AGENDA
BOARD OF DIRECTORS' MEETING
To be held at 0845 on Wednesday 07 October 2020

V = Verbal D = Document P = Presentation

Ref Nº.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0845***
TB142/20 (V)	**Chair's welcome and note of apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate.*	*No*	Chair	
TB143/20 (D)	**Declaration of Directors' Interests concerning agenda items** *Purpose: To record any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
TB144/20 (D)	**Minutes of the previous meeting** a) Meeting held on 02 September 2020 *Purpose: To **approve** the minutes of the previous meetings*	No	*Chair*	*10 Mins*
TB145/20 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*No*	*Chair*	
TB146/20 (V)	**Patient Story** *Purpose: To receive the Patient Story*	*No*	*TBA*	*20 mins*
STRATEGIC CONTEXT				**0915**
TB147/20 (D)	**Chair's Report** *Purpose: To **receive** an update on key issues from the Chair*	*No*	*Chair*	*5 mins*
TB148/20 (D)	**Chief Executive's Report** *Purpose : To **receive** an update on key issues from the CEO*	*No*	*CEO*	*5 mins*
RISK AND GOVERNANCE				**0925**
TB149/20 (D)	**Board Assurance Framework** *Purpose: To **receive** the Board Assurance Framework*	*No*	CEO/ADCG	*15 mins*

TB150/20 (D)	**Corporate Risk Register** *Purpose: To* ***receive*** *the Corporate Risk Register*	*No*	*DoN*	*10 mins*
INTEGRATED PERFORMANCE				**0950**
TB151/20 (D)	**Integrated Performance Report (IPR) Summary** *Purpose: To* ***receive*** *the IPR for assurance.*	*No*	*CEO / DCEO*	*5 Mins*
QUALITY & SAFETY				**0955**
TB152/20 (D)	**Quality and Safety Reports** a) Committee AAA Highlight Report b) Quality and Safety Performance Report *Purpose : To* ***receive*** *the reports for information and assurance*	*No*	*Cttee Chair DoN/MD*	*10 mins*
TB153/20 (D)	**CQC Progress Report** *Purpose: To* ***receive*** *the CQC Progress Report*	*No*	*DoN*	*10 mins*
OPERATIONS AND FINANCE				**1015**
TB154/20 (D)	**Finance, Performance and Investment** a) Committee AAA Highlight Report *b)* Operational Performance Report c) Financial Performance Report d) FPI Committee - Terms of Reference *Purpose : To* ***receive*** *the reports for information and assurance*	*No*	*Cttee Chair ADCG DCEO IDOF*	*15 mins*
WORKFORCE				**1030**
TB155/20 (D)	**Workforce Reports** a) Committee AAA Highlight Report *b)* Workforce Performance Report *Purpose: To* ***receive*** *the reports for information and assurance.*	*No*	*Cttee Chair DoHR*	*15 mins*
TB156/20 (D)	**Guardian of Safe Working Report** *Purpose: To* ***receive*** *the GOSW Report*	*No*	*MD / GoSW*	*5 mins*
ITEMS FOR INFORMATION				**1050**
TB157/20 (D)	**Self-Assessment Report (Health Education England)** *Purpose: To* ***receive*** *the report*	*No*	*DoHR/OD*	*10 mins*
CONCLUDING BUSINESS				**1100**
TB159/20 (V)	**Questions from Members of the Public** *Purpose: To* ***respond*** *to questions from members of the public*		*Public*	*5 mins*

received in advance of the meeting.

TB160/20 (V)	**Message from the Board** *Purpose: To **approve** the key messages from the Board for cascading throughout the organisation*	*Chair*	*3 mins*
TB161/20 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	***Chair***	*2mins*
	Date and time of next meeting: 0900, Wednesday 04 November 2020		***1110 close***

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

	The Trust Board resolves that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	***Chair***

Chair: Neil Masom

Register of Interests Declared by the Board of Directors as at 01 October 2020

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
ARMSTRONG-CHILD Mrs Trish	Chief Executive Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**16 December 2019**
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**5 January 2020**
BOTTOMLEY, Mrs Yvonne	Interim Director of Finance	**Emmett Cannell Consulting Limited** **Unity Theatre Liverpool**	**Emmett Cannell Consulting Limited**	**Emmett Cannell Consulting Limited**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**24 August 2020**
BRICKNELL, Dr David	Non-Executive Director	**Pilkington Family Trust** **St Joseph's Hospice** **The World of Glass** **Pilkington Glass Collection**	**Nil**	**Nil**	**Director, St Joseph's Hospice** **Director, Pilkington Family Trust** **Trustee at The Rainford Trust**	**Director, St Joseph's Hospice**	**Nil**	**Nil**	**Nil**	**20 February 2020** **27 March 2020**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
CHRISTIAN, Mr Steven	Deputy CEO & Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**27 February 2020**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director; Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS Management personnel**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**
GORRY, Mrs Julie	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Project Adviser: Hospice of the Good Shepherd** 2017 to date **Specialist Adviser CQC** 2015 to date **Macmillan Cancer Information & Support Specialist** 2017 to date **Public Health England**	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**24 August 2020**

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NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
						Clinical Case Worker (bank) 2020 to date				
HANKIN Dr Terence	Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**31 January 2020**
KATEMA Mrs Sharon	Associate Director of Corporate Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**02 December 2019**
LEES Ms Bridget	Director of Nursing, Midwifery and Governance	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Spouse employed as a Pharmacy Technician**	**Nil**	**Nil**	**7 February 2020**
MASOM Mr Neil	Chairman & Non- Executive Director	**Industrial & Financial Systems (IFS) AB** **NDLM Ltd**	**CQC Holdings Ltd** (manufacturer of textile products) **JSSH Ltd**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 February 2020**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Loyalty: An officer with close ties to a decision making colleague from an organisation who may seek to do business with the Trust	Other	Date of entry on register or amendment
POLLARD Mr Graham	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee at Alder Hey Children's Kidney fund**	**Nil**	**Nil**	**Employed by the University of Liverpool**	**27 April 2020**
ROYDS, Mrs Jane	Director of Human Resources& Organisational Development	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**24 February 2020**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	Nil	**Nil**	**Nil**	**Trustee – Age Concern**	**5 February 2020**
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**GS Urology Ltd: providing practice & GMC work**	**Nil**	**Nil**	**Private practice at Ramsay Health** **Trustee of the Southport and District Medical Education Centre Fund** **Trustee of the Ormskirk and District Post Graduate Medical Trust.**	**Nil**	**Nil**	**Nil**	**19 February 2020**

NHS
Southport and
Ormskirk Hospital
NHS Trust

Draft Minutes of the Board of Directors' Meeting
held on Microsoft Teams / Livestream
Wednesday 02 September 2020
(Subject to the approval of the Board on 07 October 2020)

Members Present

Mr Neil Masom	Chair
Mrs Trish Armstrong-Child	Chief Executive
Mr Jim Birrell	Non-Executive Director
Mrs Yvonne Bottomley	Interim Director of Finance
Dr David Bricknell	Non-Executive Director
Mrs Julie Gorry	Non-Executive Director
Dr Terry Hankin	Executive Medical Director
Ms Bridget Lees	Executive Director of Nursing, Midwifery and Therapies
Ms Therese Patten	Deputy Chief Executive/ Executive Director of Strategy
Mr Graham Pollard	Non-Executive Director
Mr Gurpreet Singh	Non-Executive Director

In Attendance

Mr Steve Christian	Chief Operating Officer
Mr Tony Ellis	Communications and Marketing Manager
Mrs Sharon Katema	Associate Director of Corporate Governance
Mrs Jane Royds	Director of Human Resources and Organisational Development
Mrs Juanita Wallace	Assistant to Associate Director of Corporate Governance

Apologies

Mr Steve Shanahan	Executive Director of Finance
Mrs Pauline Gibson	Non-Executive Director Designate

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
TB123/20	**Chair's Welcome and Note of Apologies**	
	Mr Masom welcomed all in attendance and in particular welcomed members of the public that were now able to observe Board meetings since they had been temporarily halted in April 2020 due to the Covid-19 pandemic. It was noted that any questions received in advance of the meeting from members of the public, would be addressed by Mrs Armstrong-Child towards the end of the meeting. Mr Masom advised that this was the first time as well that non-executive directors (NEDs) were on site and as such the meeting was split between two rooms to ensure that all delegates were in a Covid-19 secure environment thus negating the need for members to wear face masks during the meeting. The Board noted apologies for absence from Mr Shanahan and Mrs Gibson.	
TB124/20	**Declaration of Directors' interests concerning agenda items**	
	There were no declarations of interests in relation to the agenda items.	

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	RESOLVED: The Register of Directors' Interests was **approved.**	
TB125/20	**Minutes of the previous meetings**	
	The Board reviewed the minutes of the meetings held on 17 June and 01 July 2020 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the previous meetings.	
TB126/20	**Matters Arising and Action Logs**	
	The Board considered updates to the Action Log which reflected progress made in discharging outstanding and agreed actions. **RESOLVED:** The Board **approved** the action log.	
STRATEGIC CONTEXT		
TB127/20	**Chair's Report**	
	Mr Masom presented the report which highlighted the Chair's activity since the previous meeting. Over the last six months Level 4 Command and Control included fortnightly Chairs briefings from NHS England/Improvement (NHSE/I) as well as the North West Regional Director. These have recently been complemented by monthly meetings across the Cheshire & Mersey Health Care Partnership (HCP). During the past month steps have been taken towards stepping Command and Control down to Level 3. The Trust will need to concentrate on the recovery of non Covid-19 related work over the next three months and feedback would be presented at a future Board meeting. Whilst one of the points of discussion at the previous briefing had been the local outbreak management, it was noted that whilst 13 of the 20 national hotspots were in North West region, none were located within the Cheshire Mersey region. Mr Masom commended the response from members of the public during the pandemic and the subsequent increase in Charitable donations to NHS Charities Together and the Trust. On behalf of the Board, Mr Masom formally thanked the public for their support. In terms of local donations, the contributions from Southport Rugby Club were acknowledged and gratefully received. It was noted that the Trust AGM would be held virtually on Wednesday 16 September through Microsoft Livestream. **RESOLVED:** The Board **received** the Chair's update.	

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TB128/20	**Chief Executive's Report**	
	Mrs Armstrong-Child presented a summary report of the specific activities and issues that had occurred in the organisation since the last Trust Board meeting. In addition to the events highlighted within the report, the following key points were noted: • The intensive care team had been shortlisted for a Nursing Times award. The team's submission focussed on the innovative ways in which staff had worked during the peak of Covid-19 to care for patients and to meet the needs of their families. • Time to Shine Awards had been launched and there would be an opportunity for members of the public to nominate in the People's Health Hero Awards. • Thanks a Bunch Awards had been relaunched resulting in a number of nominations and the first of these awards has been presented to Rose Fairclough and Jacqui Murphy (Ormskirk stores) and Janette Mills (Head of Audit and Effectiveness). • The Control and Command structure has moved from Level 4 to Level 3 with local Gold Command meetings, chaired by Mrs Armstrong-Child, continuing on a weekly basis. • The Trust received the Phase 3 letter from NHSE/I which set out the expectations around recovery, performance, financial arrangements and winter planning. Trusts have been working to submit activity and workforce projections for the final two quarters of the financial year. • The Trust has also been successful in securing £1.7m of capital funding to support winter planning. • The Trust has introduced a Patient Advise and Liaison Service (PALS). • Mr Christian has been appointed as Deputy Chief Executive and Mr Mark Carmichael joined the Trust as the new Assistant Director of Operations for Urgent Care. • No further meetings of the Southport and Ormskirk Improvement Board (SOIB) have taken place since 04 June and the regulators were satisfied with the Trust's performance. • Following the Enforcement Notice schedule that had been issued to the Trust in March 2020 a follow up visit from the Mersey Fire and Rescue Service took place on 19 August to review the Trust's Report and Action Plan. The Enforcing Authorities Officer was reassured with the Trust's response, report and action plan. **RESOLVED** The Board **received** the Chief Executive's Report	
OPERATIONAL AND FINANCIAL PERFORMANCE		
TB129/20	**Finance, Performance and Investment AAA Highlight Report**	
	Mr Pollard presented the AAA Highlight reports from the Finance, Performance and Investment Committee meetings held on 27 July and 24 August 2020 and drew the Board's attention to the Alerts included on both AAA reports.	

