (4)	Major (4)	16	16	Extreme risk	12	High Risk	22/10/2018	22/11/2018

Assurance	Committee structure Regular engagement meetings Assurance at quality and safety & committee CBU monthly governance meetings Development of a single quality improvement action plan Engage and gain support for validation from HealthWatch, Clinical Commissioning Group (CCG) and other regulators	**Gaps in Assurance**	Engagement of key leaders from 'ward to board' reduced understanding of expectations of regulator prior, during and after inspections

Action Plan		Action Plan Due Date		Action Plan Rating	
	• Work with communications team to engage widely with staff. Develop training for staff across the organisation		31/12/2018		Little or No Progress Made
	• Key leaders to access training with lead CQC executive/manager		30/11/2018		Little or No Progress Made
	• To deliver against the 97 MUST and SHOULD DO CQC recommendations outlined in the overarching CQC Action Plan.		01/03/2019		Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
19/10/2018	1917	Director of Nursing & Quality	Megan Langley	Quality of Older Peoples Care				
Description	If the limited care of Older People in Southport & Ormskirk NHS Trust continues then harm may be caused to our older patients. The areas of concern relate to specific practices: •Deconditioning of patients •Poor falls assessment and management of bed rails •Poor mouth care •Poor nutrition & hydration management •Poor continence management •Lack of interaction and social/cognitive stimulation increasing confusion and delirium •Limited availability of Geriatricians to provide holistic comprehensive assessment and advanced care management plans for patients •Inability to discharge patients home due to lack of resource to support at home							
Controls	Commenced education and roll out of Red2Green Board Rounds to value and consider patients time Falls assessment in nursing notes Care plans and policies in place. Additional care needs bay on one ward.						**Gaps in Controls**	Care plans not always used appropriately and not all care plans are appropriate Red2Green Board Round not fully rolled out. Work Currently underway to review falls documentation Inability to consistently staff additional care bay Training for staff re: older people risks not currently provided Environment not conducive to re-abling patients and maintaining function, social interaction or orientation Environment not wholly adapted for additional/enhanced care needs e.g. dementia Lack of understanding of the impact of patients remaining in bed, in pads, with cot sides, not eating/drinking Lack of pathway/service availability to support patients with enhanced needs returning home- i.e. lack of 24hour care in community to step down
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	22/10/2018	30/11/2018
Assurance	CQC Review planned for March 2019.						**Gaps in Assurance**	Need to develop internal assurance of improved quality around all domains listed in the hazard. Need to develop action plan and Red/Amber/Green (RAG) rate, identify projects and leads for the improvements which have been identified. Need to commence audits of older people incidents, harm, impact of admission, causes of 'red days' and delays between being fit to leave and leaving hospital.	
Action Plan	• Develop a nutrition, hydration and mouth care quality improvement group to deliver identified changes to practice and therefore improve patient/relative/carer experience and outcomes. • To improve education, understanding and therefore change practices of those working with patients to manage continence appropriately, identifying when a patient may need support, maintaining the ability of patients to go to the toilet, using catheters and pads which are individually identified as a need for a patient and demonstrating better awareness of patients displaying the need to go to the toilet particularly in areas requiring enhanced care						**Action Plan Due Date**	01/01/2019 01/01/2019	**Action Plan Rating**	Little or No Progress Made Little or No Progress Made

	• Business case to be developed to enhance the provision of the geriatrician service at Southport & Ormskirk. Patients with such high frailty factors must have appropriate care and advanced care management plans with sensitive, individual conversations in order to support the individuals and families with delivering the patient's wishes and best quality end of life care possible.		01/01/2019		Little or No Progress Made
	• Review of wards to take place to establish how to maximise potential of the areas we have to provide better environments for patients particularly with enhanced needs. Particularly looking at signs, colour of objects, orientation devices, tables/chairs to encourage interaction, stimulating activities, getting up dressed and moving.		01/01/2019		Little or No Progress Made
	• Develop and work up discharge pathways group to rid of unnecessary delays which cause harm to patients who remain in the acute setting.		01/01/2019		Moderate Progress Made
	• Continue to roll out Red2Green and education across all wards		31/12/2018		Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety. SO3 - Provide care within agreed financial limit. SO4 - Deliver high quality, well-performing services. SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF			
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**						
18/09/2018	1901	Chief Operating Officer	Helen Hurst	Cancellation of elective activity in theatres						
Description	Due to high levels of vacancies and sickness within theatre team at both Southport and Ormskirk sites, elective theatre sessions are being cancelled. This is having both long and short term effects on moral within the team, productivity, efficiency, expenditure and income generation									
Controls	Use of Bank & agency staff short and long term Ask permanent staff if able to do overtime Theatre coordinator to go into theatres when to cover short notice shortfalls Clinical manager co-ordinate the theatres Ensuring appropriate skill mix of workforce Continue with extensive recruitment drive Rates of pay agreed with NHS Professionals (NHSP) Daily review of rotas to ensure safety maintained Review to be undertaken to ensure correct workforce establishment						**Gaps in Controls**	Discussion with operational managers to ensure joint decision on moving lists Clinical urgency is reviewed for each patient to ensure correct patients are cancelled with minimal impact to outcomes		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Almost Certain (5)	Moderate (3)	20	15	Extreme risk	6	Moderate risk	22/10/2018	19/11/2018	
Assurance	Theatre scheduling group kept informed at weekly meeting. Discussed at CBU meetings Discussed at Theatre Programme Steering Group Planned Care Performance Review Board (PRB)						**Gaps in Assurance**			
Action Plan	• Review of staffing across the Trust • To deliver against recovery plan for Theatre recruitment and retention • Implementation of the Get It Right First Time(GIRFT)/Elective Care project						**Action Plan Due Date**	29/03/2019 31/10/2019 30/04/2019	**Action Plan Rating**	Little or No Progress Made Little or No Progress Made Little or No Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety. SO4 - Deliver high quality, well-performing services					Link to BAF		
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
11/04/2016	1314	Chief Operating Officer	Jane Lawson	Management of mental health pathways					
Description	Patients who are admitted with mental health problems are not transferred out of Southport & Ormskirk Hospital Trust (SOHT) to a mental health bed timely due to lack of beds. Patients are therefore not in an appropriate environment. All patients on a section should be risk assessed to ensure any potential of further deterioration of their condition is mitigated and a full assessment is carried out. The delay in transfer then impacts on staff and potentially other patients								
Controls	Full Risk Assessment required to understand the individual needs of the patient and the environment Risk Assessment to be reviewed on a regular basis, i.e. changing patient's condition, change in environment, change of patient's location Ensure Mersey Care/ Lancashire Care are continually informed, escalate to Mersey Care management, escalate to Trust management and those patients on Section 136, ensure Police support remains in place Service Level Agreement (SLA) in place with Mersey Care / Lancashire Care Staff attending Conflict Resolution Training Chief Executive Officer (CEO) support and confirmed that all patients should stay in Accident & Emergency Department (AED) and not be transferred to general ward or observation ward 24 hour security presence in Southport District General Hospital (SDGH) - available to AED if required						**Gaps in Controls**	Mersey Care staff not present in the department 24hours No Registered Mental Nurses (RMNs) employed within the current Trust nursing establishment Staffing levels can prove challenging Limited availability of Advanced Mental Practioners (AMP) to carry out assessments which often leads to delay	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	12	16	Extreme risk	8	High Risk	22/10/2018	22/11/2018
Assurance	Escalation to Commissioners of current shortfalls in mental health beds and delays experienced in A&E Emergency Care Improvement Support Team (ECIS) undertaking full review of mental health pathway Nov 2018 Conflict Resolution training figures Timely Datix Incident Reporting for any incidents						**Gaps in Assurance**		
Action Plan	• Establish office space to accommodate MerseyCare on site • Documentation audits are to be scheduled to identify deficits in record keeping • Emergency Care Improvement Support Team (ECIS) undertaking full review of mental health pathway Nov 2018						**Action Plan Due Date**	29/01/2018 02/04/2018 23/11/2018	**Action Plan Rating** Completed Completed Little or No Progress Made

Strategic Objective	SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services						Link to BAF	SO2
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
20/06/2018	1862	Director of Nursing & Quality	Carol Fowler	Maintaining safe quality nursing care with current level of nursing & HCA vacancies				
Description	If levels of Nurse & HCA staffing remains below funded establishment due to vacancies then patients may experience poor quality of care (safety & patient experience).							
Controls	Safe Care monitored daily Daily staffing huddles with Matrons & Senior nurse Review Health roster Policy & compliance NHSP contract Continued review of nursing establishments Staffing data reviews See risks 1132 , 278 and high risk 1368 Datix system to identify if there has been a harm of patients due to staffing levels						**Gaps in Controls**	No formal Safety Huddle at w/ends Established budgets in some clinical areas do not meet the clinical needs of the patient group Establishment review not undertaken on a 6 monthly basis with recommendations to the TB Datix system to identify if there has been a harm of patients due to staffing levels in accordance with NICE 'red' flags NHSP contract for review in 6 months T&F group for Retention with a focus on Recruitment, supported by NHSI Workforce Plan to be developed following Establishment review See risks 1132, 278 and high risk 1368.
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	8	High Risk	22/10/2018	19/11/2018
Assurance	Workforce data (sickness & AL) Dedicated H roster Lead for N&M CQC inspection Monthly staffing report mandatory training Complaints Incident reporting Quality and safety reports Bi annual staffing reports						**Gaps in Assurance**	Establishment Review Process not consistent Workforce Plan (including retention & Recruitment) Updated E roster policy Matrons dashboard/Clinical metrics needs to be developed Mandatory training not being at Trust required standard Managing Performance Framework process	
Action Plan	• Senior nursing staff deployed to identified areas to review current nursing practice and care delivery. • Deployment of senior staff to wards identified. • Quality improvement approach of the themes to address actions form CQC inspection, complaints and incidents						**Action Plan Due Date**	29/06/2018 01/08/2018 29/03/2019	**Action Plan Rating**	Moderate Progress Made Moderate Progress Made Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety. SO4 - Deliver high quality, well-performing services. SO5 - Ensure staff feel valued in a culture of open and honest communication. SO6 - Establish a stable, compassionate leadership team					Link to BAF		BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).					
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, and high turnover.								
Controls	Leadership Master Classes Annual Shine Awards Workforce Strategy and OD Plan Junior Doctors Survey Friends and Family Test Valuing our People Working Group New post created for support of records system, recruitment process is ongoing. Staff Survey Action Plan						**Gaps in Controls**	Lack of OD resource within organisation	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	15/10/2018	31/12/2018
Assurance	Quarterly HRD report to Trust Board Result of Staff Attitude Survey Coaching in the workplace Values based recruitment based on guidance from NHS England PDR Process which includes Trust values Charter for Staff and Managers Review of culture in the Trust completed Progress against action plans for FFT, Staff Survey and Retention						**Gaps in Assurance**	Nil Identified	
Action Plan	Cultural Review as commissioned by the Board						**Action Plan Due Date**	02/02/2018	**Action Plan Rating** Completed

Strategic Objective		SO3 - Provide care within agreed financial limit					Link to BAF	BAF007
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
10/05/2016	1329	Director of Finance	Steve Shanahan	Returning to financial balance by 2021				
Description	If we do not have a plan to return to financial balance by 2021, then potentially the organisation will not exist in its current form.							
Controls	Long term financial model and an estate solution based on the sustainability report completed by the Deloitte in 2015. The Care for You programme built on the Deloitte findings. This has now been supported by the Northern England Clinical Senate report. Trust is part of the Cheshire & Mersey Health & Social Care Partnership (STP); the Sefton Transformation Board provides oversight of the Care for You Programme Building on the modelling done by KPMG (funded by STP) the Trust has commissioned MBI group to develop costed clinical options based on Northern Clinical Senate report in more detail						**Gaps in Controls**	The need to model the STP/LDS assumption in LTFM Accuracy of PLICS data and Model Hospital West Lancashire CCG member of Healthier Lancashire & South Cumbria (STP)
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	6	Moderate risk	17/09/2018	17/10/2018
Assurance	Monthly report to Trust Board re Progress of the Sefton Transformation Board Long Term Financial Model (LTFM)						**Gaps in Assurance**	No agreed clinical model for reconfiguration of services	
Action Plan	• Development of Estate plan for reconfiguration of services; identification of land sales to support capital development costs**.** Development of a financial revenue plan with savings for the reconfiguration of services. KPMG to produce 'Case for Change' by 20/07/2018. • Submission of Trust 2 year operational plans by 23/12/16. • Submission of STP plan.						**Action Plan Due Date**	07/01/2019 23/12/2016 16/10/2016	**Action Plan Rating** Moderate Progress Made Completed Completed

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB269/18**	**Report Title**	**Board & Senior Leaders Development , Well Led Review and Quality Improvement Training**
Executive Lead	Silas Nicholls, Chief Executive Juliette Cosgrove, Director of Nursing, Midwifery & Therapies Jane Royds, Director of Human Resources		
Lead Officer	Audley Charles, Company Secretary Tracy Gunn, Head of Education & Training Paul Jebb, Deputy Director of Nursing		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

Following a CQC inspection in December 2017, the Trust received an overall rating of *Requires Improvement* (*Good* for Caring Services, *Inadequate for safety in urgent and emergency care, Inadequate* for well led across medicine, surgery and the Trust overall) in a report that identified 97 improvement actions.

The Trust's Board Development Programme is an integral part of the Trust's *Vision 2020* and forms one action of several in the Trust's response to the CQC's Well Led rating (March 2018) to ensure that the Board governs effectively and in doing so builds patient, public and stakeholder confidence that their health is in safe hands.