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	Mr Masom commented that the increase in ED attendance was an indication that the public were comfortable with using the services again. **RESOLVED** The Board **received** the reports for information and assurance.	
TB130/20	**Integrated Performance Report (IPR)**	
	a) Operational Performance	
	Mr Christian presented the Operational performance reports and drew attention to the following key points: respectively • ED 4hour standard showed a positive variation, however there had been a reduction in performance against previous months due to an increase in demand to pre Covid-19 levels. The team would be looking at ways to manage demand including alternatives to admission. The Trust would be taking part in the NHS 111 pilot as part of the Phase 2 Early Adaptors programme which will be launched mid-September. Referral to Treatment (RTT) has shown a negative variation as a result of Phase 1 (response to Covid-19) during which all non-urgent activity was deferred and this has had a negative impact on the RTT waiting times. The Trust will be working with regional partners to explore pathways to offer enhanced capacity. Cancer Services maintained their services during Covid-19 and treatment rates are continuing to rise. The Endoscopy Service has seen an improvement in service with recovery being back to 300 sessions against a pre Covid-19 base line of 500 sessions per week. • Whilst theatre utilisation remains constricted by the Infection Prevention Control measures for dealing with Covid-19, an improvement programme to enhance theatre productivity from the current 50% utilisation is now in place. • Patient flow has indicated a rise in occupancy levels and internal efforts to reduce this have included the re-introduction of the Red to Green programme as well as enhanced weekend working. The bed base remains an ongoing concern.	
	b) Financial Performance	
	Mrs Bottomley presented the Finance Report advising that the Trust continued to breakeven in line with other trusts in the region. She outlined that the current financial arrangement would continue to the end of September. Mrs Bottomley raised a concern that the agency spend was above the 5% level and work was ongoing to address this. It was noted that the DHSC loans had been classified as current liabilities and these loans were due to be converted in September which would improve the Trust's Liquidity position. With regards to recovering activity, it was noted that whilst the period leading up to winter would be challenging and the Trust would need to continue improvements in productivity, the Trust had also made progress in key areas during Covid-19 and these had been acknowledged by the regulators.	

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	RESOLVED: The Board **received** the IPR for assurance	
WORKFORCE		
TB131/20	**Workforce Reports**	
	Dr Bricknell presented the AAA Highlight Reports from the Workforce Committee meetings held on 28 July and 25 August 2020 respectively and drew the Board's attention to the Alerts included in both AAA reports. The completion of mandatory training and PDRs had declined during Covid-19 and, as part of the measures to address this, both of these areas would be subjected to an intense review. It was noted that PDRs are fundamental to the culture of the organisation and significant recommendations should be forthcoming over the next few months following the deep dive analysis that was currently taking place. Time to Hire has continued to improve as the difficulties encountered during Covid-19 were having less of an impact on recruitment. Staff Turnover had increased to the level of July 2019 following 3 months of being within target. This could have been due to the inactivity in the job market. The Committee is looking at different ways to reduce medical vacancies. The Trust had successfully retained its apprenticeship funding for apprenticeships. **RESOLVED:** The Board **received** the AAA Highlight Report.	
QUALITY AND SAFETY		
TB133/20	**Quality and Safety Reports**	
	Dr Bricknell presented the AAA highlight reports from the Quality and Safety Committee meetings held on 27 July and 24 August 2020. The availability of more detailed reports has highlighted the pockets of underperformance within the Trust and the Quality and Safety Committee (CQS) was now in a position to help drive performance. He outlined that the Trust's project to address lost to follow-up patients had reviewed over 12,000 files adding that this workstream had been undertaken by staff that had been redeployed from other services. It was noted that the Committee would be monitoring progress going forward. Dr Bricknell highlighted the fact that the Cancer Services Annual Report reflected outstanding and nationally recognised work in support of patients. The team had been able to keep in touch with all cancer patients throughout lockdown. It was noted that following significant work undertaken as part of the mortality review, the Trust was no longer an outlier in this area. This was a reflection of the good work undertaken by staff at both senior and operational levels. A Medical examiner role would be introduced into the	

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	Trust during the course of September. Following the work undertaken around Falls with moderate harm there had been a decrease in this area. Fractured Neck of Femur (NOF) performance remained challenged due to theatre availability. IPC has been largely focused on Covid-19, however, all IPC indicators are performing within expected limits with no significant variation. There has been a decrease in induction rates and the trend change will be monitored through the Performance Improvement Development and Assurance Boards going forward (PIDA). There has been a continued improvement in Patient Experience, including the turn-around time in response to complaints. There have been no further mixed sex accommodation breaches and this can be attributed to the reconfiguration work carried out as well as different ways of working. **RESOLVED:** The Board **received** the reports for information and assurance.	
TB133/20	**Infection Prevention and Control Assurance Framework**	
	Ms Lees presented the Infection Prevention and Control (IPC) Assurance Framework. The IPC Assurance Framework was introduced in May 2020 and required each organisation's IPC Assurance Framework to be assessed by the CQC. The Trust was assessed on 31 July 2020, and the process concluded that there was assurance that the Trust had effective infection prevention and control measures in place with regards to Covid-19. **RESOLVED:** The Board **received and noted** the IPC Assurance Framework.	
RISK AND GOVERNANCE		
TB134/20	**Audit Committee AAA Highlight Report**	
	Mr Birrell presented the AAA Highlight Report from the Committee meeting held on 15 July 2020. Mr Birrell confirmed that the Board committees had finalised topics for their respective deep dives as follows: • FP&I will be looking into benchmarking • Workforce Committee will be looking at PDRs and workforce in more depth • The Quality and Safety Committee still need to finalise the topic of their deep dive and Dr Bricknell will be meeting with Mr Christian to discuss the discharge and flow of patients as a possible topic given the number of changes in this area. **RESOLVED:**	

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	The Board **received** the AAA highlight report	
TB135/20	**Committee Terms of Reference**	
	Mrs Katema presented the Terms of Reference (ToR) for the following committees following the periodic review: a) Audit Committee b) Charitable Funds Committee c) Hospital Management Board (HMB) d) Quality and Safety Committee e) Remuneration and Nominations Committee f) Workforce Committee She advised that the FP&I Committee ToRs would be presented at the October FP&I meeting. **RESOLVED:** The Board **approved** the Assurance Committees' Terms of Reference subject to the consideration of amendments requested.	
ITEMS FOR INFORMATION		
TB136/20	**a) Annual Resuscitation Report** Dr Hankin presented the Annual Resuscitation report which provided the Board assurance that the standards and outcomes with respect to Cardiopulmonary resuscitation were within National Guidance. The report outlined that: • there were less arrests overall • Performance as per funnel plots remained in expected range • Much higher than average asystolic cardiac arrest, with expected poor outcome. This reflected the Trust's patient demographic In response to a question raised around whether or not the data suggested that, during Covid-19 those patients who did not call 999 died at home, Dr Hankin advised that this was outside of the scope of this document. A question was raised as to whether or not the Trust had modified their policies to include amendments made by the Resus Council. Dr Hankin advised that he would look into this and advise. **ACTION:** Dr Hankin to advise whether or not the Trust policies have been amended to reflect the amendments made by the Resus Council. **RESOLVED:** The Board **received and noted** the Annual Resuscitation Report	**MD**
	b) Infection Prevention and Control Annual Report Ms Lees presented the IPC Annual report which provided an overall assessment of the previous year's key performance indicators with regards to the IPC programme and evaluated the Trust's compliance against the Health and Social Care act (2008) and the Hygiene Code.	

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	The 2020/21 work plan had been written to focus on infection rates and outbreak management where the Trust had not achieved target or where there were opportunities of stretch. This would be presented quarterly to the Quality and Safety Committee for assurance and monitoring. The report also included the performance highlights for the 2019/20 period. The Trust's contamination rate in respect of blood culture has remained consistently above the target level and many initiatives to reduce this had been undertaken. This had been included on the Work Plan going forward. Dr Bricknell advised that he had expressed concern about this in the past but following the increase in training there had been a reduction in numbers last month. Norovirus would play a key part in winter planning and the Trust would be looking at ways to work differently. In response to a comment around the graphs included in the report, Ms Lees has undertaken to ensure that the graphs are labelled going forward. **RESOLVED:** The Board **received** and noted the Infection Prevention and Control Annual Report.	
	c) Health and Safety Annual Report Ms Patten presented the Health and Safety Annual Report which outlined the arrangements that are in place for achieving and monitoring compliance with statutory and other requirements regarding: • Health and Safety • Security Management • Fire Safety Mrs Armstrong-Child advised the meeting that a fire notice had been served to the Trust and that increased funding had been allocated to the additional work required in respect of detection work. Mrs Armstrong-Child is confident that the fire notice would be dealt with satisfactorily. The Health & Safety Committee had, over the last few months, been focused on the ToR, attendance at the meetings as well as the work plan. Ms Lees would be taking over as chair of this Committee going forward. Mr Buck, Head of Health, Safety, Fire and Security, had been a significant help in ensuring that the Trust was compliant with the legislation around Covid-19 secure environments. The Board thanked Mr Buck for his hard work and requested that Mrs Katema ensured that Mr Buck is formally acknowledged. Following the latest QSC meeting the 18 objectives that had been identified for forward planning were taken offline and would be discussed with Mr Buck ahead of being presented at the next Health & Safety Committee meeting. This would ensure that timelines are drawn up based on priority.	

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	In response to the concern raised by Mrs Gorry around the number of dirty needle stick injuries Ms Lees advised that this is a standing item on the agenda for the monthly IPC meetings. Ms Lewis, Head of Health, Work and Wellbeing, had been tasked with finding an alternative way to deliver the induction and mandatory training as the Trust was unable to provide face to face training at the moment due to Covid-19 measures. Mrs Armstrong-Child would discuss what the Trust would be doing to acknowledge World Patients Safety Day on 17 September. Dr Bricknell asked the meeting how the Trust tracked near misses as it was best practice to monitor misses as a key way to reduce accidents. **RESOLVED:** The Board **received** and noted the Health and Safety Annual reports	
TB137/20	**Sefton Early Help Strategy and Children Plan**	
	Ms Patten presented the Sefton Early Help Strategy and Children Plan which informed the Board around the position in Sefton with regards to SEND services. Following a revisit in April 2020 by OFSTED and the Care Quality Commission a number of gaps in the service had been identified. The Sefton Council and their health partners drew up and received approval for a new strategy and plan and all partner Boards have been challenged to be sighted on this. Mrs Armstrong-Child and Ms Patten attended a recent meeting with Sefton Council where they were asked to present the documentation to the Trust Board to ensure that that all members are sighted on the documentation. Ms Patten advised the meeting that, whilst there was evidence of improvement, further improvement would be needed ahead of the re-inspection. The meeting was advised that the documentation included in the pack was for Sefton council only as there was no integrated module in place which included West Lancs area. Mrs Armstrong-Child would take this forward and provide feedback. Mr Birrell commented that, whilst this was an interesting read and that there was a need to support this, he was unsure of the areas of weakness in the service that the Trust provided. Mrs Armstrong-Child advised the meeting that, following the SEND inspection, it had become clear from the report that the service was fragmented and that there was a lack of oversight. This was the reason for Mrs Armstrong-Child and Ms Patten attending a call with the members from Sefton Council. It was acknowledged that Health and Social care sectors have different roles to play within the service. **RESOLVED:** The Board **received** the report	

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CONCLUDING BUSINESS		
TB139/20	**Questions from Members of the Public**	
	Mrs Armstrong-Child responded to the question received from a member of public around the restricted hours for the Children's A&E Department at Ormskirk Hospital. She confirmed that there was no permanent agreement in place with Alder Hey Children's Hospital regarding overnight cover. The Clinical Reference Group had been established to provide clinical input regarding any proposed service changes. It was noted that whilst the temporary arrangement was in place, no decision had been made as yet around the forthcoming months until the end of the current financial year. Mrs Armstrong-Child apologised for the restricted closure and, whilst this was not ideal, the decision had been based on clinical safety.	
TB140/20	**Message from the Board**	
	The Board agreed the messages to be circulated across the organisation.	
TB141/20	**Any Other Business**	
	The members of the public that had joined the live stream were invited to provide feedback on ways that future sessions could be improved. Mr Masom summarised the issues that had been encountered and reminded the meeting that this was the first time that the Board had been live streamed to include members of the public. Mr Masom formally thanked Ms Patten for her contribution to the Trust during her time as Deputy Chief Executive Officer / Director of Strategy and wished her luck in her new role. There being no other business, the chair thanked all for attending and brought the meeting to a close at 11:10	

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Board Attendance 2020/21

Members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Neil Masom (Chair)	✓	✓	✓	√		√						
Trish Armstrong-Child	✓	✓	✓	√		√						
Jim Birrell	✓	✓	✓	√		√						
Yvonne Bottomley						√						
David Bricknell	✓	✓	✓	√		√						
Bridget Lees	✓	✓	✓	√		√						

Julie Gorry	✓	✓	✓	√		√						
Terry Hankin	✓	✓	✓	√		√						
Therese Patten	✓	✓	✓	√		√						
Graham Pollard	✓	✓	✓	√		√						
Steve Shanahan	✓	✓	✓	A		A						
Gurpreet Singh	✓	✓	✓	√		√						
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Pauline Gibson	✓	✓	✓	√		A						
Steve Christian	✓	✓	✓	√		√						
Jane Royds	✓	✓	✓	√		√						
Sharon Katema	✓	✓	✓	√		√						
✓ = In attendance A = Apologies												

DRAFT

Board of Directors (Part 1)

Matters Arising Action Log

Action Log updated 30 September 2020

Status	
Red	Significantly delayed and/or of high risk
Amber	Slightly delayed and/or of low risk
Green	Progressing on schedule
Yellow	Included on Agenda
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
TB068/20	06-May-20	**Use of Resources**	The Use of Resources self-assessment to be presented at the July Trust Board.	**DoF / CEO**	06-May-20	03-Jun-20	June Update: Included on agenda. Action completed July Update: To be presented first at July's FP&I Committee and then at Board in Sept. August Update: Not complete. Interim DoF to complete self-assessment for September FP&I Committee **October Update:** Use of Resources report and Action Plan submitted to September's FP&I Committee. To be submitted to November's Board	Green
TB088/20	03-Jun-20	**Finance, Performance and Investments Committee**	The Executive Team to provide an update to the Board through FP&I of a 360 overview on aligning workforce with the financial oversight.	**DoN**	01-Jul-20	01-Jul-20	**July Update :** The work to address this action is progressing. An update will be presented at the September meeting **September Update:** Update will be provided at FP&I in September and to Board in October.	Green
TB109/20	Jul-20	**Board Assurance Framework**	A review of risk appetite to be undertaken at the next Board meeting	**CEO**	Sep-20	Sep-20	**July Update:** Will be reviewed at the October meeting. **September Update**: An update will be provided at the meeting	Included on Agenda
TB113/20	Jul-20	**Finance Report**	Mr Walsh and Mr Pollard to review earned value measures.	**DoF**	Sept	Sep-20	July Update**:** Will be discussed. **August Update:** Meeting to be arranged and the interim DoF to be included in the meeting invite. **September Update:** A meeting has been arranged and feedback would be provided as part of the AAA following the FP&I September meeting. **September Update:** Mrs Bottomley advised that a meeting had been arranged to discuss value measures and feedback would be provided to the FP&I Committee in September and to the Trust Board in either October or November via the FP&I AAA report	Amber
TB136/20	02-Sep-20	**Annual Resuscitation Report**	A question was raised as to whether or not the Trust had modified their policies to include the amendment made by the Resus Council Dr Hankin advised that he would look into this and advise.	**MD**	Oct-20	Oct-20	September Update: Dr Hankin to advise whether or not the Trust policies have been amended to reflect the amendments made by the Resus Council. **October Update:** The issues raised regarding conflicting advice in relation to 'Resus' and Covid are being taken to the Clinical Reference Group (CRG) for clarification and agreement	Green

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status
TB112/20	Jul-20	**Integrated Performance Report (IPR)**	Dr Hankin to provide assurance at next meeting around AKI patients	**MD**	Sep-20	Sep-20	July Update: Assurance will be provided at September meeting. **August Update:** Dr Hankin will provide verbal update at September meeting. **September Update:** Dr Hankin provided a verbal update at the meeting. **September Update:** Dr Hankin advised that the Acute Kidney Injury (AKI) pathway was a new pathway and that work is ongoing around education. No concerns had been noted around the mortality rate. Performance against key metrics is being monitored and feedback will be provided to the Quality and Safety Committee.	Blue

Title of Meeting	BOARD OF DIRECTORS	Date	7 October 2020
Agenda Item	TB147/20	FOI Exempt	No
Report Title	CHAIR'S REPORT		
Executive Lead	Neil Masom, Trust Chair		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	☐ To Approve ✓ To Assure	☐ To Note ✓ To Receive	

Purpose

To provide an update to the Board of Directors on the activities undertaken by the Chair since the last meeting.

Executive Summary

This report advises the Board of Directors of the Chair's activity since the previous meeting in relation to:

- North West Regional Chairs' Meetings
- Personal Activity in the Trust
- Charitable Funds
- Acute Sustainability Strategy ('Shaping Care Together')

Recommendations

The Board is asked to **receive** the Chair's Report.

Previously Considered By:

N/A

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Sharon Katema, Associate Director of Corporate Governance	Neil Masom, Trust Chair

1. Introduction

1.1 The Trust reported in its Annual Report published last month that we remained classified as a 'challenged provider' by our regulator NHSE/I. The Trust was notified at the end of September by the regulator that it had now been removed from that status. Whilst we recognise there is still much improvement work to be done, particularly in response to the 2019 CQC Inspection, this is excellent news and reflects the progress made by The Trust and all the staff who work here in progressing our strategic quality improvement objectives.

2. Feedback from North West Regional and Cheshire & Mersey Chairs Meetings

2.1 The NHSE/I North West Regional Director and his team, have continued to deliver fortnightly briefings to all NHS trust chairs' within the region during the pandemic. These have recently been complemented by monthly meetings across the Cheshire & Mersey Health Care Partnership (HCP).

2.2 The last briefing on 28 September focussed on:
a) The continued increase of Covid incidence within the Northwest, including now a number of areas with Cheshire & Merseyside, and how this is now starting to translate into increased hospital admissions.
b) Notwithstanding the increased incidence of Covid the continued emphasis on achieving restoration of non-Covid-19 services during October.

3. Personal Activity in the Trust

3.1 In general since the last board meeting I have worked remotely from the Trust but commencing this month, I plan to repeat the Wednesday afternoon back to the floor sessions I did during the first wave of Covid in the spring and early summer.

4. Charitable Funds

4.1 The restructuring of the way we govern our Charitable Funds, led by the Associate Director of Corporate Governance and non-executive sponsorship from Julie Gorry, is due to be completed during November.

4.2 Since the last Board meeting, the Charitable Funds Committee approved two significant investments, namely:
a) Revised scheme for the previously approved Health & Well Being Garden
b) The development of an Adolescent Diabetes Needs Assessment Tool (ADNAT) App to help healthcare professionals in engaging and supporting children with type 1 diabetes in decision-making and improving mental health and well-being

5. Shaping Care Together

5.1 The next stage of this programme is to commence communication and engagement during the autumn. The Shaping Care Together Programme Board, which I Chair, met during September and agreed the outline programme and resources for this activity.

6. Trust Virtual Open Week

6.1 Commencing on 5 October, Southport and Ormskirk hospitals welcomed the local community to join our first ever virtual Open Hospital event. The event replaces the usual annual open day. Sadly the usual event had to be cancelled due to ongoing Covid restrictions.

6.2 The Open Hospital event is online only, and shares a series of videos from the Trust's website, Facebook and Twitter accounts. The videos, all filmed in the last month, give an insight into:

- Older people's care
- Covid-19 care in ITU
- What therapists do to help people get back on their feet
- What it is like to have a hip replacement
- Life as a porter
- Therapy dogs.

7. In Closing

7.1 I would like to congratulate and welcome Steve Christian into his new Executive Director role on the Board following his appointment as Deputy Chief Executive and Director of Transformation.

Title Of Meeting	BOARD OF DIRECTORS	Date	7 October 2020
Agenda Item	TB148 /20	FOI Exempt	No
Report Title	CHIEF EXECUTIVE OFFICER'S REPORT		
Executive Lead	Trish Armstrong-Child, Chief Executive Officer		
Lead Officer	Trish Armstrong-Child, Chief Executive Officer		
Action Required	☐ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

The Chief Executive's Report provides an overview of specific activity and issues that have occurred in the organisation since the last Trust Board meeting.

Executive Summary

The attached briefing paper provides an overview of some high level updates since last Board meeting in September in relation to following:

- Awards and Recognition
- News and Developments
- NHSI/E/ Regulatory Meetings and Visits
- Reportable Issues Log
- Media Coverage
- Risk Register and Board Assurance Framework

Recommendation

The Board is asked to receive the report for information.

Previously Considered By:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Trish Armstrong-Child, CEO	Trish Armstrong-Child, CEO

CHIEF EXECUTIVE'S REPORT

1. Awards and Recognition

1.1 Time to Shine Awards.

We launched our annual 2020 Time to Shine Awards in September. As well as staff nominations, there is an opportunity for local people to make their nominations for the People's Health Hero Awards via the link on our website. Nominations close on Sunday 11 October 2020.

1.2 Thanks a Bunch

This month the awards went to:

- Lisa Stone, Personal Assistant Specialist Services CBU
- Ward 14B

1.3 Gold Award

Ward E, at Ormskirk Hospital became the first Gold Award winner in our Southport and Ormskirk Nursing Assessment and Accreditation Scheme (SONAAS) ward quality programme.

The ward underwent assessment on 1 September, achieving an overall score of 91%. This is commendable given that ward moves took place earlier in the year, so the team worked hard to settle in to their new environment and to continue on their improvement journey.

1.4 International Award

Well done to Dr Murty Jonnalagedda on receiving the Vamsee Vaidya Ratna Award. The citation outlined the significant contributions to healthcare he has made by offering free services to children with polio and supporting orphaned children's education.

While he was in India, he also contributed to the fields of Telugu language literature, drama and photography by offering his professional services free to charity.

1.5 SO Proud Awards

We launched our SO Proud Awards in September, asking staff to nominate colleagues who best display our Trust Values. That's being **s**upportive, **c**aring, **o**pen and **h**onest, **p**rofessional and **e**fficient, or SCOPE.
The staff chosen from this, will receive a specially-commissioned badge and letter from the chief executive.

2. News and Developments

COVID19 Update

Elective restoration:

In July 2020, the Trust received a letter from NHSE/I detailing the third phase of the NHS response to the pandemic. The premise of the letter was to set out the NHS priorities and from an elective care perspective, to accelerate the return to near-normal levels of non-Covid health services.

The Trust has submitted its plan to achieve the NHSE/I expectations and underpinning all the assumptions is a caveat that a resurgence of covid19 infections in the local area could markedly affect the ability to deliver.