This version of the Board Development Programme commenced in September 2018 and is designed around the Trust's Strategic Objectives and CQC Well Led Domains - *Strategy & Planning, Capability & Culture, Process and Structures, and Measurement.* It is comprised of a variety of assessment and developmental activities which at its core has monthly workshops to deliver on the following three Board objectives:

1. *To develop a transparent and compassionate leadership team which will create an inclusive culture where staff feel free to speak up*
2. *To support the Board to set the strategic direction of the organisation underpinned and monitored by robust governance structures and processes*
3. *To work effectively as a high performing team who role model exemplary behaviours*

The Board Development Programme acts as one work stream combining a series of connecting and supporting strategies and improvement plans. It includes working closely with AQuA (Advancing Quality Alliance) to undertake a Well Led Development Review, the outcomes of which will inform future Board development; and to deliver a Quality Improvement training programme to embed a robust proven improvement methodology.

The scope of the review programme extends to the CBUs and senior managers

NHSI's involvement will be as follows:

- Support with developing and delivering the overall plan
- Helping to review delivery of the AQuA proposal and overall preparation
- Undertaking the Clinical Service Review (including Pharmacy review)

Together with Board development, the Trust is launching a Senior Leadership programme to coincide and dovetail into the Board Development programme so that there is collaborative learning and a system-wide approach to our leadership development and culture.

Recommendation:

The Board is asked to **approve** the Board Development and Senior Leaders Programme and to **receive** the details of the Well Led Development Review.

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 ✓ Equality ✓ Finance	✓ 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)*	
The Well Led programme to commence on 5 December 2018 and will be completed in March 2019.	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds Committee ☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

1. Purpose

This report provides a comprehensive overview of the leadership and quality improvement programmes which have been commissioned and designed to align to the CQC's Well Led Domains and meet the Trust's Strategic Objectives. The development programmes are referenced in the Trust's overarching Workforce & Organisational Development (OD) Strategy and will form part of the Trust's Vision 2020 Plan.

The aim is to cultivate a cohesive and productive Unitary Board supported by a skilled Senior Leadership Team, together creating a compassionate and inclusive leadership culture focused on quality improvement.

2. Background

Southport and Ormskirk Hospital NHS Trust has had a troubled recent past. A significant financial deficit puts it by percentage of turnover as one of the worst performing hospitals in the country and two consecutive Care Quality Commission (CQC) inspections found it lacking in terms of the consistent provision of even the most basic care. Strong, values based leadership has been lacking, and the removal of the Chief Executive (CEO) and other important members of the senior team left a vacuum in terms of strategy and purposeful direction. The Trust was without a substantive CEO for more than three years and in that period there was a successive number of interims filling this and other key executive positions.

It is therefore, unsurprising, that when a substantive CEO was appointed and joined the Trust in April 2018 that his leadership was under the scrutiny of the Secretary of State for Health & Social Care. The six priorities for which the CEO is being held accountable to deliver are as follows: 1) Leadership, 2) Quality, 3) Performance and Service Transformation, 4) Medical Engagement, 5) Culture and 6) Finance. Combine this with a CQC inspection overall rating of Requires Improvement in March 2087, the Trust is determined to take action and secure a future rating of at least '*Good'*.

Since the CEO's appointment, there have been several further Executive appointments to establish a stable leadership team - Director of Nursing & Midwifery, Chief Operating Officer and Medical Director (January 2018) - and the creation of a Director of Strategy post. Add to this the appointment of two new Non-Executive Directors and the recruitment of a new Chair (in progress Oct/November 2018). To fast track the Board to function as a cohesive and high performing team, the CEO has commissioned leadership development specifically for the Board and key Senior Leaders from the Clinical Business Units and Corporate Functions. These leadership programmes are inter-connected with work by AQuA to deliver a Well Led Development Review (Q3/Q4 2019) and the roll out of quality improvement training / methodology – to be launched at a Quality Summit (January 2019).

All of the above activities have been consolidated in the Trust's new Workforce & Organisational Development Strategy (Sept 2018). This strategy and supporting action plan also includes other key deliverables which focus on leadership development and quality improvement (QI) training for the wider workforce.

3. Executive Summary

The Trust's Board Development Programme commenced in September 2018 and is designed around the Trust Strategic Objectives and CQC Well Led Domains. It is comprised of a variety of

assessment and developmental activities which at its core has monthly workshops to deliver on the following three Board objectives:

1. *To develop a transparent and compassionate leadership team which will create an inclusive culture where staff feel free to speak up*
2. *To support the Board to set the strategic direction of the organisation underpinned and monitored by robust governance structures and processes*
3. *To work effectively as a high performing team who role model exemplary behaviours*

The Board Development Programme will be interspersed with other key pieces of QI work as described above to deliver on the Board's developmental objectives.

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4. Details

4.1 Board Development Programme

It is recognised that a highly effective Board is one of the fundamental drivers of organisational performance, particularly in times of change. The Board Development Programme (**Appendix A**) aims to improve the effectiveness of our Board and transition it to a new era of shared, distributed and devolved authority.

This programme is built around monthly workshops and master classes by '*thought leaders'* such as Professor Michael West (Professor of Oganisational Psychology) and Tracie Joliff (Head of Inclusion & Leadership). It is interjected by the work with AQuA to deliver the Well Led Development Review, the outcomes of which will inform further development activities throughout 2019.

Board members have access to Executive Coaching, 360 Feedback Appraisals and Executive Leadership programmes provided by the NHS Leadership Academy. Conversations are currently underway to secure external expertise to deliver a Board Skills Audit, a programme of self-assessment, and interventions to develop a high performing team.

4.2 Senior Leaders Development Programme

Great leadership development improves leadership behaviours and skills, better leadership leads to better patient care, experience and outcomes. The 12 month programme (Appendix B) is designed to provide a combination of leadership diagnostics, seminars, team development and coaching. The programme is flexible to allow leaders to work with their mentor and/or coach to personalise their own leadership journey and identify their specific learning needs. In turn, the expectation is that senior leaders will individually and collectively apply their learning and improvements in to their own workplace. Where further learning needs are identified outside of the programme, they will be addressed on an individual basis.

The programme is predominantly aimed at Senior Leaders within the Clinical Business Units and Corporate Functions but recognises the importance of collaborative leadership therefore our senior leaders are invited to attend the Board workshops and master classes to learn together, share ideas and work in a collaborative way.

4.3 AQuA Well Led Development Review and Quality Improvement Training Programme

Throughout 2018-2020, the Trust will be working with Advancing Quality Alliance (AQuA) to deliver two improvement programmes.

i. ***To undertake a developmental review of leadership and governance using the CQC Well Led Framework in preparation for a Well Led CQC Inspection in March/April 2019.***

The development review will act as one of the dialogic tools for this leadership programme, analysing the Trust's approach to governance and leadership. Based on the findings and subsequent recommendations from the well led development review, targeted development interventions will be added to this programme to secure and sustain future performance. This review will also underpin the design of future leadership development at all levels. (**see Appendix D below) .** The scope of the review programme involves the CBUs and senior managers

NHSI's involvement will be as follows:

- Support with developing and delivering the overall plan
- Helping to review delivery of the AQuA proposal and overall preparation
- Undertaking the Clinical Service Review (including Pharmacy review)

ii. ***To deliver a 2 year quality improvement programme to upskill, equip and empower our workforce to make quality improvements for our services and patients. This training forms one of the training offers in the current Senior Leaders leadership programme***. **This also informs the Well Led Review**

This two-year plan forms part of our staff engagement approach, measured by improvements in the NHS Staff Survey in Key Finding 7 - an increase in the percentage of staff stating that they are able to contribute towards improvements at work, and an increase in overall staff engagement.

5. Recommendation

The Board is asked to **approve** the report and recognise the importance of engaging with the programme and encouraging our Senior Leaders to access the appropriate development opportunities through talent conversations.

6. Appendices

Appendix A – Board & Senior Leaders Development on a page

Appendix B - Board Development Programme

Appendix C - Senior Leaders Development Programme

Appendix D – Well Led Development Review - Approach

Appendix E - Quality Improvement Training Programme

APPENDIX A

Board & Senior Leaders Development on a page

- ✓ To develop a transparent and compassionate leadership team which will create an inclusive culture where staff feel free to speak up
- ✓ To support the Board to set the strategic direction of the organisation underpinned and monitored by robust governance, structures and processes
- ✓ To work effectively as a high performing team who role model exemplary behaviours

Appendix B

NHS
Southport and Ormskirk Hospital
NHS Trust

Board Development Programme

"Outstanding for our patients"

2018 - 2019

Keep Learning
Grow Innovate Evolve Adapt

Table of Contents

1. Introduction and context

The purpose of the Board is to govern effectively and in doing so build patient, public and stakeholder confidence that their health is in safe hands. This fundamental accountability to the public is delivered by building confidence:

- In the quality and safety of our services
- That resources are invested in a way that delivers optimal health outcomes
- In the accessibility and responsiveness of our health services
- That patient and public can help to shape health services to meet their needs
- That public money is spent in a way that's fair, efficient, and effective, and of economic benefit.

This Board Development Programme is designed to assist the delivery of the above. The objectives for Board development are informed by the following drivers:

- changes to the membership of the Trust Board, with newly appointed Non-Executive and Executive Directors
- the constantly changing and demanding external environment within which the Trust is operating
- the recommendations from external inspections and regulatory and compliance issues regarding the Trust Board.
- the emphasis on partnership working within the local health and social care system
- the key roles of the Board in respect of risk management and patient safety
- the importance of corporate governance both within current organisational structures and new models
- the Board's own assessment of its performance and effectiveness
- the stated aim that the board leads the organisation-wide leadership development and model the leadership behaviours

1.1 Board Development Objectives

The following key objectives underpin this Board Development Programme and are aligned to the goals of the organisational development plan.

BD1 – To develop a transparent and compassionate leadership team which will create an inclusive culture where staff feel free to speak up
BD2 – To support the Board to set the strategic direction of the organisation underpinned and monitored by robust governance structures and processes
BD3 – To work effectively as a high performing team who role model exemplary behaviours
Within the following framework, the programme sets out what the Board has achieved to date and sets out further areas of development, with timescales for delivery throughout.

BD1. To develop a transparent and compassionate leadership team which will create an inclusive culture where staff feel free to speak up

What we have already achieved…

- Appointed a Freedom to Speak Up Guardian, a Board Champion and departmental champions to promote a culture where staff feel free to speak up
- Listened to patients, staff and their relatives about their experience and considered qualitative information about the services we provide
- Celebrated the work of staff through annual staff awards with a new brand for 2018 "Time to Shine" and new categories recognising the contribution our students and learners
- Improved relationships with our CCG and GP colleagues

What we will do…

- Work collaboratively with our medical, clinical and senior management teams to drive forward the required changes
- Become more strategic and less operational by reviewing the Trust Board's strategic objectives and refocusing the Trust Board agenda to include a review of these objectives on an annual basis
- Consider more reflective and evaluative discussion at Board meetings including a review of behaviours, values, collaboration and inclusivity
- Strengthen engagement with patients: '*Ward to Board'* by devising a programme of 'patient pathway walks' and 'hearing the stories'
- Hold one another to account by being more challenging, constructive and evidence based by using seminars and workshops to develop strategy, enable wider engagement and take forward Board development

- Work with partner organisations across the Health and Social Care System through joint boards and seminars by agreeing a programme of joint boards/seminars with key partners

BD2. To support the Board to set the strategic direction of the organisation with robust governance structures and processes

What we have already achieved…

- Appointed a Director of Strategy to focus on the strategic direction of the organisation
- Engaged in a programme of Acute Sustainability and working in conjunction with the Sefton Transformation Board with regards to service change
- Undertook a review of strategic and operational governance to ensure there are robust governance processes and systems in place to enable operational performance to be monitored more efficiently
- Reviewed on an annual basis the Board's performance and effectiveness
- Embedded risk management systems with a revised Risk Management Strategy, Board Assurance Framework and Corporate Risk Register

What we will do…

- Develop succession plans for Board members as approved by the Remuneration and Nomination Committee
- Have individual, tailored skills development, by agreeing individual plans and undertaking of 360° appraisals
- Ensure the Trust's business systems are effective and support good governance and that Terms of Reference for committees are consistent, by developing *Committee Governance Packs* for all Committees of the Board, including *Committee Performance & Effectiveness Assessment Tools*, and publish these in our Corporate Governance Handbook
- Review information needs of the Board and continue to evaluate Board effectiveness by undertaking Board effectiveness evaluation (baseline and annual) in line with the '*Well Led Framework (Domains)'*, including reviewing the information needs of the Board
- Identify and regularly review our principal risks linked to our strategic objectives and priorities which will include revision of the *Board Assurance Framework* and the Corporate Risk Register including completion of risk assessments.
- Review the risk management system and function across the Trust to reflect the Clinical Business Units (CBUs) structure and wider architecture
- Clarify the role of Board Committees in respect of risk management via review of their Terms of Reference.

BD3. To work effectively as a high performing team who role model exemplary behaviours

What we have already achieved…

- Strengthened the Board with new substantive appointments
- Reviewed the size and composition of the Board and ensured timely insightful, focused and well-presented papers by preparing and publishing a Standard Operating Procedure
- Have in place Annual Business Cycles (work plans) for the Board and its committees
- Benchmarked against other Trusts for good practice
- Developed a Standard Operating Procedure relating to preparation and submission of Board and Committee reports
- Developed a Performance and Assessment Tool for the Board and committees to undertake an assessment of its performance and effectiveness to ensure timely insightful, focused and well-presented papers come to it.

What we will do…

- Undertake a 12 month programme of "*Building a High Performing Team*" to better understand roles and behaviours that impact on leadership and decision making
- Undertake a skills mix exercise of all Board members and plan training programmes accordingly.
- Conduct a number of seminars and workshops to aid in the performance of the unitary Board.

2. Principles of Board Development

The Board Development Programme will commence in September 2018 and run for the next 12 months or thereafter as required. It will consist of workshops, seminars using keynote speakers, and will be structured around the three Board objectives identified above and within the Well Led Domains-Strategy & Planning, Capability & Culture, Process

and Structures and Measurement. These will also be matched to the Trust's strategic objectives. In the spirit of collaborative leadership and where applicable, senior leaders from across the Trust and key stakeholders will be invited to support the development of system-wide changes at the Trust and in the local health economy. The suggested development programme can be found at **section 8 below.**

3. Personal Development

All Board members participate in an appraisal on an annual basis. A summary of the key outputs from this process for executive directors will be shared at the Remuneration and Nominations Committee meeting. In addition any collective development needs will be identified and fed into future development programmes.
The identification of individual development needs, including continuing professional development, and implementation of any follow up action is undertaken as part of the appraisal process.

4. NHS Healthcare Leadership Model / 360 degree appraisal

The undertaking of a 360° appraisal process at Board level based on the NHS Leadership Model will be built into the development programme throughout the year. The Trust has pre-purchased 360 appraisals for staff, to access a funded 360 please contact Colette Halliday – c.halliday@nhs.net or call Ext 6876

5. NHS Leadership Academy Programmes

The NHS Leadership Academy has designed programmes for every level of leadership. For Board members, the follow programmes may be suitable.

- Aspiring Chief Executive Programme – preparing individuals for tomorrow's CEO role
- Chief Executive Development Network – support CEO personal development
- Director Programme – role development and support
- Ready Now Programme for senior BAME leaders

For more information about all NHS Leadership Academy programmes please access the website at - www.leadershipacademy.nhs.uk/programmes

6. Coaching and mentoring

All Board members are encouraged to take up coaching and/or mentoring support this year, in addition to utilising informal networks, and professional programmes offered by the NW Leadership Academy.
North West Leadership Academy will fund two Board members for three coaching sessions each. Coaches can either be accessed through their online Coaching Register or via an existing coaching provider that you already have a relationship with. For further details contact Tracy Gunn, Head of Education & Training or Audley Charles, Company Secretary

7. Succession Planning

Throughout the programme, the Company Secretary in conjunction with the Chair, Chief Executive and Associate Director of Human Resources, will support the Board to produce a succession plan for all members in order to identify any key risk areas and put in place talent management processes, and contingency plans.

8. Well Led Development Review

The Board Development programme will be underpinned by the Well Led Development Review delivered by AQuA and MIAA and will be subject to any recommendations identified.

9. Board Development Programme 2018 to 2019

Date 18-19	Time	Masterclass	Speaker/ Facilitator/Lead	Venue	Delegates	Strategic Objective (SO)	Board Dvlpt Objectives (1,2,3)	CQC Well Led Domain
2018								
5th Sept	14:00-17:00	General Data Protection Regulation (GDPR) 2018	Emma Stockwell - Hill Dickinson	Seminar Room, CEC	Board ADO/AMD/HoN	All	2	Process & Structure
3rd Oct	14:00-17:00	Effective use of the IPR to monitor Trust performance	Caroline Griffiths, NHSi Steve Christian, COO Anita Davenport, Performance Manager	Seminar Room, CEC	Board ADO/AMD/HoN	4	2	Measure-ment
7th Nov	14:00-17:00	External mortality review report with recommendations and action plan	Jugnu Mahajan, MD Chris Goddard, Consultant Tracy Sparks, Jean McLeod	Ruffwood Suite, ODGH	Board ADO/AMD/HoN	2 & 4	2	Process & Structure
5th Dec	10:30-16:30	• CQC overview and requirements aligned to CQC well-led requirements. • Board consideration of the Well-Led gaps identified in the PIR assessment. • Overview and interrelationship to quality improvement training for embedding QI	AQuA / MIAA	*Family Life Centre	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	All	All	All
2019								
Jan - Feb	……	Well Led Development Review	AQuA	SDGH / ODGH	TBC	All	All	All
9th Jan	14:00-17:00	Objective setting/Strategic Planning/Board Assurance	Therese Patten, Dir of Strategy Audley Charles, CoSec	Seminar Room, CEC	Board ADO/AMD/HoN	All	All	All
6th Feb	14:00-17:00	Review of the strategic plan and associated risk management processes (BAF)	Therese Patten, Dir of Strategy Audley Charles, CoSec	Seminar Room, CEC	Board ADO/AMD/HoN	All	All	All
6th Mar	14:00-17:00	Well Led Development Review Report / Feedback (tbc)	AQuA / MIAA	*Ruffwood Suite, ODGH	Board ADO/AMD/HoN	All	All	All
3rd Apr	14:00-17:00	Leadership Masterclass – topic tbc Open event / invitations to NW Trust and Local Authority Execs/Leaders	Professor Michael West Professor of Organisational Psychology, Lancaster University	*Ruffwood Suite, ODGH or external venue	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies External delegates	5 & 6	1 & 3	Capability & Culture

Date 18-19	Time	Masterclass	Speaker/ Facilitator/Lead	Venue	Delegates	Strategic Objective (SO)	Board Dvlpt Objectives (1,2,3)	CQC Well Led Domain
1st May	14:00-17:00	"How increased ownership of inclusive leadership behaviours will reduce discrimination, unfairness, bullying and harassment, and how it's everyone's responsibility"	Tracie Joliff - Head of Inclusion and Systems Leadership (NHS Leadership Academy)	*Ruffwood Suite, ODGH or External venue	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	5 & 6	1 & 3	Capability & Culture
5th Jun	14:00-17:00	*HELD - Outcome of Well Led Review*						
3rd Jul	14:00-17:00	*HELD - Outcome of Well Led Review*						
4th Sep	14:00-17:00	*HELD - Outcome of Well Led Review*						
2nd Oct	11:00-17:00	*HELD - Outcome of Well Led Review*						
6th Nov	14:00-17:00	*HELD - Outcome of Well Led Review*						
4th Dec	13:00-17:00	*HELD - Outcome of Well Led Review*						

* Venue to be confirmed

10. Other development opportunities

More links, contacts and information to further external development opportunities for Board members:

Good Governance Institute - www.good-governance.org.uk/events-page

Improvement Director Network - contact karla.parker@nhs.net to join the network.

Induction sessions for Executive and Non-Executive Directors (provided in partnership with NHS Providers) - see: http://nhsproviders.org/courses-events/courses/executive-director-induction

Advancing Quality Alliance - www.aquanw.nhs.uk/events/

NHS Improvement - https://improvement.nhs.uk/events/

NHS Providers - http://nhsproviders.org/courses-events

NHS Employers - https://www.nhsemployers.org/events

Health Education England - https://hee.nhs.uk/

King's Fund - https://www.kingsfund.org.uk/events

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Tracy Gunn - Head of Education & Training
Audley Charles - Company Secretary
October 2018

Appendix C

NHS
Southport and Ormskirk Hospital
NHS Trust

Senior Leaders Development Opportunities

“Outstanding for our patients”

2018 - 2019

Keep Learning
Grow Innovate Evolve Adapt

Table of Contents

11. Introduction

"Great leadership development improves leadership behaviours and skills… Better leadership leads to better patient care, experience and outcomes".

The Senior Leaders' Development Programme 2018 to 2019 is in response to the Trust's commitment to deliver on the CQC standards for Well Led, to move the Trust from its current 'inadequate' rating (2017) and aim towards 'outstanding' for our patients.

The 12 month programme is designed to provide a combination of leadership diagnostics, seminars, team development and coaching. The programme is flexible to allow leaders to work with their mentor and/or coach to personalise their own leadership journey and identify their specific learning needs. In turn, the expectation is that senior leaders will individually and collectively apply their learning and improvements in to their own workplace. Where further learning needs are identified outside of this programme, they will be addressed on an individual basis.

12. Who are the leadership opportunities for?

The programme is predominantly aimed at Senior Leaders within the Clinical Business Units (Groups 1 & 2) but recognises the importance of collaborative leadership with our Corporate& Specialist Services Senior Leaders so learning and its application is across the wider leadership team.

The target audience is split in to three groups and is clearly identified on the programme which opportunities are open to which members of each group - described below.

Group 1 x 11 members
Associate Director of Operations – 1 x Planned, 1 x Urgent, 1 x Specialist Services
Associate Medical Director – 1 x Planned, 2 x Urgent, 1 x Specialist Services, 1 x Patient Safety
Head of Nursing – 1 x Planned, 1 x Urgent, 1 x Specialist Services

Group 2 x 35 members
Clinical Director – 8 x Planned, 1 x Urgent, 3 x Specialist Services
Matron – 6 x Planned, 4 x Urgent, 4 x Specialist Services
Directorate Manager – 3 x Planned, 2 x Urgent, 3 x Specialist Services
1 x Head of Therapies

Group 3 x 7 members
Deputy Director of Finance
Deputy Director of Nursing
Deputy Medical Director
Deputy Director of HR
Deputy Chief Operating Officer
Chief Pharmacist

Deputy Director of Infection Prevention and Control

13. Well Led Development Review & Quality Improvement (AQuA)

Throughout 2018-2019, the Trust will be working with the Advancing Quality Alliance (AQuA) to deliver two improvement programmes.

1. **To undertake a developmental review of leadership and governance using the CQC Well Led Framework.**

Anticipated outcome: The development review will act as one of the dialogic tools for this leadership programme, analysing the Trust's approach to governance and leadership. Based on the findings and subsequent recommendations from the well led development review, further development interventions will be added to this programme to meet the outcomes of the assessment. This review will also underpin the design of future leadership development at all levels.

2. **To deliver a 2 year quality improvement programme to upskill, equip and empower our workforce to make quality improvements for our services and patients. This training forms one of the training offers in the current Senior Leaders leadership programme.**

Anticipated outcome: This 2 year plan forms part of our staff engagement approach, measured by improvements in the NHS Staff Survey in KF7 staff able to contribute towards an increase in the percentage of staff stating that they are able to contribute towards improvements at work and an increase in overall staff engagement.

14. Types of leadership opportunities

4.1 Diagnostics / Assessment

Well Led Development Review (AQuA) is described above in section 3. This will define any further leadership development to meet the CQC well led framework.
Team Profiling is all about greater understanding – greater understanding of yourself, your staff, how your team can work more effectively as a unit and also what else you may need in your team.
360 Degree Feedback (NHS Leadership Academy) is a powerful tool to help individuals identify where their leadership strengths and development needs lie. The process includes getting confidential feedback from line managers, peers and direct reports. As a result, it gives an individual an insight into other people's perceptions of their leadership abilities and behaviour.
Wave® Professional Styles (personality questionnaire) measures motives, talents, preferred culture and competency potential in one online questionnaire. This will be available from early 2019.

4.2 Training Programmes

Master Class Programme – the Senior Leadership programme dovetails in to the Board Development programme so that there is collaborative learning. The master classes in 2018 will focus on leadership, culture, governance, and business planning and for 2019, development will be defined by the outcomes of the Well Led Development Review.

Well Led Development Review (AQuA) – The Well Led Development Review feedback will inform future development requirements for both the Board and Senior Leaders

Quality Improvement Programmes (AQuA) will be confirmed in autumn 2018. The Head of PMO will lead on the programme and will work with senior leaders & form a QI Project Group to agree the improvement projects and identify the right people for each level of QI training programme.

The Shadow Board programme (NHS Leadership Academy) - intends to provide the organisation with the opportunity to tailor a development intervention to their own current needs, resulting in a bespoke programme which is relevant and provides participants with an authentic experience of Board exposure. The programme is also designed to improve diversity at this top level of the talent pool, and the two-way feedback mechanism allows and encourages 'different' thinking and innovation, fostering an inclusive culture where diversity of thought can thrive.
The approach has two key parts to it;
1. A three-day executive education course, which covers necessary learning that will help senior leaders to understand the role and responsibilities of a Director more fully;
2. The formation of a 'Shadow Board', which sees the participant group hold simulated Board meetings within their own organisation, which will deal with live Board agenda items and will help participants transform their thinking from operational to strategic, as well as helping participants become accustomed to everyday issues and challenges that a real Board faces.

NHS Leadership Academy Development Programmes are advertised on their website or will be circulated out to the senior leaders groups as they are received. Senior leaders are encouraged to have a talent conversation with their line manager to choose the most appropriate programme for their personal development.

Senior Leader Master's Degree is a fully funded apprenticeship programme**.** Read more information about the standard here.

4.3 Individual and team learning

Coaching and mentoring are processes that enable both the individual and teams to achieve their full potential.

Coaching is "a process that enables learning and development to occur and thus performance to improve.

Mentoring is "off-line help by one person to another in making significant transitions in knowledge, work or thinking"

Team coaching is "an individual and team development process that uses an integrated combination of interventions to improve collaborative leadership skills, and team performance."
Action learning is an approach to solving real-life problems that involves taking action and reflecting upon the results. This helps improve the problem-solving process as well as simplify the solutions developed by the team.

Attending Committee or Board meetings is a powerful learning tool for individuals who would not normally have access to Board or Sub Board level meetings. Individuals would normally be accompanied by committee member and time agreed and allocated pre- and post- the meeting to discuss and reflect on any learning.

Shadow an Executive is a great opportunity for an aspirational Director and an opportunity to form part of the succession planning and talent management process.

15. Succession Planning

Throughout the programme, Senior Leaders are asked to hold talent conversations with their coach and/or mentor and respective line manager to set out a career development plan and produce a succession plan

for their role, to identify any key risks and put in place talent management processes, and contingency plans.