The clinical and operational team are focused on improving productivity and have embarked on a number of improvement programmes across Elective Care. As part of the improvement work is a focus on theatre utilisation and the patient journey through theatres has been re-written in line with new PHE and NICE guidance.

Trust Winter Plan with COVID-19:

There has been a significant amount of work and focus to prepare for a very challenging winter. This includes:

- Our new Same Day Emergency Clinic (SDEC) will open very soon, creating more pathways to offer safe alternatives other than hospital admission
- Medical Day Unit (MDU) will remain at Ormskirk (temporarily over the winter period) and work has commenced to ensure the environment is comfortable and fit for purpose. The relocation will allow us to fully reinstate our endoscopy service.
- Capital improvements to both Emergency Departments (ED) are underway to support adherence to social distancing measures and PHE guidance.
- The decision to temporarily close the Children's ED at Ormskirk has been reviewed. The clinical teams have conducted a fresh assessment of the service and a significant workforce challenge remains around offering a 24 hour service. However, we are in a position to extend the opening hours and from Monday 19 October and the revised opening hours will increase from 8am to midnight (with medical cover available until 2am).
- Soon we will launch NHS111 First, which will allow us to better manage patient flow by offering bookable appointments to non-urgent patients

System Winter Plan:

The Trust has been actively involved in workshops to develop a system wide winter plan. The System Director of Urgent Care is the lead for its production and submission acting on behalf of Southport & Formby CCG. The CCG has recognised the additional pressures for winter and has agreed to go at risk in funding the CCG led-schemes as part of the plan. This means the commissioning team will work with all providers via the A&E delivery board to prioritise the schemes and support implementation.

The risks remain high in regards to workforce availability and timescales to fully implement the out of hospital schemes. The failure in not delivering the out of hospital schemes is a significant risk to the Trust as hospital occupancy levels will rise and the Trust may need to consider its full capacity protocols which include opening up of additional escalation areas which put strain and pressure on the Trust across all fronts.

3. NHSI/E/ Regulatory Meetings and Visits

The Trust has received notification that NHSE/I have removed Southport & Ormskirk from challenged provider status. The Southport and Ormskirk Improvement Board, chaired by the Regional Medical Director, will now be stepped down. The decision was taken in recognition of the improvements made in several of our performance indicators.

4. Reportable Issues Log

Issues occurring between 25/08/2020 to 28/09/2020

4.1 Serious Incidents and Never events

- No Never Events reported within the time scale
- One serious incident reported in relation to a patient fall

4.2 Level Four and Five Complaints

- Two level 4 complaints received:
- The themes were care, communication and discharge planning. These are currently being investigated.

4.3 Regulation 28 Reports

None to report.

5 Media Coverage

- NHS staff go the extra mile in charity walk (Champion newspapers, 24/9/20)
- Hospital staff nominated for national award for efforts during pandemic (Champion newspapers, 18/9/20)
- Lancashire hospitals discharged hundreds of patients with coronavirus back into care homes (Lancashire Live, 15/9/20)
- Nurses climb Snowdon to fund children's smiles (4/9/20)

6 Risk Register and Board Assurance Framework

The revised BAF forms part of this month's Trust Board agenda

Trish Armstrong-Child
Chief Executive
Date 23/09/20

Title of Meeting	BOARD OF DIRECTORS	Date	7 OCTOBER 2020
Agenda Item	TB149/20	FOI Exempt	No
Report Title	Board Assurance Framework (BAF)		
Executive Lead	Trish Armstrong-Child, Chief Executive		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance Simon Regan, Deputy Director of Quality, Risk and Assurance		
Action Required	✓ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

This report provides an update on the strategic risks as at the end of August 2020 that may impact on the achievement of the Trust's strategic objectives for 2020/21.

Executive Summary

The Board Assurance Framework (BAF) provides a structure and process which is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. Since the last meeting, the format of the BAF has been substantially reviewed and updated to provide greater clarity and easier tracking of the strategic risks. A review of the content of the BAF was conducted by each Executive Lead and actions have been identified where there is a gap in either Controls or Assurances.

This iteration of the BAF also proposes an increase to the current risk score for **SO2** which is predominantly associated with the:

- Impact of COVID-19 on operational performance and likely potential impact on patients who require treatment.
- Fragile services;
- The unresolved issue of the non-RTT tracker.

Target risks have been set for the end of the financial year and progress/movement in the current risk scores is expected during Q3/Q4.

Recommendations

The Trust Board is asked to:

- Confirm the risk scores along with the controls, assurances, gaps and actions for each strategic risk.
- Approve the increase in 'current' risk score for Risk ID 2 which is the risk associated with strategic objective 2 (SO2).
- Receive and approve the Board Assurance Framework.

Previously Considered By:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Simon Regan, Deputy Director of Quality, Risk and Assurance	Sharon Katema, Associate Director of Corporate Governance

1. INTRODUCTION

1.1. The Board Assurance Framework (BAF) provides a structured process which is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks that may impact on the delivery of the strategic objectives.

1.2. During the development and update of the BAF Executives have been through a process of identifying the main sources of risk balanced against the controls and assurances we have in place to enable discussion and scrutiny at Board level.

1.3. Assurance is fundamentally about arriving at informed conclusions through robust evidence. The most objective assurances are usually obtained from independent/external reviewers supported by internal sources such as self-assessment and management update reports and KPI monitoring.

2. BACKGROUND

2.1. Since the last update on the Board Assurance Framework (BAF) to Trust Board, there has been a substantial review which includes updating the format to provide greater clarity and easier tracking of progress against actions to improve the position against strategic risks.

2.2. The Deputy Director of Quality, Risk and Assurance has worked with each Executive Director to build on the previous version of the BAF and ensure a clear updated position as at the end of August 2020.

2.3. Updated versions of the BAF have been shared with the Finance, Performance and Investment Committee, Quality and Safety Committee, Workforce Committee and Hospital Management Board in September 2020.

2.4. An overview of the committees aligned to the strategic objectives and risks can be seen at Appendix A.

3. PROGRESS

3.1. At the end of August 2020, none of the strategic risks have seen any improvements in the current risk score. However, this is considered normal at this point in the financial year with the numbers of actions still to be taken before financial year end. In addition, COVID-19 has impacted progress and in some cases, increased the level of risk.

3.2. *Risk ID 2: If the Trust cannot achieve its key performance targets it may lead of loss of services*, relating to *Strategic Objective 2: Deliver services that meet NHS constitutional and regulatory standards* has seen an increase in the level of risk due to impact of Covid-19.

3.3. As a result, it is proposed that the current risk rating is accepted as 16, which is an increase in the likelihood (previous score of 12) since the last update to Trust Board.

3.4. Target risks have been set for the end of the financial year and progress/movement in the current risk scores is expected during Q3/Q4.

3.5. In addition to receiving the Board Assurance Framework, there is a process to review corporate and operational risks through Risk and Compliance Group and subsequently Board Committees.

3.6. The full Board Assurance Framework can be found at Appendix B.

4. RISK APPETITE

4.1. Risk appetite can be broadly defined as the amount of risk that an organisation is willing to take or the total amount of risk an organisation is willing to accept in order to meet its strategic objectives.

4.2. Risk exists in all environments, especially in Healthcare and the Trust recognises that its impossible to achieve its aims and objectives without taking risks.

4.3. The amount of risk that we are willing to accept will vary. This is captured in each of the strategic risks and may change as we move forward.

Appendix A – BAF Overview

Strategic Objective	Strategic Risk	Risk Appetite	Inherent Risk	Current Risk Score as at 31/08/2020	Target Risk Score	Lead Committee/ Group	Executive Lead	Direction of travel
SO1: Improve clinical outcomes and patient safety to ensure we deliver high quality services	**Risk ID 1**: If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety	**CAUTIOUS**	16	12	8	Quality and Safety Committee	DoN/MD	
SO2: Deliver services that meet NHS constitutional and regulatory standards	**Risk ID 2:** If the Trust cannot achieve its key performance targets it may lead of loss of services	**OPEN**	16	16 (Proposed)	8	Finance, Performance and Investment Committee	Dep CEO/COO	
SO3: Efficiently and productively provide care within agreed financial limits	**Risk ID 3:** If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.	**OPEN**	16	16	12	Finance, Performance and Investment Committee	DoF	
SO4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	**Risk ID 4:** If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience	**OPEN**	12	12	8	Workforce Committee	Dir of HR & OD	
SO5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	**Risk ID 5:**If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted	**OPEN**	12	12	8	Workforce Committee	Dir of HR & OD	
SO6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	**Risk ID 6:** There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services	**HUNGRY**	15	15	9	Hospital Management Board	CEO	

Risk Description: If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety

Strategic Objective 1: Improve clinical outcomes and patient safety to ensure we deliver high quality services	**Assurance Committee:** Quality & Safety Committee **Executive Lead:** Director of Nursing / Medical Director

RISK ID	**1**	**Risk Description**	**If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety**

Inherent Risk			**Risk as at 31/08/2020**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	4	**16**	3	4	**12**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Governance Structures. 2. Trust policies and procedures. 3. Quality strategy encompassing four priority areas: • Care of the deteriorating patient; • Care of Older People; • Infection Prevention and Control; • Medicines Management. 4. Risk Management Strategy. 5. Quality impact assessments (QIAs) for all service changes that are considered. 6. Single accountability framework for reviewing CBU areas for development/strengths. 7. Clinical audit programme /outcomes. 8. Application of clinical pathways and guidelines. 9. Programmes in place for clinical standards and professional practice. 10. Mortality and SJR Process. 11. Work plans for medical staff. 12. Clinical revalidation. 13. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle; • 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off	1. Lack of visibility of key quality performance indicators at all levels. 2. Fully established and agreed cycle of business for some governance meetings 3. Non-standardised Trust approach to quality improvement. 4. Clinical workforce strategy not fully developed. 5. Nursing, midwife, AHP and support staff recruitment and retention programme needs further development. 6. Further risk management training/support needed at speciality and CBU level.	**LEVEL 1** (Operational Management) 1. Quality and Safety Committee 2. Finance, Performance and Investment Committee. 3. Workforce Committee. 4. Health and Safety Committee 5. Risk and Compliance Group 6. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 7. CBU Governance Meetings 8. Harm free care panel 9. Serious Incident Review Group 10. Alert, Advise, Assure (AAA) reports 11. Patient feedback (FFT/Patient Surveys) 12. Clinical audit 13. Ward quality checks (via perfect ward app) **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): o Mortality metrics o Never events o Incident data o Serious Incidents o CQUINS o Performance data o Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. SONASS ward accreditation programme 7. VitalPac deterioration measures **LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits.	1. CQC 'Must and should do' actions not addressed in full. 2. Consistent reporting of key KPI's. 3. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests and audit. 4. Lack of consistent documentation review programme. 5. Inconsistent approach to health and safety/fire risk assessments/audits. 6. Medical examiners and medical examiner's office not fully established. 7. Patient Safety Specialist not yet in place. 8. Nurse establishment review not yet complete.	1. KPI dashboards for wards and CBUs to be reviewed, including visibility at key governance/committee meetings. **– By end October 2020.** 2. Cycle of business to be reviewed for Trust-wide and CBU governance meetings. **– By end of October 2020.** 3. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out **– By end March 2021** 4. Clinical workforce strategy to be completed **– by end of March 2021.** 5. Nursing, midwife, AHP and support staff recruitment and retention programme to be fully developed. – **By end of November 2020.** 6. Risk management training with senior leaders in the organisation **– By end of November 2020.** 7. Complete CQC Must and Should Do actions – **By end of Jan 2021.** 8. Review KPIs that goes to all governance meetings – **By end Mar 2021.** 9. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. **– By end of Jan 2021.** 10. Complete the full roll-out/reporting of Perfect Ward app measures **– by end of November 2020.** 11. Review health and safety/fire risk assessment/audit programme – **by end of December 2020.** 12. Complete appointments to medical examiners roles and fully establish programme to review all deaths **– by end of Feb 2021.** 13. Appoint patient safety specialist **– by end of November 2020.** 14. Nurse establishment review to be completed – **By end of October**