16. Ongoing support and guidance

Throughout the senior leaders programme, leaders can seek support from the following:

- Personal coach
- Personal mentor
- Line Manager
- Head of Education & Training
- HR Managers

17. For all enquiries and bookings

Contact the Training Department: soh-tr.leadership@nhs.net

18. Senior Leaders Development Opportunities 2018-2019

8.1 Master Classes Programme

Further dates will be added once the outcomes of the Well Led Development Review are defined in terms of leadership development

Date 2018-19	Time	Masterclass	Speaker/ Facilitator/Lead	Venue	Delegates	Strategic Objective (SO)	CQC Well Led Domain
3rd Oct	14:00-17:00	Effective use of the IPR to monitor Trust performance	Caroline Griffiths, NHSi Steve Christian, COO Anita Davenport, Performance Manager	Seminar Room, CEC	Board ADO/AMD/HoN	4	Measure-ment
7th Nov	14:00-17:00	External mortality review report with recommendations and action plan	Jugnu Mahajan, MD Chris Goddard, Consultant Tracy Sparks, Jean McLeod	Ruffwood Suite, ODGH	Board ADO/AMD/HoN	2 & 4	Process & Structure
5th Dec	10:30-16:30	• CQC overview and requirements aligned to NHSI well-led requirements. • Board consideration of the Well-Led gaps identified in the PIR assessment. • Overview and interrelationship to quality improvement considering the Trust's plans for embedding QI	Advancing Quality Alliance (AQuA) / MIAA	*Family Life Centre	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	All	All
2019 Q4	……	Well Led Development Review	Advancing Quality Alliance (AQuA) / MIAA	SDGH / ODGH	KEY STAKEHOLDERS	All	All
9th Jan	14:00-17:00	Objective setting/Strategic Planning/Board Assurance	Therese Patten, Director of Strategy Audley Charles, CoSec	Seminar Room, CEC	Board ADO/AMD/HoN	All	All
6th Feb	14:00-17:00	Review of the strategic plan and associated risk management processes (BAF)	Therese Patten, Director of Strategy Audley Charles, CoSec	Seminar Room, CEC	Board ADO/AMD/HoN	All	All
6th Mar	14:00-17:00	Well Led Development Review Report / Feedback (TBC)	AQuA	*Ruffwood Suite, ODGH or External venue	Board ADO/AMD/HoN	All	All
3rd Apr	14:00-17:00	Leadership Masterclass – topic tbc Open event / invitations to NW Trust and Local Authority Execs/Leaders	Professor Michael West Professor of Work and Organisational Psychology at Lancaster University Management School	*Ruffwood Suite, ODGH or External venue	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	5 & 6	Capability & Culture
1st May	14:00-17:00	"How increased ownership of inclusive leadership behaviours will reduce discrimination, unfairness, bullying and harassment, and how it's everyone's responsibility"	Tracie Joliff - Head of Inclusion and Systems Leadership (NHS Leadership Academy)	*Ruffwood Suite, ODGH or External venue	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	5 & 6	Capability & Culture

*** Venue to be confirmed**

8.2 Leadership Development Programmes

Type of programme	Details	Funding and dates
Quality Improvement Programmes Advancing Quality Alliance (AQuA)	Programmes • Improvement Practitioners • Medical Leaders in Practice • Improvement Leaders in Practice • Advanced Improvement Practitioners	• Relevant delegates will be approached by the Trust's QI Project Group • Funded by Trust AQuA membership
Senior Leadership Programmes NHS Leadership Academy Programmes	Programmes • Aspirant Directors • Nye Bevan • Ready Now • Health & Care Leaders Scheme • Clinical Executive Fast Track Scheme	• Dates are published on NHS Leadership Academy website • Applications direct to the Academy • Some programmes are funded by the Academy, alternatively discuss funding with your CBU Budget Lead
Senior Leader Master's Degree (Lvl7) University of Central Lancashire or JMU	A fully funded 18 month senior leaders apprenticeship programme at Master's Level.	• Funded by the Trust's Apprenticeship Levy • Contact the Trust's Apprenticeship Lead for dates - v.kearney1@nhs.net
Shadow Board Offer NHS Leadership Academy	As described above	• Funded through a Trust bid • Dates tbc • Delegates to be selected in conjunction with the Executive Team

8.3 Team Development

Team Opportunities	Details	Dates
Well Led Development Review Advancing Quality Alliance (AQuA)	The Trust will work with AQuA to undertake a Well Led Development Review. The outcomes will inform future development.	Tbc / early 2019
Team Profiling (CBU level) External provider tbc	As described above	tbc
Team Coaching (CBU Level) External provider tbc	As described above	tbc
Action Learning Sets External provider tbc	As described above	tbc

8.4 Individual Development

Individual Opportunity	Details	Dates
Individual coaching NHS Leadership Academy Coaching Network	Delegates to access via: NHS Leadership Academy Coaching & Mentoring Network	Coaching sessions are agreed independently with your coach
Mentoring NW Mentoring Scheme	Delegates to access via: NHS Leadership Academy Coaching & Mentoring Network	Mentoring sessions are agreed independently with your mentor
Wave® Personality Questionnaire Saville Assessment Tool	As described above	On request contact: soh-tr.leadership@nhs.net
360 degree appraisal NHS Healthcare Leadership Model	As described above	On request contact: soh-tr.leadership@nhs.net
Shadow an Exec	As described above	On request contact: soh-tr.leadership@nhs.net
Be a member of a sub-Board Committee	Sub Board Committees: • Quality & Safety • Workforce & Organisational Development • Audit • Finance, performance & Investment • Mortality Assurance & Clinical Improvement • Charitable Funds	Delegates to contact the Chair of the relevant Committee

19. Other development opportunities

More links, contacts and information to further external development opportunities for Board members:

Advancing Quality Alliance - www.aquanw.nhs.uk/events/

NHS Improvement - https://improvement.nhs.uk/events/

Aspiring Finance Leaders programme (provided in partnership with HFMA) - see: http://www.futurefocusedfinance.nhs.uk/great-place-work/FinanceLeaders

Good Governance Institute - www.good-governance.org.uk/events-page

Improvement Director Network - contact karla.parker@nhs.net to join the network.

Induction sessions for Executive and Non-Executive Directors (provided in partnership with NHS Providers) - see: http://nhsproviders.org/courses-events/courses/executive-director-induction

Advancing Quality Alliance - www.aquanw.nhs.uk/events/

NHS Improvement - https://improvement.nhs.uk/events/

NHS Providers - http://nhsproviders.org/courses-events

NHS Employers - https://www.nhsemployers.org/events

Health Education England - https://hee.nhs.uk/

King's Fund - https://www.kingsfund.org.uk/events

Appendix D

AQuA
Advancing Quality Alliance

NHS
Mersey Internal Audit Agency

3. Approach

Recognising the challenge each of the requirements outlined in section 2 above places on the Trust, it is proposed that the sequencing of developments is as follows:-

Stages	Proposed Approach	Action / Timescales
1. CQC Assessment	The Trust anticipates an assessment in March 2019. Up to 6 months prior to that assessment the Trust will receive the Provider Information Request (PIR) which incorporates questions regarding 'Well-Led'. CQC issue this to providers and require responses within 3 weeks. Whilst recognising that these documents can change, it is not usually material. It is recommended that the Trust complete this document in September 2018. This will then identify any gaps or weaknesses, providing opportunity to improve the Trust's position prior to the final submission. https://www.cqc.org.uk/guidance-providers/nhs-trusts/provider-information-request-pir-nhs-trusts	**Trust completion of PIR** **September to October 2018**
2. Board Development Session	It is understood that the Board is newly formed. To support this, a Board Development Programme is being prepared by the Trust. As part of the programme of Board Development, it is proposed that the December session focuses on:- – CQC overview and requirements aligned to NHSI well-led requirements. – Board consideration of the Well-Led gaps identified in the PIR assessment. – Overview and interrelationship to quality improvement considering the Trust's plans for embedding QI.	**AQuA and MIAA to lead a session** **5th December 2018**
3. Well-Led Developmental Review	It is proposed that the scope of the review is structured around the eight key lines of enquiry (KLOEs set out below in Figure 4.1). This will ensure that under the "comply and explain" principles the trust will not have to explain any departure from the guidance. The team would utilise the PIR evidence to inform the scoping of a review (Stage 1 above). The Trust would provide supplementary evidence documentation. Refer to the process summarised in the tables below:- Table 4.2 Review Steps Table 4.3 Methodology This would incorporate a review into the Trust's Accountability Framework. This will provide opportunity for Board Member interviews as part of their preparation for the CQC assessment. The review output will provide the Trust with a clear focus for developments that can be incorporated into their wider plans.	**AQuA / MIAA conduct a Well-Led Developmental Review** **January to February 2019**

Stages	Proposed Approach	Action / Timescales
4. Quality Improvement **Key AQuA Contacts:** **Lesley Massey, Director** **Emma Walker, Associate Director**	The Trust is in the process of developing their quality improvement strategy and approach. It is anticipated that the priorities will include:- • Frail Older People • Orthopaedics. • Mortality The Trust is planning a two year quality improvement programme. The Trust need to identify the leads and teams that are delivering on each of these programmes. Following finalisation of the priorities and identification of the teams, a programme can be agreed with AQuA to address the quality improvement priorities in terms of embedding improvement methodology into the Trust's approach.	**Trust to provide AQuA with an Executive Lead Contact.** **AQuA/Trust agree a strategy for implementing QI aligned to Quality initiatives** **September / October 2018**
	As the Trust develops its Quality Strategy, AQuA could provide peer review support and assessment regarding best practice.	**Timing TBC**
	Following the CQC assessment and the board being more embedded within the Trust. Consider the timing and appropriateness for adopting a full system for improvement	**Timing TBC**

Appendix E

Southport & Ormskirk NHS Trust – Quality Improvement Training Plan 2018 - 2020						
	2018-2019		2019-2020			
	Quarter 3	Quarter 4	Quarter1	Quarter 2	Quarter 3	Quarter 4
QI Project Group PMO / Training / Comms / Strategy	**Sept** Head of PMO joins the Trust **Oct/Nov** Head of PMO to establish QI Project Group **Oct-Dec** Identify appropriate staff and quality improvement projects linked to business need **Dec-Jan** Development of communication materials aligned to Board/Senior Leaders outcomes **Jan 2019** Quality Summit		**QI Project Group** ▪ Ongoing monitoring of QI projects ▪ Internal support for programme delegates ▪ Reports to Hospital Management Board			
TARGET AUDIENCE	**Quarter 3**	**Quarter 4**	**Quarter1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Board / Senior Leaders	**5th Dec Well Led** AQuA / MIAA launch Well Led Development Review	**Jan-Feb** Quality Summit	**Well Led** 6th March – Well Led Outcomes Report	**Well Led** Board development based on outcomes	**Well Led** Board development based on outcomes	**Well Led** Board development based on outcomes
Advanced improver	**Advanced Improvement Practitioner** 10 day programme / dates tbc / S&O offered places externally (places available in 2019) *Development of a Trust Quality Improvement Faculty*					
Practitioner	**Medical Leaders in Practice** 4 day programme /dates tbc / S&O offered places externally **Improvement Leaders in Practice – Associates** Dates tbc / S&O offered places externally					
Champion	**Improvement Practitioner (dates to be confirmed)** 1 x 4 day programme / dates tbc / S&O offered places externally 1 x 4 day programme / dates tbc / possible in-house delivery					
Foundation Shared learning basis for future sustainability		**Introduction to improvement programme (Feb/Mar)** 25 delegates / onsite / 3 day programme	**Introduction to improvement (dates tbc)** 25 delegates / onsite / 3 day programme		**Introduction to improvement (dates tbc)** 25 delegates / onsite / 3 day programme	
All staff		**E-learning modules available to all staff following Quality Summit launch** 1) Quality improvement, 2) human factors, 3) shared decision making				

Board & Senior Leaders Development on a page

- ✓ To develop a transparent and compassionate leadership team which will create an inclusive culture where staff feel free to speak up
- ✓ To support the Board to set the strategic direction of the organisation underpinned and monitored by robust governance, structures and processes
- ✓ To work effectively as a high performing team who role model exemplary behaviours

AQuA Well Led Development Review

Strategy & Planning

Capability & Culture

Process & Structures

Measurement

Board Development

Self Assessment

Skills Audit

Workshops & Key Note Speakers

Collaborative learning

Senior Leaders Development

Talent Management & Succession Planning

Coaching & mentoring

Workshops & Key Note Speakers

Qualifications

Bespoke learning

AQuA Quality Improvement Training & Methodology

Quality Improvement Faculty

QI training for all staff

Higher levels of QI training key clinical projects

Date 2018-19	Time	Masterclass	Speaker/ Facilitator/Lead	Venue	Delegates	Strategic Objective (SO)	CQC Well Led Domain
3rd Oct	14:00-17:00	Effective use of the IPR to monitor Trust performance	Caroline Griffiths, NHSi Steve Christian, COO Anita Davenport, Performance Manager	Seminar Room, CEC	Board ADO/AMD/HoN	4	Measure-ment
7th Nov	14:00-17:00	External mortality review report with recommendations and action plan	Jugnu Mahajan, MD Chris Goddard, Consultant Tracy Sparks, Jean McLeod	Ruffwood Suite, ODGH	Board ADO/AMD/HoN	2 & 4	Process & Structure
5th Dec	10:30-16:30	• CQC overview and requirements aligned to NHSI well-led requirements. • Board consideration of the Well-Led gaps identified in the PIR assessment. • Overview and interrelationship to quality improvement considering the Trust's plans for embedding QI	Advancing Quality Alliance (AQuA) / MIAA	*Family Life Centre	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	All	All
2019 Q4	……	Well Led Development Review	Advancing Quality Alliance (AQuA) / MIAA	SDGH / ODGH	KEY STAKEHOLDERS	All	All
9th Jan	14:00-17:00	Objective setting/Strategic Planning/Board Assurance	Therese Patten, Director of Strategy Audley Charles, CoSec	Seminar Room, CEC	Board ADO/AMD/HoN	All	All
6th Feb	14:00-17:00	Review of the strategic plan and associated risk management processes (BAF)	Therese Patten, Director of Strategy Audley Charles, CoSec	Seminar Room, CEC	Board ADO/AMD/HoN	All	All
6th Mar	14:00-17:00	Well Led Development Review Report / Feedback (TBC)	AQuA	*Ruffwood Suite, ODGH or External venue	Board ADO/AMD/HoN	All	All
3rd Apr	14:00-17:00	Leadership Masterclass – topic tbc Open event / invitations to NW Trust and Local Authority Execs/Leaders	Professor Michael West Professor of Work and Organisational Psychology at Lancaster University Management School	*Ruffwood Suite, ODGH or External venue	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	5 & 6	Capability & Culture
1st May	14:00-17:00	"How increased ownership of inclusive leadership behaviours will reduce discrimination, unfairness, bullying and harassment, and how it's everyone's responsibility"	Tracie Joliff - Head of Inclusion and Systems Leadership (NHS Leadership Academy)	*Ruffwood Suite, ODGH or External venue	Board ADO/AMD/HoN DM/CD/Matron Corporate Deputies	5 & 6	Capability & Culture

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 November 2018

Agenda Item	**TB270/18a**	**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 petty cash spending limits.