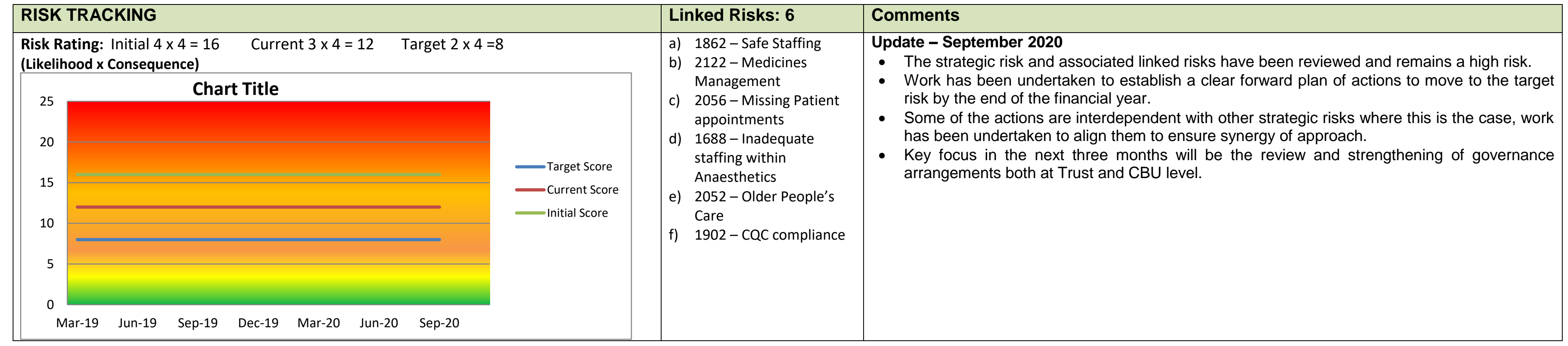
	meeting. 14. Training programme (mandatory and non-mandatory). 15. CQC action plan to address areas of underperformance highlighted on inspection. 16. Quality Visits/Senior Walkabouts including focus on Patient Safety 17. Supervision and education of clinical staff across all professions. 18. Application of Patient Safety and other safety alerts.		3. CQC inspection visits 4. CQC Insight Report 5. CQC Outlier Alerts 6. CQC engagement meetings 7. Healthwatch 8. National Audits 9. Peer Reviews and accreditation. 10. Getting it right first time (GIRFT) programme. 11. NHSI/E oversight meetings 12. Quarterly and Annual Guardian of Safe Working Report. 13. CCG monthly quality and performance meetings 14. Internal/External Audit 15. Quality Account		**2020 and every six months thereafter** 15. PIDA, agreed suite of measures in place. **- COMPLETE** 16. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. **- COMPLETE**

The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge

AMBITION: To improve clinical outcomes and patient safety to ensure we deliver high quality services

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	**The Trust is willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 6	Comments
Risk Rating: Initial 4 x 4 = 16 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	a) 1862 – Safe Staffing b) 2122 – Medicines Management c) 2056 – Missing Patient appointments d) 1688 – Inadequate staffing within Anaesthetics e) 2052 – Older People's Care f) 1902 – CQC compliance	**Update – September 2020** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • Work has been undertaken to establish a clear forward plan of actions to move to the target risk by the end of the financial year. • Some of the actions are interdependent with other strategic risks where this is the case, work has been undertaken to align them to ensure synergy of approach. • Key focus in the next three months will be the review and strengthening of governance arrangements both at Trust and CBU level.



TB149_20c - BAF SO2

Risk Description: If the Trust cannot achieve its key performance targets it may lead of loss of services

Strategic Objective 2: Deliver services that meet NHS constitutional and regulatory standards	**Assurance Committee:** Finance, Performance and Investment Committee **Executive Lead:** Chief Operating Officer

RISK ID	**2**	**Risk Description**	**If the Trust cannot achieve its key performance targets it may lead of loss of services**

Inherent Risk			**Risk as at 31/08/2020**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	4	**16**	4	4	**16**	2	4	**8**

Risks to objective

RISK
If the Trust cannot achieve its key performance targets it may lead of loss of services

CAUSE
Lack of clear vision for transformation and partnership working in fragile services; inability to recruit in certain medical specialities; year on year rise in demand for urgent and emergency care; capacity and demand; flow through the hospital; system discharge challenges; COVID-19 impact – causing delays in discharge, elective, diagnostic and cancer pathways.

CONSEQUENCE
Delays in the provision of care and treatment resulting in poor patient outcomes and standards of care; over-reliance on temporary workforce leading to increasing prevalence of fragile services; failure of national performance target (cancer, referral to treatment (RTT); failure to reduce delayed transfers of care; failure to deliver NHS constitutional targets; duplication of services with negative impact on CIP; impact on patient experience; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.

Controls

1. Shaping care together programme.
2. Southport and Ormskirk Improvement Board.
3. Southport and Ormskirk Admissions and Discharge Working Group.
4. North Mersey A&E Delivery Board.
5. Single accountability framework for reviewing CBU areas for development/strengths.
6. Part of C&M hospital cell group monitoring COVID-19 recovery and sharing capacity where possible.
7. Bronze, silver, gold command structure for oversight and decision making.
8. Weekly Senior Operational Leadership Team (SOLT) meetings
9. Agreed in-hospital winter plan 2020/21.
10. Directorate Manager role that is solely responsible for Access - providing greater strengthen in governance and compliance.
11. Quality impact assessments (QIAs) for all service changes that are considered.
12. Trust policies and procedures updated in line with SITREP requirements / guidance against the constitutional standards.

Gaps in Controls

1. The workforce of the Trust does not have the sufficient level of expertise to ensure QI methodology can be applied;
2. Non-standardised Trust approach to quality improvement.
3. Lack of agreed out of hospital (system) winter plan 2020/21.
4. Clinical workforce strategy not fully developed.
5. Partnership working not fully established in all fragile services.
6. Insufficient economies of scale to deal with social distancing / workforce impacts arising from COVID-19.
7. Further risk management training/support needed at speciality and CBU level - to develop an improved understanding in risk management / appetite to help support performance improvement and sustainability of clinical services.
8. Lack of capacity to validate the non-RTT tracker.

Sources of Assurances

LEVEL 1
(Operational Management)

1. Finance, Performance and Investment Committee.
2. Operational Performance & Improvement Group (OPIG) oversees work against the four operational priorities:
   - Theatre Utilisation;
   - Patient Flow improvements;
   - Operational productivity;
   - Cancer wait improvements.
3. Quality and Safety Committee
4. Workforce Committee.
5. Risk and Compliance Group.
6. Clinical Effectiveness committee;
7. Performance, Improvement, Delivery and Assurance (PIDA) Boards.
8. CBU Governance Meetings.

LEVEL 2
(Reports and Metrics monitored at assurance committees and/or Board)

1. Integrated Performance Report to Board and Q&S Committee (monthly):
   - Mortality metrics
   - Never events
   - Incident data
   - Serious Incidents
   - CQUINS
   - Performance data
   - Complaints and compliments
2. Quarterly report to FP&I on progress against each key constitutional standard to offer assurance in actions being taken to maintain and / or improve performance

LEVEL 3
(Independent/Semi-Independent)

1. NHSI Single Oversight framework and monitoring arrangements

Gaps in Assurance

1. Local IPRs for CBUs not fully established.
2. Not always delivering the 95% standard of all patients presenting to ED being seen, treated and discharged / transferred within 4 hours.
3. During COVID-19 outbreak the Trust has postponed all non-essential elective activity which has adversely impacted on waiting list and compliance against the diagnostic standard.
4. Not consistently delivering the national standard due to workforce challenges across a number of tumour groups in particular Haematology and Head & Neck services.
5. The Trust does not have a Head of Performance role that would offer the internal assurance that the Trust complies to SITREP guidance against constitutional standards.
6. Peer review boards not in place.

Mitigating Actions/Progress

1. Develop an Integrated Performance Report that allows the Trust to measure improvement and understand variation, taking on best practice set by regulatory bodies. - **COMPLETE**
2. Introduction of a Single Accountability Framework - **COMPLETE**
3. SOPs developed for validation processes that are signed off by the COO. - **COMPLETE**
4. Quality improvement strategy in process of being developed with internal engagement and external support. Strategy to be developed and rolled out **– By end March 2021**
5. Out of hospital winter plan **– to be complete by end of October 2020.**
6. Clinical workforce strategy to be completed **– by end of March 2021.**
7. Engage system partners and agree sustainability plans for fragile services **– by end of March 2021.**
8. Risk management training with senior leaders in the organisation **– To be complete by end of November 2020.**
9. Develop sustainable plan to address validation issues in relation to the non-RTT tracker. **– To be completed by end of December 2020.**
10. Develop local IPRs for CBUs **– COMPLETE – in place from end of July 2020.**
11. Recruitment for a Performance Manager post **– appointed and due to start in post in November 2020.**
12. Develop peer review boards **– to be completed by end of October 2020.**

	13. Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. 14. Clinical prioritisation. 15. Access policy for validation of all patients on waiting lists. 16. Use of additional locations to provide treatment where possible.		2. CQC 3. CCG monthly quality and performance meetings. 4. NHS benchmarking data. 5. Getting it right first time (GIRFT) programme. 6. Cancer alliance oversee delivery and performance regarding cancer metrics. 7. Internal Audit 8. External Audit.		

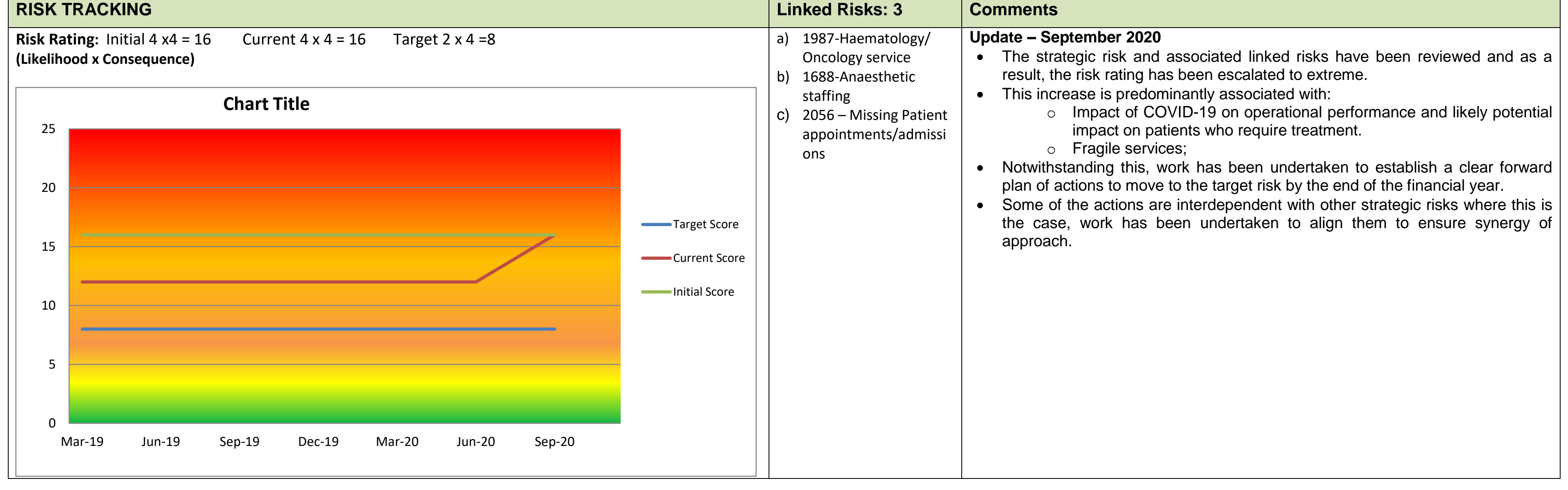
The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To give every person the best care every time and deliver our operational performance standard

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 3	Comments

Risk Rating: Initial 4 x4 = 16 Current 4 x 4 = 16 Target 2 x 4 =8
(Likelihood x Consequence)
	a) 1987-Haematology/ Oncology service
	b) 1688-Anaesthetic staffing
	c) 2056 – Missing Patient appointments/admissions
		Update – September 2020
		• The strategic risk and associated linked risks have been reviewed and as a result, the risk rating has been escalated to extreme.
		• This increase is predominantly associated with:
		  ○ Impact of COVID-19 on operational performance and likely potential impact on patients who require treatment.
		  ○ Fragile services;
		• Notwithstanding this, work has been undertaken to establish a clear forward plan of actions to move to the target risk by the end of the financial year.
		• Some of the actions are interdependent with other strategic risks where this is the case, work has been undertaken to align them to ensure synergy of approach.



Risk Description: If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.

Strategic Objective 3: Efficiently and productively provide care within agreed financial limits

Assurance Committee: Finance, Performance and Investment Committee
Executive Lead: Director of Finance

RISK ID	3	Risk Description	If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.

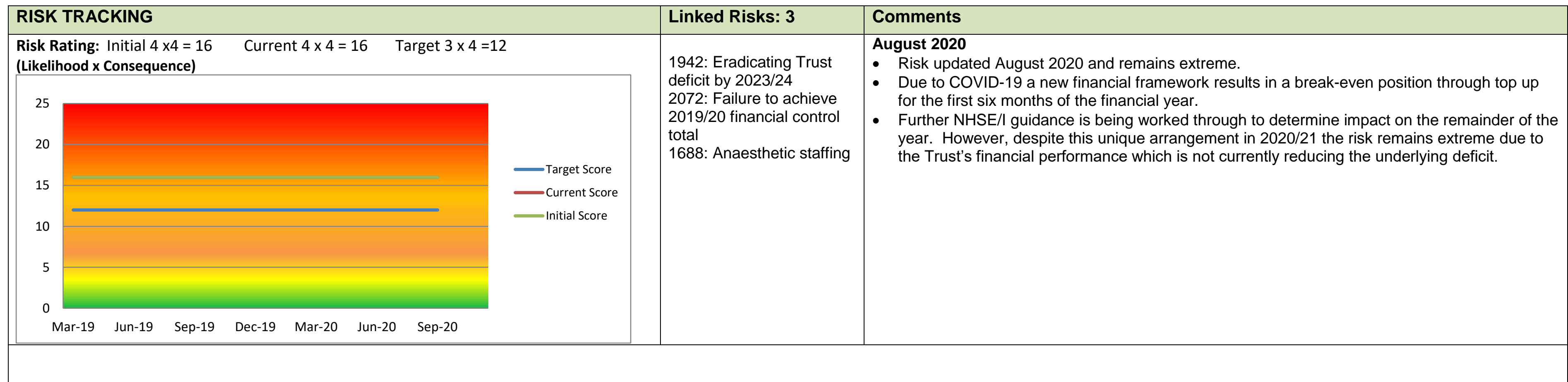
Inherent Risk			Risk as at 31/08/2020			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	3	4	12

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question. **CAUSE** Fluctuating income and activity; Inability to deliver the required levels of CIP; inability to control agency costs and premium payments to support fragile services; insufficient liquid cash to meet expenditure obligations on a monthly basis; capital cost estimations are higher than originally predicted. **CONSEQUENCE** Shortfall in funding (PSF/FRF); reductions in services or the level of service provision in some areas; potential loss in market share; regulatory intervention; lack of financial stability; missed opportunities to invest in services and new technologies; failure to deliver the capital programme.	1. Financial Systems and processes. 2. Scheme of Reservation and delegation 3. Standing financial instructions 4. Budget holder training. 5. Short term financial plan for the Trust. 6. Cheshire and Mersey Health Care Partnership (HCP) 5 year plan 7. Business Development and Investment Sub-Committee (BDISC) approves all business cases and reports to FP&I Committee. 8. Capital Investment Group 9. Strategy Task and Finish Group 10. Shaping care together programme 11. Health Trust Europe (HTE) Procurement Framework 12. Cheshire and Mersey Framework 13. National Agency Team Support 14. People Activity Group (PAG) 15. Cost improvement (CIP) programme. 16. Smart sheet software from PMO. 17. e-Rostering	1. Insufficient financial governance 2. Due to COVID-19 unable to accurately forecast the Trust's income. The temporary arrangements for 2020/21 will eventually come to an end but there is no clarity on the future of the Payment by Results (PbR) tariff. 3. Currently no financial recovery plan that delivers break-even/ services the underlying deficit. 4. Lack of three year medium term financial model, taking into account current position and savings from any reconfiguration in line with Sefton Transformation Board Strategy. 5. Use of resources action plan not developed. 6. 2020/21 CIP not commenced. 7. E-rostering system not fully utilised across the Trust.	**LEVEL 1** (Operational Management) 1. Finance, Performance and Investment Committee 2. Audit Committee 3. Hospital Management Board 4. Business Development and Investment Sub-Committee (BDISC) 5. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 6. Model Hospital Group 7. Trust Board 8. Detailed agency spend reviewed by Efficiency Programme Group (EPG) 9. Monthly CIP review meetings 10. Monthly cash flow forecast **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report (IPR) 2. Monthly financial position reports/CIP Reports to HMB, FP&I Committee and Board 3. Activity and performance reports **LEVEL 3** (Independent/Semi-Independent) 1. NHS England/Improvement 2. CQC 3. CCG 4. Internal Audit 5. External Audit 6. National Agency Team reports	1. Inability to monitor trajectory against financial recovery plan until developed. 2. Robust tracking of CIP programme. 3. High level forecasting is a manual driven process.	1. Implement robust financial governance framework **– by end of November 2020** 2. Develop realistic financial recovery plan in line with Shaping Care Together programme **– by end of January 2021** 3. Develop sustainability reporting mechanism in line with recovery plan – **by end of January 2021.** 4. Internal audit review of CIP programme **– by end of March 2021.** 5. Commence CIP programme **– by end of November 2020** 6. Develop Use of Resources action plan **– to be presented at board in October 2020.** 7. Complete actions identified in Use of Resources Action plan – **by end March 2021.** 8. E-rostering to be fully rolled out in all areas **– by end of March 2021.** 9. NHS Shared Business Services developing a new forecasting and budgeting tool **– to be tested by end March 2021 with aim to use in 21-22 financial year.**

	The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To provide care efficiently and productively, within agreed financial limits

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.**	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.



RISK TRACKING	Linked Risks: 3	Comments
Risk Rating: Initial 4 x4 = 16 Current 4 x 4 = 16 Target 3 x 4 =12 **(Likelihood x Consequence)**	1942: Eradicating Trust deficit by 2023/24 2072: Failure to achieve 2019/20 financial control total 1688: Anaesthetic staffing	**August 2020** • Risk updated August 2020 and remains extreme. • Due to COVID-19 a new financial framework results in a break-even position through top up for the first six months of the financial year. • Further NHSE/I guidance is being worked through to determine impact on the remainder of the year. However, despite this unique arrangement in 2020/21 the risk remains extreme due to the Trust's financial performance which is not currently reducing the underlying deficit.

Risk Description: If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience

Strategic Objective 4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	**Assurance Committee:** Workforce Committee **Executive Lead:** Director of HR and OD

RISK ID	**4**	**Risk Description**	**If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience**

Inherent Risk			**Risk as at 31/08/2020**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective

RISK
If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience

CAUSE
Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas.

CONSEQUENCE
Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of

Controls

1. Workforce and OD Strategy
2. Recruitment & Retention Strategy (Linked to Trust and NHSI Nursing Retention Programme).
3. Trust policies/procedures
4. Recruitment processes including Right to Work and DBS checks (as indicated).
5. Coaching Strategy
6. Overseas Recruitment Campaign for Nurses
7. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.
8. Job plans for medical staff.
9. Corporate staff induction
10. Training programme (mandatory and non-mandatory).
11. PDR process
12. Clinical revalidation.
13. E-Rostering
14. Ward/departments non-medical staffing position is controlled through:
    - 3 x daily at staffing huddle;
    - 7 day staffing matron in place for oversight and management;
    - Weekly staffing review and sign off;
    - Roster sign off meeting.
15. Communication and Engagement Strategy and Plan
16. People Activity Group (PAG)
17. The Big Brew staff

Gaps in Controls

1. Workforce and OD Strategy does not yet reflect NHS People Plan
2. Lack of a fully developed and scoped Clinical Workforce strategy.
3. Recruitment & Retention Strategy needs to be reviewed.
4. In need of earlier identification of junior doctor rota gaps and proactive block booking to address.
5. Possible delays in international recruitment due to host countries not releasing staff due to COVID-19 pandemic and isolation requirements.
6. E-rostering system not fully utilised across the Trust
7. Training Needs Analysis' (TNAs) are not all validated to individual area and assigned competencies for specialist subjects are in need of review.

Sources of Assurances

LEVEL 1
(Operational Management)

1. Workforce Committee
2. Workforce Improvement Group (OPIG) oversees work against the four operational priorities:
    - Job Planning
    - PDR's / Appraisals
    - Mandatory Training
3. Quality and Safety Committee
4. Clinical Effectiveness Committee
5. Finance, Performance and Investment Committee.
6. Risk and Compliance Group.
7. Clinical Effectiveness committee;
8. Performance, Improvement, Delivery and Assurance (PIDA) Boards.
9. CBU Governance Meetings.

LEVEL 2
(Reports and Metrics monitored at assurance committees and/or Board)

1. Integrated Performance Report to Board and Workforce Committee (monthly):
2. Mandatory training;
3. PDR completion;
4. Sickness rates.
5. Absence Data
6. Turnover Data
7. Vacancy Rate
8. Time to Hire monitoring and reporting.
9. Staff Survey & Quarterly Staff FFT/Survey
10. GMC Medical Staff survey – annual
11. Nursing temporary staffing fill rate/ NHSP contract performance

LEVEL 3
(Independent/Semi-Independent)

1. NHS England / Improvement
2. CQC

Gaps in Assurance

1. Sickness absence above target but improved
2. Low compliance rates for PDR completion
3. Time to hire is longer than 30 day target (however better than regional and national median)