Furthermore, to ensure that the petty cash is used appropriately the following actions have been taken:

- new temporary operating guidance (in line with the discretionary spend policy) has been introduced;
- new form for sign off has been introduced; and
- the Director of Finance has been asked to draft a new petty cash policy by end of November 2018.

The purpose of these measures is:

- to ensure scrutiny over petty cash spend;
- to provide clarity around what is regarded as appropriate spend; and
- to bring the petty cash spend in line with the discretionary spend policy introduced in September 2018.

This change in this governance arrangement needs to be reflected in a change to 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 Trust's balance sheet and of the Trust's 18/19 Statutory Instruments, namely of the Scheme of Reservation and Delegation concluded that the Petty Cash Disbursements 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:

14. Petty cash disbursements (through central cashier office at each site) Expenditure up to £50	**14. Petty cash disbursements (through central cashier office at each site)** Expenditure up to £10	Budget manager or delegated budget manager with the additional signature from the turnaround director or senior member of the finance team

NHS
Health Education England

2018 Education & Training Self-Assessment Report (SAR)

Reporting Period: 1 August 2017 to 31 July 2018

Deadline for submission to HEE: 31 October 2018

Trust's name:	**Southport and Ormskirk Hospital NHS Trust**
Value of contract / funding with HEE:	1. Total initial 18/19 LDA value *(including undergraduate)*: £5,589,875.56 2. Total for salaries for doctors in training in 18/19: £2,338,966 3. Total estimated Medical placement tariff in 18/19: £1,434,258 4. Total estimated Non-medical placement tariff in 18/19: £396,791.07
Trust Chief Executive's name:	**Mr Silas Nicholls**
Director(s) of Education's name: **(or equivalent, please state job title):**	**Mrs Tracy Gunn** Head of Education & Training **Mr Sanjeev Sharma** Director of Medical Education
Name of Board Level Exec/Non-exec Director responsible for Education and Training strategy within your organisation:	**Mrs Jane Royds** Associate Director of Human Resources
Report compiled by (responsible for completion of):	**Miss Dawn Aspinall** Medical Education Manager **Mrs Tracy Gunn** Head of Education & Training
Report signed off by:	**Dr Jugnu Mahajan, Medical Director**
Date signed off:	**31 October 2018**
Board Approval: **1. Approved by / on behalf of the Trust Board: (date / details)** **2. Date seen at or scheduled for Board meeting**	**Non-Executive Directors of Workforce Committee with the support of the CEO and Director of Human Resources-31 October 2018** **Scheduled for Board Meeting 7 November 2018**

Contents

Health Education England

Section 1: Organisation overview linked to the HEE Quality Framework

1.1. Statement of how the HEE Quality Domains are being met organisationally

This SAR is aligned to the HEE Quality Framework: https://hee.nhs.uk/our-work/quality
For medical education the SAR is also aligned to the GMC Standards: http://www.gmc-uk.org/education/index.asp

Trust's response (max of 500 words)

The Trust has an overarching Integrated Governance Framework. Education is governed through this structure to ensure that the Trust is meeting the HEE Quality Domains via a Medical Education Committee and a (Non-Medical) Clinical Education Committee. Both committees report to the Workforce Committee, which in turn, provides assurance or escalates to the Board.

The Trust has fast track processes for issues relating to medical education through the work of the Guardian of Safe Working who presents a monthly exception report to the Board and the Director of Medical Education who has a two monthly presence at Board.

The Trust has dedicated teams to support our learners – the Medical Education Team, the Clinical Education Team and Practice Education Facilitator Team. These teams work collaboratively to provide a consistent approach to medical and clinical training delivery i.e. a multi-disciplinary approach to the delivery of Acute Illness Management Training, simulation training, clinical skills training, and a weekly Grand Round for all staff.

The Trust has a team of Practice Education Facilitators who provide an annual placement quality report and self-assessment to HENW to monitor the quality of placements for non-medical students and support for mentors. The wider Clinical Education team includes a Community Engagement Manager; this team delivers educational provision and support to students, Preceptees, Nursing Associates, clinical staff and Health Care Support Workers.

Further investment has been secured to ensure that the medical education team structure is fit for purpose to provide the pastoral care and support trainees require. Both clinical and educational supervisors have their educational role recognised within their job plans; two new Clinical Tutor roles have been created – an Undergraduate Lead and a Postgraduate Clinical Tutor for Educators – increasing the annual educator development programme; and the creation of 3 x Clinical Education Leads (Band 7) to focus on the delivery of the HEE Quality Framework and GMC Standards.

The Trust provides two Education Centres and Libraries based at both sites to ensure our learners have access to the relevant resources, IT facilities and support they require to improve their learner experience. Investment has been secured to upgrade our simulation mannequin and improve our learning environment at the centres. Our new Clinical Education leads, in conjunction with the Clinical Education Team, are currently reviewing where quality improvements can be made.

1.2. Top three successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period.

Description of success	Domain(s)	Standard(s)
1. The development and employment of new roles and skills mix to support a future sustainable workforce i.e. physician associates (students and employees), nursing associates and assistant practitioners supported by clinical educators and mentors within the organisation	Developing a sustainable workforce	6.2, 6.3,
2. The comprehensive review of the role and value of medical educators for our learners including 100% achievement of accredited trainers on the trainer database, recognition of the role in job planning, a programme of development opportunities throughout the year, recruitment of a Postgraduate Clinical Tutor for educators and 3 x clinical education leads to support educators and learners together	Supporting and empowering educators	4.1, 4.2, 4.3, 4.4
3. All learners within the organisation receive an appropriate induction and assigned a mentor or educational supervisor who is trained to provide support and pastoral care.	Supporting and empowering learners	3.1, 3.2, 3.3, 3.4

1.3. Top three challenges or prominent issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
1. Educational governance needs further scrutiny to ensure its effectiveness to deliver the standards of the HEE Quality Framework	Educational governance and leadership	2.1, 2.2, 2.3,
2. Rota gaps and staffing levels affect the quality and experience of both student and postgrad medical / clinical placements	Learning environment and culture	1.1
3. Transparency of funding to support quality improvements in education	Learning environment and culture	1.1, 1.4,1.5, 1.6

1.4. Strategic Workforce Plan

Does your organisation have a strategic workforce plan (delete as appropriate)?

Yes	

Health Education England

Who within your organisation is responsible?

Name and job title	Alison Mercer, Senior Assistant Director of Finance

Section 2: Exception Reporting against HEE Quality Domains

2.1. Multi-professional

2.1.1. Organisation overview linked to the HEE Quality Domains

Please report, by exception, where your organisation does not meet the HEE Quality Framework within the reporting period for the groups listed in the guidance notes. In addition, please provide an overall narrative along with some organisational / departmental / unit examples which support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

The Practice Education Facilitators (PEF), Southport and Ormskirk NHS Trust, will report on the core outcomes that are structured to reflect NHS Education Outcomes Framework Domains:

1. Excellent Education – placement quality and safety, Learner experience and joint action planning with Educational Institutions.

2. Competent and capable staff – Multi-professional mentorship/placement capability, curriculum development and delivery

3. Adaptable and Flexible workforce – Structure and co-ordination of inter-professional learning

4. NHS Values and Behaviours – Quality of Education, quality of care

5. Widening Participation – Identified educational resources accessible to learners of placement

   Any concerns/issues routinely discussed initially during the monthly PEF pre-meet then fed through the monthly PEF meetings (with line manager) and escalated to the Non-Medical Clinical Education Committee meetings, Nursing and Midwifery Board then the Workforce Committee.

HEE Domain 1 Learning Environment and Culture
For additional guidance refer to HEE Quality Framework, page 10

HEE priority for 2018 reporting in this domain is:

- *A focus on workplace behaviours and strategies for resolution of issues of concern*

As a Trust all clinical areas have the Placement Charter. There is a clear process for raising concerns, which is on the wards in the form of a flowchart. Any concerns around placements and students are documented, shared within the team and escalated to the line manager and/or the University and then if necessary put on the risk register. Concerns are also reported quarterly on the QSG template.

Working in partnership with the on-line PARE and INplace teams to encourage participation from the learners and mentors alike. To optimise placement quality, learners are also encouraged to complete PARE evaluations during Trust Induction with the Practice Education Facilitator (PEF) team. Feedback is discussed at the Non-Medical Education Committee (NMEC) to ensure transparency and quality within the learning environments. The Trust has the highest feedback completion rate with the region.

HEE Domain 2 Educational Governance and Leadership
For additional guidance see HEE Quality Framework, page 11 -12

HEE is keen to understand new models of learning in practice and the impact this is having on your organisation. Please include within your response:

- *Have you increased capacity for learners in your organisation?*
- *Have you increased your numbers of supervisors/mentors?*

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE.*
- *Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

The PEF's in collaboration with University College of Central Lancashire (UCLAN) deliver four cohorts for non-credit bearing Mentorship programmes successfully increasing our mentor numbers by 51. We run Supporting Learners in Practice multi-professional workshops four times a year. To maintain sign off capacity we held six educator/mentor sign-off workshops this year in addition to bespoke sessions.
The above has allowed us to significantly increase our pre-registration nursing cohorts following collaboration with our North-West HEI partners. The on-going Trust developments have led to positive changes such as a brand new Outpatients placement area has been created thus increasing capacity.
During this period all of our placements bar one had 4 star ratings on the on-line PARE.

We continue to support Pharmacy and Mental health students in their request to get some nurse based experience. This is aimed at promoting Inter-professional Learning at clinical area/ward level.
All Multi-professional placements audits were in date.

As PEFs we continually strive to include learners on Trust training e.g. Acute Illness Management (AIM). We regularly complete IPL sessions.

The Corporate Lead for clinical education, community engagement lead, PEFs, and clinical education team have collaboratively been working in partnership with local colleges such as Southport College developing bespoke programmes i.e. ACORN Cadet BTEC in Health and Social Care Award. The students study for 2 years and the Trust provides placements in a variety

of areas covering multi-professions.
This is a very popular programme with the college being oversubscribed with applications. We have had requests to replicate this with other local FEs and will be discussing this prior to September 2019 intake. We believe that this is just one of the ways to engage with our local schools and colleges offering young people the chance to work with us and develop our future workforce.
The ACORN Cadet programme began in 2016 with 20 students a further 20 recruited in 2017 and 17 second years, 2018 a further 22 recruited with 19 second years

Our ACORN students have been successful in joining our NHSP Nursing bank, acceptance of pre-registration Nursing programmes, midwifery and paediatrics and other AHP professions

Nursing associates The organisation was part of the 2nd wave fast follower pilot for the Trainee Nursing Associate (TNAs) in Mersey and Cheshire. This is a work based learning programme and we have been encouraged and developed opportunities to develop our local workforce. We have TNAs on this programme qualifying in March 2019 and have subsequent applicants ready for the next cohort in spring 2019. Southport and Ormskirk have also joined the Lancashire and Cumbria partnership with 6 TNAs joining programmes in June 2018 a further programmed planned for spring 2019

Assistant Practitioners
June 2018 - 3 x TAPs in AED and urgent care settings qualify
Jan 2018 - 12 x Trainee Assistant Practitioners in a variety of clinical settings ward based and specialist areas such as theatre

HEE Domain 3 Supporting and Empowering Learners
For additional guidance refer to HEE Quality Framework, page 13-14

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Root Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

The current process is that any Datix involving a student is flagged to the PEFs however issues arise if the term student/learner has not been used.
ACTION: Develop an improved process of how issues are followed up and how students/learners are supported and lessons learn. To develop flowchart in collaboration with Risk.
We have had 26 Datix involving students.
ACTION: To theme incidents and report to Non-Medical Education Committee meeting every 6 months.
Concerns are also reported quarterly via the QSG template.

HEE Domain 4 Supporting and Empowering Educators
For additional guidance refer to HEE Quality Framework, page 15

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

Multi-disciplinary Supporting Learners in Practice workshops held in house. Credit bearing and non-credit bearing Mentorship modules offered. Relevant training courses available to non-medical staff. Regular mentor updates and mentor/educator sign-off workshops are facilitated and hosted by the PEFs. Mentors attend updates for other programmes e.g. Radiology on a two yearly basis held at the University where curriculum is discussed. Physiotherapy updates hosted in-house but delivered by HEI or mentors can attend at the Higher Education Institutes (HEI). HEI links attend and support Trust mentor updates which allows for peer review.

PEF's delivered training on on-line PARE and supported new mentors with documentation.
Attendance at the curriculum standards meetings by the PEFs.
Staff are invited to HEIs to participate in the interview and selection programme of potential learners/students.
In discussion with Electronic Staff Record (ESR) for students to be on E-roster to ensure students/learners on shift with suitably prepared mentors and give an auditable process to check sign off students working allocated time with mentor.
ACTION: To ensure student added to ESR and processes in place for audit purposes.
ACTION: Create an auditable process for mentor criteria to ensure demands and needs of Trust are met.

HEE Domain 5 Delivering Curricula and Assessments
For additional guidance refer to HEE Quality Framework, page 16

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

PEFs work in collaboration with North West HEIs to ensure standardised achievable outcomes for learners across the Networks. Placement profiles are visible to all relevant learners on the Online PARE.
Aware of issues around movement of mentors during winter pressures. PEFs acknowledge this and aware of the need for the team to offer clinical support when staffing has been an issue which can take pressure off mentors.
ACTION: Ensure flowchart available of what happens to student/learner in event of mentor being moved.
Students and mentors are encouraged to fill in a Datix if their supernumerary status isn't being upheld- issues identified have been and continue to be escalated to PEFs' line manager.
Discussions and visit been done around the implementation of CLIP/Synergy.
ACTION: Moving forward with implementation of either CLIP or Synergy this year.