Mitigating Actions/Progress

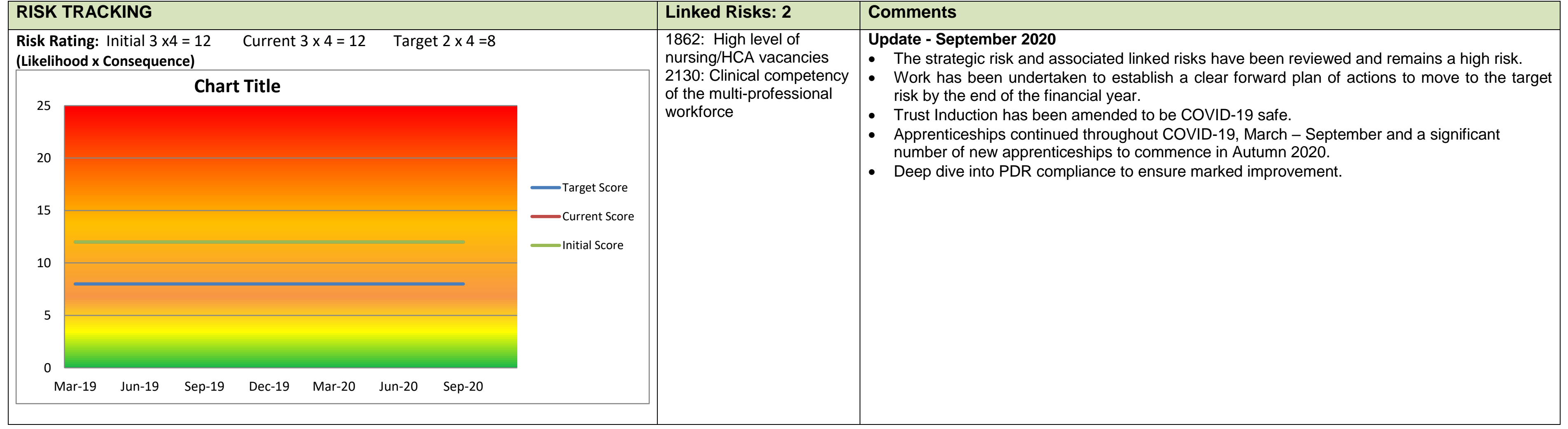
1. Workforce and OD strategy reviewed and rolled out **– by end of March 2021**
2. Clinical workforce strategy to be completed **– by end of March 2021.**
3. Review recruitment and retention strategy **– by end of Jan 2021.**
4. Early liaison with Lead Employer and progression to fill gaps by Trust at easiest opportunity – **review end March 2021**
5. Health and Wellbeing action plan in place, requires alignment to the NHS People Plan **- by end of March 2021**
6. Incorporate Lead Employer liaison into the recruitment team and establish a process to get early notification of shortages in the junior doctor rotation programme **– to be complete by end of December 2021**
7. Monitor guidance about travel and isolation for international recruitment of nurses **– COMPLETE and monitor ongoing.**
8. E-rostering to be fully rolled out in all areas **– by end of March 2021.**
9. Training Needs Analysis (TNA) and clinical competency deep dive underway led by the Director of Nursing, Midwifery and AHPs **– to be completed by end of March 2021.**
10. Monitor sickness levels through integrated performance report and respond where appropriate - **ONGOING**
11. Deep dive into PDR/Appraisal Process **– to be complete by end of December 2020**
12. PDR Action planning with CBU's **- trajectories to be agreed by end of October 2020**
13. Ongoing monitoring and review of time to hire process with month on

services.	engagement programme. 18. 'At our Best' Leadership development programme 19. Supporting attendance policy.		3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		month reduction being achieved. Identification of potential causes of delay. Reports to Workforce committee. **– to aim to achieve time to hire target by end of March 2021.**
The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Merseyside and Lancashire

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 2	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	1862: High level of nursing/HCA vacancies 2130: Clinical competency of the multi-professional workforce	**Update - September 2020** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • Work has been undertaken to establish a clear forward plan of actions to move to the target risk by the end of the financial year. • Trust Induction has been amended to be COVID-19 safe. • Apprenticeships continued throughout COVID-19, March – September and a significant number of new apprenticeships to commence in Autumn 2020. • Deep dive into PDR compliance to ensure marked improvement.



Risk Description: If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Strategic Objective 5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	**Assurance Committee:** Workforce Committee **Executive Lead:** Director of HR and OD

RISK ID	5	**Risk Description**	**If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted**

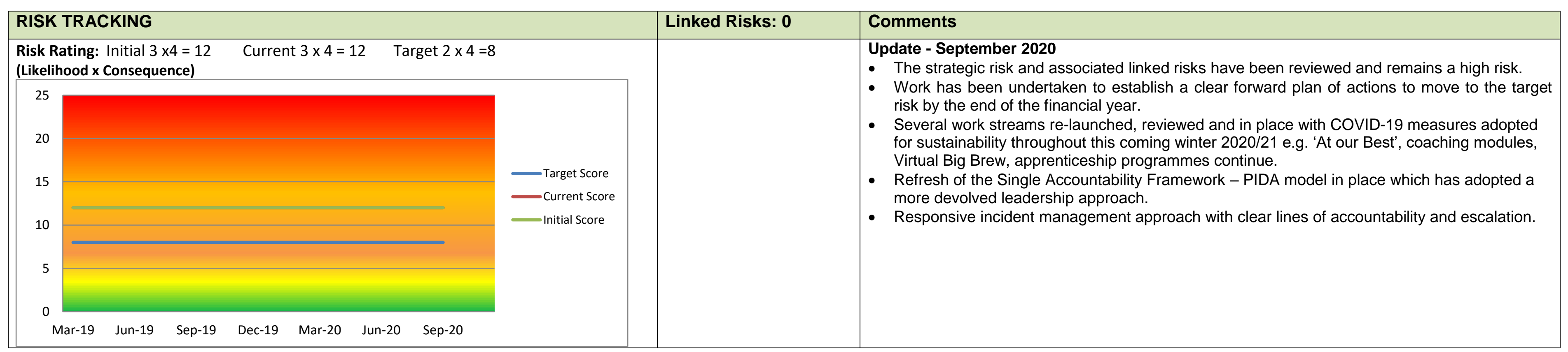
Inherent Risk			**Risk as at 31/08/2020**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours; leaders not always supported or developed; no clear definition of what talent management looks like at the Trust; board approved leadership and staff engagement strategies not owned across the organisation; equality and diversity not fully recognised and responded to; ineffective team working; less than optimal management practice in some areas; lack of clarity for staff on direction of travel for the organisation. **CONSEQUENCE** Negative impact on quality of patient care, experience and service provision; poor retention of staff; inability to recruit the right people; staff are not developed to be patient-centred leaders; high levels of sickness; low staff morale; potential of poor outcomes of regulatory assessments; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.	1. Workforce and OD Strategy 2. Underpinning strategies: o Leadership Strategy 2019-2021 o At our Best programme re-launched Sept 2020 o Coaching o Staff engagement 3. Recruitment & Retention Strategy (Linked to Trust and NHSI Nursing Retention Programme). 4. Trust Values & Behaviours Framework in development 5. 'At our Best' Leadership Development Programme 6. 'Being our Best' management development sessions 7. Trust policies/procedures 8. Value of our People Group 9. Single accountability framework to measure success of leaders and areas for improvement. 10. Equality Strategy 11. Equality, diversity and inclusion networks in place. 12. Processes for raising/investigating concerns 13. Freedom to speak up guardian 14. Joint negotiating committee (JNC) 15. Staff Engagement approach adopted – The Big Brew. 16. Bespoke team developments based on values & behaviours 17. Access to NHS	1. Workforce and OD Strategy does not yet reflect NHS People Plan. 2. Recruitment & Retention Strategy needs to be reviewed. 3. Re-launch of Trust Values and Behaviour Framework, delayed due to COVID-19. 4. Succession Planning – not fully in place. 5. Leadership and development activity paused due to COVID-19. In the interim, coaching modules have been launched across the Trust that are free for staff to access. 6. Medical leadership programme paused due to COVID-19. 7. Talent management - no capacity to deliver TM approaches with effective outcomes 8. Pause of Board Development sessions due to COVID-19. 9. Insufficient visibility of Executive Team and Non-Executive Directors due to limitation caused by COVID-19 and social distancing.	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (OPIG) oversees work against the two agreed priorities: • Appraisals • Values & Behaviours Framework 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Remunerations and Nominations Committee. 9. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 10. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): o Mandatory training; o PDR completion; o Sickness rates. 2. Turnover; 3. Vacancies; 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG	1. Staff Survey Engagement score not significantly improved in year and remains below national average in some areas. 2. Low compliance rates for PDR completion and need to ensure it meets the Trust's and individual's needs. 3. Need to understand and address relatively poor engagement with Equality, diversity and inclusion networks.	1. Workforce and OD strategy reviewed and rolled out **– by end of March 2021** 2. Review recruitment and retention strategy **– by end of Jan 2021.** 3. Launch new Staff Charter by end of November 2020 4. Trust Values and Behaviours Framework launch in line with new appraisal process **– by end of April 2021** 5. Review approach to succession planning for critical roles **– to be completed by April 2021** 6. Re-start leadership and development activity **– by end of October 2020** 7. Medical leadership programme to be restarted using funds from NHSI. **– to run from January to July 2021** 8. Re-start board development sessions **– by end of October 2020 and ongoing.** 9. Re-start back to the floor sessions – **by end of October 2020 (COVID-19 permitting).** 10. Re-start 15 steps board walkabout programme – **by end of October 2020 (COVID-19 permitting).** 11. Initiate reporting on staff survey as an assurance mechanism **– by end of October 2020.** 12. Develop and implement staff survey engagement plan to engage staff after the staff survey has been completed – **to be completed by end of November 2020.** 13. Deep dive into PDR/Appraisal Process **– to be complete by end of December 2020** 14. Review of E,D&I engagement with networks to agree an approach to increase engagement **– to be completed and presented at WIG by end of December 2020**

	Leadership academy Programmes & 360 feedback 18. Mandatory and role specific training programme in place 19. Appraisals – policy and process. Personal development review (PDR) and training form part of this. 20. Apprenticeship programmes leadership & management offer Levels 3-7 21. Apprenticeship Steering Group – bi-monthly 22. Board visibility through: o Back to the floor sessions; o 15 steps walkabouts in wards/departments 23. Board Development sessions planned throughout the year		4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		
The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Cheshire & Merseyside

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.**	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.



RISK TRACKING	Linked Risks: 0	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**		**Update - September 2020** • The strategic risk and associated linked risks have been reviewed and remains a high risk. • Work has been undertaken to establish a clear forward plan of actions to move to the target risk by the end of the financial year. • Several work streams re-launched, reviewed and in place with COVID-19 measures adopted for sustainability throughout this coming winter 2020/21 e.g. 'At our Best', coaching modules, Virtual Big Brew, apprenticeship programmes continue. • Refresh of the Single Accountability Framework – PIDA model in place which has adopted a more devolved leadership approach. • Responsive incident management approach with clear lines of accountability and escalation.

Risk Description: There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services

Strategic Objective 6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	**Assurance Committee:** Hospital Management Board and Trust Board **Executive Lead:** Chief Executive

RISK ID	6	**Risk Description**	**There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services**