HEE Domain 6 Developing a Sustainable Workforce
For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*
- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

PEFs work closely with HEIs to keep learners in placement where appropriate.
Non-Medical Education Committee escalates to Workforce Committee via an AAA report - Alert, Advise and Assure.

The Corporate Lead for Clinical Education, PEFs and workforce development lead are developing a pre-preceptorship programme which will see our final placement students receive a period of engagement with the organisation such as brew and reviews and access to practice clinical sessions to support the transition into professional life and get them ready for their 12 month preceptorship in the Trust. This is part of the recruit and retain grow our own strategy currently in place in the organisation.

There are preceptorship development groups for the Nursing associates currently being developed in the Mersey and Cheshire and Lancashire and Cumbria partnerships

PEFs are responsible for UCLan's placement journey to ensure all outcomes are covered which

allows for close working links to the Private and Independent Sector and other Trusts. Through collaboration with Cheshire and Mersey, PEFs other HEIs have adapted their curriculum to ensure students/learners are guaranteed a hospital placement within their 1st year of training.
Through listening to the students and discussions with the Clinical Education Team we are currently developing a pre-preceptee programme to ensure sign-off pre-registration students all have certain skills to prepare them for their transition to a qualified member of staff.

ACTION: To ensure training is set up for next cohort of pre-registration sign off students.

2.1.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include Trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2).

Description of good practice and profession(s) it relates to (and a named contact for further information)	Description of why this is considered to be good practice	HEE Domain(s)	HEE Standard(s)
PEF Team signed up to and have been actively involved in the development of a standardised regional/national ESR Educator register- this went live early Oct-18	Increases mentor compliance and provides a smoother transition when educators/mentors move from one area to another.	2 4	2.2 4.1 4.2
Pharmacy Students trial now part of pathway to ensure ward based training.	Ensures cross professional learning.	1 3 6	1.6 3.5 6.2
Opened more capacity for mental health students to get ward based experience.	Led to discussion of new role on ward for mental health nurses.	1 3	1.6 3.5
Alison Gaskell - extended role as PEF co-chair CMPEF network.	Collaboration at regional level thus enhancing the quality of education and training.	2	2.1 2.2

2.1.3. Challenges or important issues that HEE should be aware of.

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the profession / professions)	HEE Domain(s)	HEE Standard(s)
Implementation of new NMC standards with respect to supporting learners and staff in practice.	2 4	2.1 2.2 4.1 4.2 4.3 4.4
Supporting learners and staff with the possible implementation of	5	5.1

standardised documentation (PAN London Document)		5.2
Difficulties around the effectiveness of IN place and allocations.	1	1.1 1.2 1.5 1.6
Coaching training for PEF's to assist with implementation and update of the new standards.	4 3	4.1 4.2 4.4 3.1

2.2. Postgraduate Medical

2.2.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for postgraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC theme 1 Learning Environment and Culture
For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:
A focus on workplace behaviours and strategies for resolution of issues of concern

Workforce & Organisational Development Strategy
The Workforce Committee signed off the Trust's Workforce & Organisational Development Strategy and supporting action plan (Sept 2018). The plan includes three strategic pillars: 1) to create a healthy culture, 2) to build a responsive workforce and 3) to develop a skilled workforce. The plan describes the objectives to create 'the way we do things around here'.
Below is a sample of some of the objectives from the plan:

- To create a compassionate and inclusive leadership culture at all levels
- To develop an open and honest culture where staff are confident to speak up freely and are supported
- To recognise the value of our staff and learners
- To improve staff health and wellbeing so that staff are happy, healthy and here
- To develop a quality improvement culture across the organisation so that staff are skilled and confident to make improvements in the workplace for our patients
- To create a learning environment where we have a supportive and flexible approach to role design and career pathways to develop and retain our learners

The strategy & plan are monitored by the Workforce Committee on a monthly basis which reports to monthly Board. The strategy aims to embed the right culture for staff through our behaviours and values and includes a focus on the value and recognition of the contribution of our learners i.e. Time to Shine Awards – Student of the Year, Apprentice of the Year, Clinical Mentor of the Year.
The plan includes a medical engagement programme which includes regular meetings for our CEO and Medical Director with our SAS and Consultant workforce to ensure the clinical voice is hear in our Trust decision making process.

Freedom to Speak Up
The Board is committed to bringing about a culture of openness and transparency. The Trust has appointed a Freedom to Speak Up (FTSU) Guardian and his visibility is an important step towards achieving this end. There is an overarching FTSU action plan which is led by the Director of Nursing and monitored at Workforce Committee. THE FTSU Guardian has recruited FTSU champions from a cross sector of the organisation to encourage an open culture.
The FTSU Guardian has attended the Trainee Doctors Forum to discuss whistleblowing directly with trainee representatives and he is scheduled on all induction programmes for medics and non-medical staff.

GMC theme 2 Educational Governance and Leadership
For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE.*
- *Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

The Head of Education & Training meets with the Trust Account Manager once a month to discuss the non-pay budget. The pay budget for the medical education team is managed by St Helens & Knowsley The annual Undergraduate & Postgraduate budgets are set based on the out

turn of the previous financial year. Any requirement for further funding is managed through capital bids and business cases.

Incident Reporting & Confidentiality
The Risk Department continues to deliver a broad and robust range of training to all trainees – from undergrad to postgrad – through induction programmes, core programmes of teaching, and also through ongoing liaison and discussion which takes place via the conduit of the Trainee Doctors Forum.
Training content remains subject to ongoing review based on user feedback and also through interaction with the education department, the Guardian of Safe Working and the Mortality Operational Group.
The Trust supports and promotes an open and blame free-culture and will continue to communicate this to all our colleagues. Furthermore this specific issue has been raised for discussion in the weekly Medical Directors forum and the monthly meeting of the CDs and AMDs - it has been emphasised to all colleagues that the Trust encourages raising of concerns by all the staff members and that those who report incidents must be supported by the Trust protection promise.
Monthly reports produced by Risk in relation to Never Events, SUI's etc. are provided to the Medical Education Department for review by the DoME and Medical Education Manager. Where identified as necessary, further supportive interventions are instigated from this level.
Data collated from these reports is also triangulated with other key factors to aid and support early identification of DiD's for instigation of structure support mechanisms.

GMC theme 3 Supporting Learners
For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Root Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

As referenced in GMC Theme 2, above, the Trust has a 'Doctors in Difficulty' process which is aligned to the HEE Policy and managed by the Director of Medical Education (DoME), in liaison with the Medical Education Manager and Guardian of Safe Working, where appropriate. The DoME retains overall responsibility for the management of Level 2 or 3 concerns.

GMC theme 4 Supporting Educators
For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

The Trust has a dedicated central Postgraduate Medical Education Team and Medical Staffing Team which manage and monitor trainee doctors training placements. Day to day rota management is managed by Clinical Business Unit Rota Coordinators. The Trust has a newly appointed Head of Resourcing for medical staffing to resolve rota gaps and staffing issues.

An organisational restructure of the Medical Education Team (early 2018) saw further investment in PA's and the creation of a new post for Doctors to support the delivery of medical education

- 3 x PA's for the Director of Medical Education
- 1 x PA for a new Postgraduate Clinical Tutor with responsibility for educator development
- The appointment of 3 x Clinical Education Leads (CEL) to lead on quality, innovation, development and implementation of medical education projects across the Trust to achieve consistency, effectiveness and excellence in all specialty areas (aligned to Undergrad, Foundation, Postgrad).

- The medical education coordinators who support each element of medical education are aligned to the CEL's and in turn also aligned to CBU areas.

In early 2018, it was agreed that as part of the job planning process, all Educational and Clinical Supervisors would be recognised through SPA allocation for their role to deliver educational support.

There is a robust programme of Educator Development delivered by the Trust, including AoME accredited courses to support our clinical educators. Following a training needs analysis, this programme has been expanded to include additional training opportunities including Curriculum Mapping, Essentials of Teaching, Giving & Receiving Feedback, Coaching/Mentoring and Careers Lead/IAG training.

These measures ensure recognition, support, training and consistency with a clearly defined structure and strategic approach to meeting the requirements of the HEE Quality Domains.

GMC theme 5 Developing and implementing curricula and assessments
For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

To mitigate winter pressures adversely impacting on the Trusts' ability to deliver training effectively, the following measures form part of an action plan managed by the Medical Education Team.

- The Clinical Education Leads (CEL) are leading on a collaborative project to develop Learning Maps aligned to all curriculum training programmes with the aim of creating a shared online resource, accessible to trainees and students 24/7.
- The aim is to have all training available online for when a student/trainee is unable to attend training due to winter pressures, staffing levels etc., they will be able to access the online resources at any time so that they don't miss the relevant training.
- Students/trainees who are unable to physically attend the formal teaching sessions will be required (compulsory) to access the teaching materials and complete an assessment for submission – thereby evidencing they've accessed, and benefited from, the learning materials.
- As this measure requires extra work and time commitment on the part of the student/trainee, over time our expectation is they will feel more empowered to insist upon physical access to their scheduled teaching time and the specialty areas will be compelled to address the root of the service constraints more urgently and persistently.
- Issues of rota gaps in our "at risk" areas are currently being addressed with some urgency; additional SAS doctors and Consultants have been recruited and business cases have been approved for further recruitment e.g. 6 x Senior Clinical Fellows in Medicine. The Trust is also maximising opportunities for expansion of recruitment to other roles, e.g. Physician Associates to further bridge the gaps.
- The Trust will be utilising Skype for Business – implementation in the very near future – which will also support more effective delivery, and therefore access to, education opportunities for trainees across the two Trust sites.
- The Medical Education team is finalising bids for additional resource materials which will support innovative ways of working across sites, enabling more interactive training and effective gathering of qualitative data/feedback.

HEE Theme 6 Developing a sustainable workforce
For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*

- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

The Trust is implementing a robust Workforce Plan which will address existing workforce gaps.

The Trust recognises that workforce issues have impacted adversely upon delivery of training in placement areas and have therefore made at risk areas a priority.
The Trust Job Planning policy will further underpin and support our training workforce with formal recognition and support for their educational remit
The recruitment of 3 x Clinical Education Leads in the core Medical Education Team, each with their respective portfolio areas (Undergraduate Medical Education, Foundation Programme and Postgraduate Medical Education) are facilitating increased engagement with the Clinical workforce, supporting development and implementation of robust and consistent frameworks for education, whilst also developing innovative ways to address ongoing problems of access to training etc.
The Trust has recruited a new role in the form of a Head of Resourcing (medical staff) with the responsibility to improve rota management, access to quality locums, reduce the number of staffing level issues. This post has only been active for 3 months so it is too early to identify the benefits.

2.2.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include Trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Recruitment of 3 x Clinical Education Leads aligned to designated CBU Portfolio areas	This allows thorough scoping Trust-wide to establish gaps and identify areas of best practice. Developing robust and innovative approaches to resolve historic ongoing issues of access to teaching, consistency in delivery and the negative impact on the trainee experience.	1; 3; 4; 5	1.2 to 1.6 3.1-3.5 4.1-4.4 5.1-5.3

2.2.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Rota gaps remain an issue for learners to access training. The Trust is taking steps to reduce the problem with the recruitment of critical staff in key areas through its workforce planning –	3, 4 & 6	

consultants, SAS Doctors and Physician Associates. The Trust is also looking to introduce Advanced Care Practitioners.		

2.2.4. Medical faculty roles, organisation and accountability

If there have been any changes to your organisation's educational governance structures within the reporting period please detail this here, otherwise please state 'no changes'.
If there are any vacant roles, or risks to medical education please describe these here, including any plans to mitigate that risk.

No changes to the educational governance structure for Medical Education.

Educational governance arrangement will form part of an overall quality improvement programme for education 2019/2020.

Pending changes to the Medical Education Team include:

Director of Medical Education

- Current post holder continues in the role
- The recruitment of a new Director of Medical Education
- Interviews confirmed 9th November 2018

College Tutor for Clinical Skills & Simulation

- Current post holder continues in the role
- Interviews to be scheduled

Clinical Sub-Dean for Undergraduate Medical Education

- Current post holder continues in the role
- Interviews to be scheduled

2.2.5. Staff and Specialty Grade Doctors (SASG) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK http://www.nact.org.uk/documents/national-documents/.

Questions	Trust's answer
Number of SASG doctors within the Trust	**69**
Total SASG funding received	**£38321**
Is the SASG funding ring-fenced to support SASG doctors only? (Y/N)	**No - 0.6wte Band 4**
Please describe the process by which the development needs of SASG doctors within your organisation were individually and collectively identified. Using funding allocated for SASG development; How were priorities decided?	• Study leave applications • Identification of group development needs by SAS Lead
SASG nominated lead within the Trust	Dr Jo Anna Robson

Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)

	Spending	Detail
1. Individual doctor's development (i.e. details of spending used to support the development of	**£44,210**	Report available separately

individual doctors including an anonymised list of amounts and what it was used for)		
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered)	£12,000	• 6 full day courses x 20 delegates • 1 educational evening x 30 delegates **Topics:** • AF Overview • GMC Social Media Boundaries • Serious Investigations/Never Events/Duty of Candour • Clinical Audit & Managing Change • Reflection & Job Planning • Handling Difficult Conversations • Improving Patient Experience/Clinical Excellence
3. Payment for SAS tutors/leads sessions	£9,198	1 PA
4. Administrative costs to support SAS tutors	tbc	0.4wte Band 4 allocated for SAS administrative support
5. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)		None available

2.3. Undergraduate Medical

2.3.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for undergraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC standard theme 1 – Learning Environment and Culture
▪ Students were provided with sufficient opportunities to meet learning outcomes ▪ Students received sufficient feedback to track and direct their learning ▪ Students were satisfied with the overall organisation of the placement ▪ Students were satisfied with the overall quality of the Stage ▪ Clinical teachers were punctual and reliable in their attendance. (Due regard will be given to mitigating circumstances of urgent clinical need) ▪ The overall quality of the teaching was of a consistently high standard

- Students benefit from a robust and varied timetable of education and training activities including supervised training in all specialty areas, scheduled specialty specific teaching and learning activity, CBL's – all appropriately linked to the curriculum.
- Students receive appropriate feedback to track and direct their learning which will be further enhanced 2018/2019 with the allocation of a named Educational Supervisor (ES) for the year in addition to named placement/specialty area ES for each rotation
- Students have a monthly dedicated monthly Student Forum for open and honest discussion of all issues impacting (either positively or negatively) upon their experience each month, at which a nominated Consultant Lead is present.
- Students have been satisfied – evidenced by periodic data gathered by the University and further supported during the Student Forum discussions - with the overall quality of this stage of their training and where negative feedback has been received a robust action plan has been developed to address those issues. Increasing numbers of CP4/5 students return to the Trust as FY1 doctors.
- Clinical teachers are generally reliable in attendance to teaching commitments and where urgent clinical need results in absence alternative teaching/training arrangements are made.
- Overall quality of teaching was consistently high.

The Medical Education team has been expanded to include 2 x Undergraduate Leads and a dedicated Undergraduate Clinical Educational Lead to support further development of the programme. This will serve to support expansion and variety of training opportunities and improve upon consistency, quality and effectiveness of all teaching and training.

GMC standard theme 2 – Educational Governance and Leadership

- Trust systems are in place to detect and investigate patient harm involving or as a result of student activity
- Trust systems are in place to ensure informed consent is taken in areas where patients may encounter students
- Clinicians / teachers are appraised against their teaching

- All students receive intensive training and support in relation to Trust systems for detection and investigation of patient harm. This is delivered at induction, further supported by reference materials and with clear guidelines on appropriate reporting and management of incidents involving students. The process itself is documented in handbooks (for ongoing reference) provided to each student and trainee at induction, and displayed throughout education centres on both sites.
- Consent training is provided to all students at their core induction upon commencement with the Trust.
- All clinical teachers receive an annual trainer appraisal which is structured and supported with evidence of their own related CPD and the teaching delivered in the reporting period.

GMC standard theme 3 – Supporting Learners

- Appropriate guidance and support was available outside of formal teaching
- Students were satisfied with the overall quality of the facilities for students.
- Teaching took place in appropriate settings and surroundings
- Good quality learning resources were available to support learning
- Access to IT facilities was adequate
- The programme of study outlined for the course was delivered

- Students have a dedicated Undergraduate Coordinator (first point of contact), Undergraduate Clinical Education Lead, Medical Education Manager, Clinical Sub-Dean and Undergraduate Year Lead, all of whom are available to provide guidance and support outside of formal teaching.
- Students have demonstrated that they are satisfied with the overall quality of facilities for students but have commented they would appreciate additional clinical skills drop-in facilities if the accommodation available were to allow for this. There is a plan in place to address this as part of an over-arching business case in 2018/19.
- Teaching takes place in dedicated clinical skills labs, training rooms and in the clinical setting where appropriate.
- Good quality learning resources are provided but the Trust medical education team continue to explore opportunities to expand and improve upon facilities and resource available therefore this will also be addressed in the aforementioned business case
- Students have access to drop in IT facilities at Libraries on both Trust sites and iPad/laptops are available for hire to support independent study
- The programme of study outlined for the course is delivered effectively

GMC standard theme 4 – Supporting Educators

- Clinicians / teachers have time in job plans for teaching including educational supervision.

- Specialty Leads and teachers involved in the delivery of the undergraduate medical student programme are recognised and supported by the Trust with a robust programme of educator development and recognition in job plans

GMC standard theme 5 – Developing and implementing curricula and assessments
▪ The Trust has processes to ensure those undertaking summative assessments are appropriately trained ▪ The Trust has a system in place to provide educational supervision ▪ The Trust has an executive or non-executive director at board level responsible for supporting training programmes
• The students are provided with additional training opportunities, drop-in sessions and revision sessions to support preparation for summative assessments • The Trust applies a consistent policy and process in the assignment of named Educational and Clinical Supervisors to all students • The Trust Medical Director is the board level responsible person for supporting medical education training programmes.

HEE Theme 6 Developing a sustainable workforce For additional guidance refer to HEE Quality Framework, page 17
Standard 6.1 The Trust has invested in a new Undergraduate Lead to support our Clinical Sub Dean to ensure that our medical education programme is fit for purpose; our medical students have the best experience and are appropriately supported. The Trust has also invested in a Undergraduate Clinical Education Lead dedicated to pastoral support, clinical skills and simulation training delivery, and supporting the Specialty Leads to deliver consistent and effective programmes. The Undergraduate Clinical Education Lead is visible in the clinical placements to provide regular support in the work environment, trouble shooting issues in real time, and following up where applicable. The Clinical Education Lead is responsible for identifying where the Trust has current gaps and for identifying innovative ways to fill the gap. Standard 6.2 All Educational Supervisors are being provided with the opportunity for additional professional development in the role of Careers Information, Advice and Guidance to support students and trainees in structured careers conversations. In addition, existing internal and external careers/ information events are offered and publicised to all students and trainees. 6.3 The Trust is streamlining its current provision of training to ensure that it is fit for purpose, curriculum mapped and quality assured to attract, recruit and retain our current and future undergraduate students. Additional opportunities are currently under development to enhance the training offer i.e. mentoring, coaching, reflection and leadership. The Trust has a view to increase the number of medical students in 2019/2020.

2.3.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include Trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)

2.3.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
The Medical Education Department recognises that we are currently limited in terms of the support we can provide to the wider cohorts of undergraduate students i.e. Physician Associates, largely due to capacity within the existing team.	3	

2.4. Academic Training

Please describe how your organisation supports academic learners, including Integrated Academic Training Programmes e.g. NIHR, clearly highlighting any challenges or good practice items.

Trust's response

We support Academic Clinical Fellows as part of their training. Currently we have an ST2 trainee in Obstetrics & Gynaecology who does one week out of four in research at Liverpool Women's Hospital.

We have supported this by altering timetables to ensure research components can be met effectively.

Section 3: Reference List of Supporting Information

Organisational policies and processes in support of delivery of the HEE Quality Framework

This section will need completing once, in subsequent annual returns only changes and updates will need to be highlighted.
Please list key policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required.
Please advise which domains and standards are being supported the policy.
Please note, we do not require copies of documents. Please do not embed documents or insert links. If required the quality team will request a copy by exception.
Please advise if you have made a reference to a policy/process in other section(s) of the SAR.

Description of supporting information	HEE/GMC Domain(s)	HEE/GMC Standard(s)	Please advise if document referenced in the SAR e.g. *SAR, section 1.4 and 2.1.1*
Doctors in Difficulty Process	3 & 4	3.1	2.2.1
Supervision of Doctors in Training	3 & 4	3.2; 3.3; 3.4;	
Study Leave Policy	4	4.1; 4.4	
Operational use of the Education Centres Policy	All	1.2; 1.5	

Job planning policy	4	4.4	
Integrated governance structure	All	2.1-2.5	
Medical Education Committee Terms of Reference	All	2.1-2.5	
Non-Medical Clinical Education Committee Terms of Reference	All	2.1-2.5	
Workforce & OD Strategy and action plan	All	6.1-6.4	2.2.1
Freedom to Speak Up Action Plan	All	3.1	2.2.1
Vision 2020	All	6.1 -6.4	
Quality Improvement Strategy & Plan	All	All	
Quality Improvement Training Programme	All	All	
Medical Appraisal & Revalidation Policy	All	4.3	
Procedure for Maintaining High Professional Standards in the Modern NHS	All	3 & 4	

NHS
Health Education England

Section 4: 17/18 and 18/19 LDA Funding

		Total paid in 17/18	Estimated 18/19 funding
Total paid to the Trust in 17/18:		£5,896,476.82	n/a
Total initial 18/19 LDA value *(including undergraduate)*:		n/a	£5,589,875.56
Total for salaries for doctors in training:		£,2326,878.67	£2,338,966
Tariff for placement activity			
Postgraduate Medical	Tariff *(as per DoH guidance* £12,152 + MFF)*	£1,426,000.67	£143,4258
	Contribution to basic salary costs *(as per DoH Annex A*)*	£2,326,878.67	£2,338,966
	Total	£3,752,879.34	£3,752,879.34
Total Non-medical placement tariff: *(as per DoH guidance* £3,112 + MFF)*		£357,302.97	£396,791.07

**2017-18 Education & training placement tariffs: Tariff guidance and prices from 1st April 2017*

A placement in England that attracts a tariff payment must meet each of the criteria in line with the DoH guidance*. Please provide details of how you utilised your 17/18 placement tariff within the financial year April 17 to March 18 to support learners and educators.
Please note figures entered below should reconcile to the 17/18 tariff figures shown in the table above. Please provide details of expenditure and associated costs.

	Trust's Response
Postgraduate Medical Placement Tariff *The E&T placement tariffs cover funding for all direct costs involved in delivering E&T by the provider, for example (please see DoH guidance page 6):* *Direct staff teaching time within a clinical placement* *Teaching and student facilities, including access to library services* *Administration costs* *Infrastructure costs*	**Postgraduate** / **17/18** Education costs pay: 223,044 Education costs non-pay: 11,447 Direct teaching costs: 271,472 Cost of staff teaching while delivering patient care: 289,379 Cost of checking trainees work: 155,372 Cost of trainees attending courses or examinations: 82,850 Total trainee staff cost for time in training: 2,237,062 Overheads: 482,253 3,752,879
Non-Medical Placement Tariff *As above*	**Non Medical** / **17/18** Education costs pay: 21,236 Education costs non-pay: 1,090 Direct teaching costs: 25,846 Cost of staff teaching while delivering patient care: 27,551 Cost of checking trainees work: 14,793 Cost of trainees attending courses or examinations: 7,888 Total trainee staff cost for time in training: 212,986 Overheads: 45,914 357,303

Additional Funding *Please confirm how any additional money has been spent.*	

Section 5: Simulation, Patient Safety and Human Factors

5.1. Patient safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Dr Chris Goddard is the Trusts Associate Medical Director for Patient Safety, working with Mrs Mandy Power Assistant Director for Integrated Governance.
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	Dr Goddard has a day a week dedicated to this role and chairs the Trust Mortality Operational Group which is the forum for receipt of information relating to mortality and patient safety. Dr Goddard and Mrs Power are permanent members of the Trusts Serious Incident Review Group which meets weekly. Ms Power reviews all incidents reported on a daily basis with the Trusts senior nursing team.
3. In which areas would you like support from HEE? E.g. educational events, funding, specific areas of training for example quality improvement?	Design, building and progressive operationalising of the Trusts 'Safety Hub' designed as an operations centre to house critical care outreach, resus services, bed management, patient flow and palliative medicine. Electronic tools have been created to provide overview of hospital and ward acuity to facilitate bed meetings and flow. We are in the progress of devising the clinical system to collate and assure information from board rounds and clinical handover is recognised and acted on to ensure all patients are monitored effectively.

5.2. Simulation

Prompt: We advise you to consult with your Simulation Manager or Lead when compiling your response.

Questions	Trust's response
1. Who is the Simulation lead in your organisation? Please advise on name, job title and email address. What support do they receive in delivering this role? E.g. job-planned time, resources etc. Are they linked in with the HEE Simulation Network in their locality?	**Dr Mike Aisbitt** Consultant in Emergency Medicine and Trust Simulation lead. Programmed approx. 0.5 PA. Linked to NWSEN
2. Who is responsible for keeping an inventory of the simulation equipment within the Trust including all task trainers and low fidelity mannequins?	**Shared responsibility for this sits with our 3 newly appointed CEL's:** **Mr Andrew Burke -** Clinical Education Lead for Undergraduate Med Ed;

	Miss Nicola Downey - Clinical Education Lead for Foundation Programme**;** **Ms Sharon Roberts -** Clinical Education Lead for Postgraduate Med Ed
3. How many simulation specific trained faculties does the Trust have?	Currently there are between 22 and 25 faculty members within the Trust. Covering the broad range of Simulation Training provided
4. Which directorates or inter-professional groups are actively engaged with simulation based education within your organisation? How do you encourage equitable access to simulation for all staff?	Simulation training is integrated in to Medical Student and Foundation Training. Last year saw the completion of CP4 Simulation days as recommended by the University and we were the first Trust locally to complete a full cycle of Foundation Simulation as Recommended by NWSEN (1 x FY1 half day/1 x Mixed FY1+FY2 half day/ 1 x FY2 half day per trainee). This was supported by Mark Hellaby from NWSEN. This process is ongoing in this academic year. Simulation forms part of the Training in the Emergency Department, both in-situ training and also additional Simulation for ACP and PAs within the Department. MDT teaching occurs across Obstetric/Anaesthetics involving medical and Maternity staff, on the ICU and Theatres in Operating department and ICU specific scenarios. The core members of the Simulation faculty cover medical, nursing, OPD and Physio, ensuring access for all members of the team, both undergraduate and postgraduate. Physiotherapy simulation prepares new Physiotherapists for on call, covering scenarios often encountered on call, and Tracheostomy simulation covers incidents which have arisen in response to patient safety incidents.
5. Is there strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews?	Foundation Simulation is based around Real patient safety incidents. Any incidents escalated via simulation would be raised to departmental and CBU governance.

5.3. Human Factors

Questions	Trust's response
1. Who is the Lead for Human Factors in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	There is no Specific lead for Human Factors in the Trust although to some extent this falls in the role of Simulation lead
2. Please describe the extent to which your HF training covers the following domains: • People – the individual & teamwork • Environment – the physical aspects of a workspace • Equipment and technology • Tasks and processes • Organisation • Ergonomics and research methods	There is no specific, stand-alone training in Human factors, however all the simulation programmes encompass Human Factors training in terms of communication, teamwork, challenging, tasks and processes

3. For the training delivered in the reporting period please also consider and describe the following: • The audience to which HF training is being delivered, including details of multi-professional staff. • Frequency of training, or whether ad hoc events. • Who are the faculty that deliver the training? Please describe their "HF expertise", professional background, specialty, whether they have job-planned time to deliver HF training. • What is the wider Trust context within which HF training is delivered? Is there a link between patient safety incidents, SI investigations, and root cause analysis? • To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process?	As part of the Simulation training, Human Factors training covers medical students, Foundation doctors, other training grades and SAS doctors, also including consultants In addition, groups covered include ODP, theatre nurses, physio therapists, ANPs, PA and Nurses, including nursing students The faculty involved in training are the Simulation faculty, the majority of whom have undertaken training via the NWESN or the RCEM training the trainers course. There is no Job planned time specific for HF There is no specific link between SI and RCA HF is currently not directly integrated other than via Simulation training and debrief

Section 6: Equality and Diversity

The HEE Quality Framework states clearly that education and training opportunities should be based on principles of diversity and inclusion.

The HEE equality, diversity and inclusion strategy reflects HEE's commitment to this important area of work and features strategy for HEE employees, as well as the opportunity to influence wider. An example of this is the HEE workforce strategy, used to inform our work in developing a comprehensive system-wide understanding of workforce needs for the future. Diversity and inclusion will be integral in how we look to influence the healthcare system to achieve greater representation and social mobility.

As well as applying these principles across all professional groups, there is also a specific work stream and duty to consider and capture information for doctors in training. The GMC continue their work in equality and diversity, reflecting their standards; promoting excellence.

For medical education, the GMC and local offices continue to consider differential attainment; different rates of attainment between different groups of doctors. This work includes ethnicity and country of primary medical qualification.

Prompt: In the responses below, please consider:
- *Organisation wide themes*
- *Examples of good practice from across professional groups*
- *As well as specific consideration and comment on differential attainment for doctors in training*

Question	Trust Response
Name of Trust Equality, Diversity and Inclusion Lead:	**Robert Davies**
1. How do you ensure that learners with different protected characteristics are welcomed and supported into the Trust, demonstrating that you value diversity as an organisation?	The Trust has an equalities policy. All policies are equality impact assessed. There is no specific action around protected characteristics but candidates are asked to identify if they have additional requirements as part of the joining administration. The Trust has signed up to the Disability

	Confident Employers Scheme and Mindful Employer and has the NAVAJO Charter mark which is specific to LGBT Reasonable adjustments are available for employees with a disability / long term medical condition, i.e. equipment, flexible working, information in various formats i.e. large print etc.
2. How do you liaise with your Trust Equality, Diversity and Inclusion Lead to: • Ensure Trust reporting mechanisms and data collection take learners into account? • Implement reasonable adjustments for disabled learners? • Ensure your policies and procedures do not negatively impact learners who may share protected characteristics? • Analyse outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	This data is available via ESR. Advice would be taken from equalities lead as required. All policies and procedures are subject to Equality Impact Assessment This is not currently centrally recorded. ** Workforce Race Equality Standard (WRES) The Trust as part of the evidence collected for the WRES report indicator 4. Relative likelihood of staff accessing non –mandatory training and career progression, monitors and reports on BME and white staff data in regarding to WRES indicator 4
3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?	Candidates are asked to identify any additional needs as part of joining instructions Issues raised by /with individuals will be discussed on an individual basis and any barriers will be addressed to ensure appropriate support processes are in place to support the learner.
4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the Trust?	The Trust uses the national ESR on line training package and all new employees are expected to complete the module. All Trust employees have to maintain compliance throughout their employment. Information can also be provided in a different format to support individual needs i.e. hardcopy. Information leaflets are available on Equality and Diversity Unconscious Bias, information on various diverse community events / activities are promoted via the Trust Internet, information leaflets and newsletters from various community groups and through information sessions from different organisation are also promoted to Trust staff
5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?	All educators are trained and are also required to complete the e-learning package. Additional training and advise is available from the Equalities Lead.

	Information on various diverse community events / activities are promoted via the Trust Internet, information leaflets and newsletters from various community groups and through information sessions from different organisation are also promoted to Trust staff.

Section 7: Libraries and Knowledge Services (LQAF)

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the ***HEE Library and Knowledge Services Policy*** (https://hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf) namely:

   "To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:
   - Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.
   - Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England."

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services' strategy or annual action/implementation/business/service improvement plan.

Trust's response

The Southport & Ormskirk Library & Knowledge Service (LKS) informs the delivery of high-quality, evidence-based health care across the Trust.
There is a library on both hospital sites, membership of which is freely available to all Trust staff and students on placement. 24/7 "swipe- in" access is available on request.
A range of up to date print and electronic resources is available including book and journal collections, reference collections, point of care tools, e-learning and evidence based resources.
All e-resources are available remotely (both on and off site), many via NHS OpenAthens and can be accessed via the library's website www.sonhslks.com
IT, printing and study facilities are available in both libraries along with a separate Wi-Fi service.
The library provides information skills training and journal club facilitation on request. A full literature search and information consultancy service is available. Current awareness and alerting services are available across a range of clinical specialties and to senior managers.
The library staff are members of both regional and national networks, attending a range of CPD and collaborative meetings to ensure that they are up to date with the correct skills to continue to enable evidence-based decision making across the organisation.

2. HEE's ***Library and Knowledge Services Policy is*** delivered primarily through local NHS Library and Knowledge Services.

- Please identify the budget allocated to your Library and Knowledge Service in the current financial year.
- If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.

Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

Trust's response

- Library Budget (non-pay) 2018-19**: £41,678**
- Library Budget (pay) 2018-19: **not known** (SLA with St Helen's & Knowsley FT)
- Funding for external sources 2018-19: **£32,908** (**£12,708** SLA with Edge Hill University & **£20,200** SIFT Allocation / SLA with Health Care Libraries Unit (HCLU))

3. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.
   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence of impact on clinical practice, impact on management decision-making (including cost savings) and any innovation submissions originating from your Library and Knowledge Service.

Trust's response

The LKS works with the Risk team to develop and share Lessons Learnt Bulletins.
The LKS has developed a Human Factors webpage to direct staff to a range of resources to support patient safety including evidence based resources on sepsis, the deteriorating patient and pressure ulcers. http://www.sonhslks.com/human-factors.html

The LKS has developed a collection of reminiscence resources to facilitate the sharing of memories and improve patient experience on the dementia ward.
http://www.sonhslks.com/dementia-patient-information.html

4. The **Learning and Development Agreement** that Health Education England has with your organisation states that the LKS should achieve a minimum of 90% compliance with the national standards laid out in the current Library Quality Assurance Framework (LQAF).

   If your LKS has a score below 90% please describe the improvements you are planning to attain this minimum requirement in 2018-19.

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. The details should be available from the LQAF Action Plan developed following the 2017-18 LQAF.

Trust's response

LQAF Score 2017: 97%

LQAF Score 2018: due December 2018

Health Education England

Section 8: Additional Information

8.1 Supporting Learners at Coroners' Court and following Serious Incidents

To help HEE better understand how your organisation supports learners please complete the questions below.

Serious Incidents and Never Events

Questions	Trust's Response
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?	The learner would be identified on review of the incident via DATIX or they could be identified as the investigation unfolds The supervisor would be expected to support the learner along with the Clinical Business Units and the Integrated Governance Team (IGT) Learners and/or staff who have been involved in an incident are identified when patient records are reviewed. Learners are also identified when critical incidents reports are reviewed or via new information Learners are identified on review of any incident and they are contacted via their Educational Supervisors or Manager/Mentors. The supervisor is expected to support the learner along with the Clinical Business Units and the Integrated Governance Team (IGT)
What support systems exist to support learners? How are these systems monitored?	AS per RM 06 Reporting and Management of Incidents Policy the Trust recognises that serious incidents can have a significant impact on staff who were involved or who may have witnessed the incident. Like victims and families they will want to know what happened and why and what can be done to prevent the incident happening again. Staff involved in the investigation process should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process. When a Serious Incident occurs Learners are contacted via their supervisors so they can support the learner. The IGT also supports learners by providing updates on the investigations and also by providing support with statement writing The Trust monitors whether staff are supported via the incident management system (DATIX). DATIX

	allows prompts staff to record whether staff were supported, feedback was provided.
What feedback do you receive from learners about their experience of being involved in Serious Incidents?	Post incident support for staff is initially provided by the line manager and Risk Management Policy No. 17 "Supporting Staff" should be adhered to including ensuring that staffs are aware of the Occupational Health support available and the counselling service availability as appropriate. The feedback we receive is usually via emails when a learner thanks the IGT for its support and also for the updates provided. The Supervisor would also provide the feedback on the students behalf when they report on their reflective practice / discussion held.
What formal organisational links exist between the Governance team coordinating investigations and the Postgraduate team supervising the trainees? The HEIs supporting learners?	The Integrated Governance Team work with the trainee's supervisor when an incident involves a trainee so we are assured they are supported and learning occurs The Integrated Governance Team would go via the trainees supervisor when an incident involves a trainee so we are assured they are supported and learning occurs The Integrated Governance Team produces monthly reports highlighting all serious incidents involving trainees. This is sent to the Medical Education Manager, Post Graduate Clinical Tutor and Director of Medical Education.
How many patient safety incidents have you reported to NHSI?	Nil
How many serious incidents impacting on trainees' revalidation have you made to your HEE local office within the reporting period? What proportion of these have been resolved/closed after completion of investigations?	Nil – we have had no Serious Incidents involving learners within this timeframe This is covered by RM 06 Reporting and Management of Incidents Policy – States the following: Directors of Education and Quality (DEQ) in Health Education England (HEE) and its Local Education and Training Boards are responsible for the quality of the education and training provided to medical, nursing, dental and Allied Health Professionals (AHP) students and others, and training grade doctors. These students may be involved in serious incidents and HEE have a duty of care to them. Also they are an excellent source of feedback on the standard of patient care experienced in their placement. HEE DEQs should therefore be informed about serious incidents where trainees are involved. The provider should ensure that the responsible DEQ is made aware of the incident as soon as possible. This does not, however, alter the serious incident

	management process which should be undertaken in line with national serious incident Framework. Care must be taken to ensure all parties understand that notification of serious incidents involving trainees is focussed on supporting those trainees and ensuring the standards of training are appropriate. It is very rare that serious incidents are the result of individual failings and notifications sent to DEQs are not intended as a comment or judgement on the capability of trainees.
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?	As per policy (Reporting and Management of Incidents Policy (Including Serious Incidents, Never Events and Information Incidents) the Trust aims to support staff with their responsibilities by creating a culture of openness, willingness to admit mistakes and is committed to being a learning organisation where lessons learnt can be embedded into practice. The sharing of these lessons can be achieved through: • Training courses • Team briefings • Meetings • Quality and Risk Newsletter publications sharing good practice tips and lessons learned examples.

Coroners Hearings

Questions	**Trust's Response**
What support is available for learners who are required to provide statements and/or attend Coroners hearings?	As per policy (Reporting and Management of Incidents Policy (Including Serious Incidents, Never Events and Information Incidents) the Trust aims to support staff with their responsibilities by creating a culture of openness, willingness to admit mistakes and is committed to being a learning organisation where lessons learnt can be embedded into practice. The sharing of these lessons can be achieved through: • Training courses • Team briefings • Meetings • Quality and Risk Newsletter publications sharing good practice tips and lessons learned examples
How is your organisation involving learners in responding to Duty of Candour responsibilities?	Learners have access to the Staff Duty of Candour leaflet on the Intranet. They also have access to the Duty of Candour Video on the Intranet. Learners are bound by Trust Policies RM 24 Being Open and Duty of Candour Policy Medical Students receive Duty of Candour at Trust Induction

Guardians of Safe Working

Questions	Trust's Response
10. Please describe the interrelationship between the GOSW and the Director of Education?	The GOSW meets with the Director of Medical Education and reports directly to the Board.
11. Please provide a summary of the exception reports you have received within the reporting period, number, type and time to resolve.	

Total Exception Reports ERs	**206**
Completed ERs	**131/206**
Not Exception Reports*	**5/206**
Trainees	**25**
Episodes	**251**
Review Interview Held	**192/206**
A&E	**0/206**
Medicine	**183/206**
Surgery	**6/206**
Orthopaedics	**6/206**
Anaesthetics	**0/206**
Ophthalmology	**0/206**
Paediatrics	**9/206**
Obs & Gynae	**0/206**
GP	**2/206**

8.2. Educational Opportunities during winter pressures

Please describe how your organisation Maintains curriculum delivery opportunities during winter pressures

Questions	Trust's response
1a) Please describe how winter pressures in 2017/18 affected your ability to deliver training to all learners within your organisation? 1b) Please detail the specific areas, placements and programmes which were adversely affected by last winter's pressures.	Winter pressures cause difficulties in terms of trainee access to teaching and the trainer's ability to fulfil their teaching commitments – this can often impact upon all specialty areas and therefore the trainees therein. The Medical Education Team are aiming to mitigate this with the development and implementation of robust plans for a shared resource area – accessible online – whereby teaching sessions missed can be accessed independently. Trainees will be expected to provide evidence of completion, through a self-assessment form submitted to the team for review or asked to produce a short presentation summarising the learning points gained.
2. Please describe what strategies you used to protect training for all learners	All rotas now reflect the scheduled teaching periods which trainees are expected to be released to

across their whole placement with your organisation in 2017/18 e.g. moving educational sessions to times of less pressure, ring fencing specific clinics, lists etc. for training	attend.
3. Please describe what plans you are putting in place to mitigate the effects of winter service pressures on training in 2018/19.	As per answer Question 1 In addition, the Medical Education Team, through our new CEL's plan to expand cross-site delivery of clinical skills sessions and will also support training within departments wherever practicable or appropriate.