Inherent Risk			**Risk as at 31/08/2020**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	5	**15**	3	5	**15**	3	3	**9**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services **CAUSE** Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire; lack of system-wide workforce planning to address the issues around qualified staff pipeline over the next 5 years and current speciality specific emerging workforce gaps; lack of Cheshire & Mersey Health & Care Partnership (CMHCP) wide acute provider partnership approach; challenges around working across two ICS/STP footprints; lack of clarity about additional capital funding support at CMHCP/NHSE/I level to enable emerging scenarios to address sustainability challenges; lack of public engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges. **CONSEQUENCE** Clinical unsustainability due to current and projected workforce gaps as well as	1. Robust system governance in place, including: o Southport, Formby & West Lancs Programme Board: Shaping Care Together o Shaping Care Together operational groups: Delivery Group and Communication & Engagement Group o Southport, Formby & West Clinical Leaders Group o Sefton Provider Alliance 2. Robust internal governance in place, including: o Hospital Improvement Board (HIB) - leading Vision 2020 and Single Improvement Plan 3. Southport and Ormskirk Improvement Board (SOIB) - leading Vision 2023 4. Documentation in place: o KPMG Case for Change o Sefton 2gether o West Lancs Building for the Future o Acute Sustainability Vision and Design Principles o Shaping Care Together roadmap, draft outline Pre-Consultation Business Case (PCBC) and core acute services paper. o Cheshire and Mersey sustainability and transformation	1. Clear alignment between Shaping Care Together programme and System Management Board. 2. Whole system engagement from health, social care, voluntary, community and faith sectors (VCFS) partners to be able to address whole system change to ensure appropriate and specialist care can be provided as locally as possible 3. Lack of established Patient & Public Reference Group.	**LEVEL 1** (Operational Management) 1. Trust Board 2. Hospital Management Board 3. Finance, Performance and Investment Committee. 4. Quality and Safety Committee 5. Workforce Committee 6. Risk and Compliance Group 7. Clinical Effectiveness Committee 8. Vision 2020 agreed at Board, updated version now in development 9. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 10. Ongoing review and management of 'fragile services'. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. CEO's reports to Board 2. Integrated Performance Report (IPR) to Board and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including: o Mortality o Incident data o CQUINS o Operational performance data o Complaints and compliments 3. Single Improvement Plan reports to Improvement Board 4. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group **LEVEL 3** (Independent/Semi-Independent) 1. Southport, Formby & West Lancashire Joint Committee	1. Finalised and agreed Shaping Care Together (SCT) programme plan for delivery 2. Patient and public engagement 3. Lack of system wide Equality, Health Inequality and Quality Assurance process. 4. Programme highlight report is not currently available to HMB.	1. Reporting of progress monthly internally to Trust Board via HMB, and externally to SOIB. **– COMPLETE and ongoing** 2. Establish reporting line into the newly set up CMHCP/NHSEI Oversight Group **- to be complete by end of October 2020.** 3. Develop, implement, embed and review Communication and Engagement Strategy and Plan with an effective patient and public forum. **– to be complete by end of October 2020.** 4. Production of an agreed SCT Programme Plan to include key milestones to enable public consultation **to be complete by end of October 2020.** 5. Southport, Formby & West Lancashire Clinical Strategy development aligned with organisational strategic directions and emerging solutions from the engagement work **to be complete by end of August 2021.** 6. Strategic Partnership criteria, principles and framework to be developed in line with engagement approach to ensure transparent and robust partnerships developments that may be required to address sustainability challenges **to be complete by end of December 2020.** 7. System wide Equality, Health Inequality and Quality Assurance process to be established **to be complete by end of December 2020.** 8. Programme highlight report to be monitored internally through Hospital Management Board (HMB) **– to be in place by end of October 2020.**

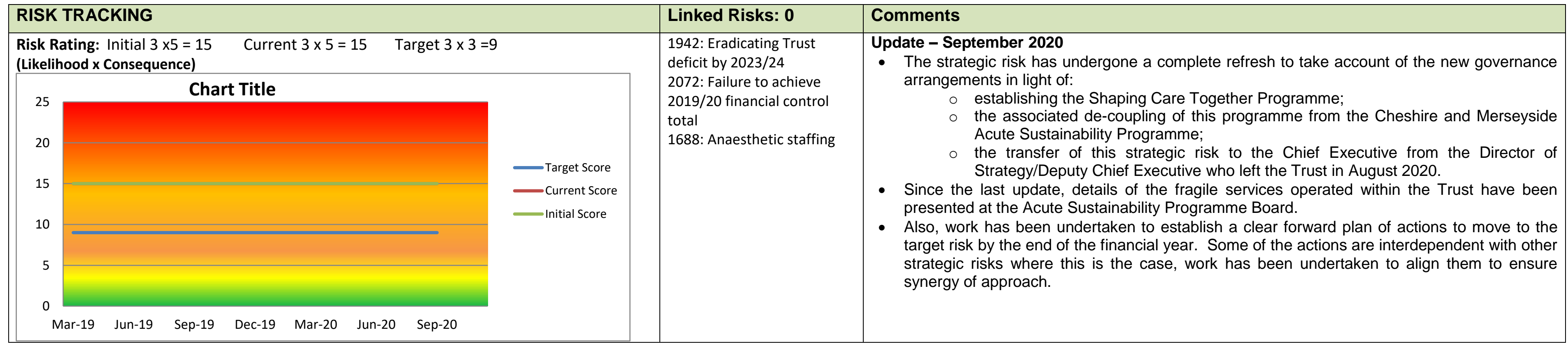
activity outweighing capacity; financial unsustainability due to costs significantly outweighing income; poor estate utilisation due to inability to fully reconfigure services; unsustainability of a standalone organisation to continue to deliver acute services for the population; potential impact on neighbouring organisations and services if core acute services can no longer be delivered by the Trust.	partnership (STP) plan. 5. Quality and equality impact assessments completed and reviewed before any changes to Trust service provision.		2. Southport & Ormskirk Improvement Board - meets monthly. 3. Cheshire & Mersey Health & Care Partnership (CMHCP): Strategic Oversight Group (reporting line) 4. Sefton Provider Alliance. 5. West Lancashire Multi-speciality community partnership (MCP). 6. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 7. NHS England / NHS Improvement 8. CQC 9. CCGs 10. Internal Audit 11. External Audit.		

The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To provide sustainable services for the patients we serve

Category	AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

RISK TRACKING	Linked Risks: 0	Comments
Risk Rating: Initial 3 x5 = 15 Current 3 x 5 = 15 Target 3 x 3 =9 **(Likelihood x Consequence)**	1942: Eradicating Trust deficit by 2023/24 2072: Failure to achieve 2019/20 financial control total 1688: Anaesthetic staffing	**Update – September 2020** • The strategic risk has undergone a complete refresh to take account of the new governance arrangements in light of: ○ establishing the Shaping Care Together Programme; ○ the associated de-coupling of this programme from the Cheshire and Merseyside Acute Sustainability Programme; ○ the transfer of this strategic risk to the Chief Executive from the Director of Strategy/Deputy Chief Executive who left the Trust in August 2020. • Since the last update, details of the fragile services operated within the Trust have been presented at the Acute Sustainability Programme Board. • Also, work has been undertaken to establish a clear forward plan of actions to move to the target risk by the end of the financial year. Some of the actions are interdependent with other strategic risks where this is the case, work has been undertaken to align them to ensure synergy of approach.



Title of Meeting	BOARD OF DIRECTORS	Date	7 October 2020
Agenda Item	TB150/20	FOI Exempt	No
Report Title	**Corporate Risk Register**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Mandy Power, Assistant Director of Integrated Governance		
Action Required	✓ To Approve ✓ To Assure	☐ To Note ☐ To Receive	

Purpose

To provide an update on the current extreme risks to the organisation.

Executive Summary

There is currently one extreme risk on the risk register: **2230 Fragile Services**

An update on the progress against this risk is shown below.

The **preliminary phase** has been completed; this includes scoping of the strategic risk, assessment of the services included and establishment of the process for the management and mitigation of this risk. The process that has been proposed is the completion of a Boston matrix, assessing all trust services against a number of criteria including:

- PLICs data contribution to overheads
- Growing / declining market
- Strategic Importance
- Workforce constraints

Phase two – diagnostic and investigation phase is now in progress, this is being co-ordinated via the PMO, with technical / CBU input. The sources of data for this diagnostic will include IPR, PLICS, Model Hospital and GIRFT.

- Workshop sessions were held in early September with each CBU, attendees included clinical and operational staff and HR/BI/Finance Business Partners
  - The outputs from each workshop where summarised by the AD Strategy and Improvement for CBU validation and presentation at the September PIDA meetings
  - These outputs included key CBU themes, CBU specific issues and an initial classification of services for each CBU.
  - Once these outputs have been validated by CBUs and shared with PIDA it is expected that a full report will be written outlining the next steps as we move into the review and consideration phase.

Phase three – review and consideration phase

- It is expected that the outputs of this process will systemically assess the Trust services whilst using divergent thinking to propose solutions / mitigations for both specific services and the strategic trust.
- Solutions are expected to include potential partnership opportunities / internal redesign for services that are strategically important and the consideration of exiting any services in a planned manner.

Recommendations

The Board is asked to receive the risk register.

Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	✓ **Quality & Safety Committee** ☐ **Workforce Committee** ☐ **Audit Committee**

Strategic Objectives
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
✓ **SO3** Efficiently and productively provide care within agreed financial limits
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Katharine Martin, Senior Information Analyst	Bridget Lees, Director of Nursing, Midwifery and Therapies

Board/Sub-Board Committee: Trust Board Risk Register

Strategic Objective	SO1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services SO2 - Deliver services that meet NHS constitutional and regulatory standards SO6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	Link to BAF	

Opened	ID	ADO/Exec Lead	Risk Lead	Title
21/05/2020	2230	Chief Operating Officer	Donna Lynch	Fragile Services

Description	There is a risk that the trusts clinical services become increasingly difficult to deliver (fragile) and that clinical outcomes are compromised due to unwarranted variation, fragmentation of services and sub-scale specialties. In this case the definition of Fragile is those clinical services provided by S&OHT which are a cause for concern due to workforce shortfalls or excessive financial cost; and are in danger of not being able to be sustained (time period to be quantified by clinical service. The main clinical services that meet this definition are Haematology, Pain, Dermatology, Older People Services (Geriatricians), Anaesthetics, Radiology, General Medicine, Head & Neck, Stroke, Community Paediatrics, Dietetic services, Ophthalmology and Acute Medicine

Controls	Diagnostic phase for all Trust services underway and presented at PIDA The Trust has formally declared at Trust Board ongoing challenges in delivering safe and consistent clinical services mainly are attributed due to workforce pressures. This has triggered formal acknowledgement and dialogue with NHS England and other NHS providers to determine & consider next steps. This is progressing with System Management Group to review pathways to minimise risk. Closure of referrals Haematology, Pain, Dermatology – minimise impact to patients An over reliance in using temporary workforce solutions (i.e. agency and outsourcing) across the 14 fragile clinical services which is adversely affecting the expenditure bill of the Trust and more importantly increases the variation in clinical practice; and therefore risk in delivery of efficient, responsive and effective services. The introduction of the System Management Board / Group for Southport & Formby and West Lancashire to determine any possible system transformation between secondary and primary care to look at alternative models of care that support improving resilience and accessibility of clinical for the local population. Introduced targeted recruitment campaigns to support strategies to influence the market forces including targeted work in specific areas. Formal discussions have commenced for short term support Formal discussions have commenced for strategic support - exec to exec for Haematology and Cardiology Fragile Services review has commenced - CBU sessions took place in September with the outputs presented at PIDA NED involved in the methodology for FS review commenced - paper sent for comments - follow up discussions at September FP&I	**Gaps in Controls**	As continue through the different phases of Covi-19 the Trust will continue to experience staffing issues which will continue to impact Trust fragile services. The Trust needs agreement on the formal links with other NHS providers to commence robust clinical dialogue in achieving sustainable models for the local population. At this moment without this direction the Trust is working through ad-hoc arrangements with multiple NHS providers without any clear MOU and / or mandate. This makes engagement at all levels challenging. The COO has initiated a System Management Group with CCG leads to review local solutions against a number of the fragile services. The conversations are positive however the main risk here is that those services defined as fragile at the Trust are indeed that service lines that other local NHS providers are also experiencing some difficulties with.

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	09/09/2020	07/10/2020

Assurance	Each of the 14 clinical services has individual risk assessments (including mitigating actions) that are monitored at each CBUs Governance meetings and escalated through to the Risk & Compliance Group. The risk assessments are also reviewed at the CBU PIDA Boards which oversees the Trust Single Accountability Framework which ensures those mitigation actions are progressing and supported. The Trust is actively engaging formal support from NHS England – the solution to acute sustainability is being managed through the Shaping Care Together programme. The Trust is actively in dialogue with other local NHS providers and CCG to review mutual aid and alternative models of care between current secondary and primary care providers across the local health economy	**Gaps in Assurance**	Many of the fragile services are indeed related to workforce pressures which are national issues however compounded greatly at the Trust due to size and workforce numbers.

	NEDs involved in CBU planning process Outputs of diagnostic will, where relevant, link into the SMG QIPP schemes where alternative service provision is being developed to include mutual aid / regional service provision / formal partnership arrangements				
Action Plan	To develop a consolidated action plan for all Fragile Services. Delivery against the action plans identified through the SMG QIPP Programme; Dermatology, Ophthalmology, Haematology and Cardiology	**Action Plan Due Date**	30/09/2020 30/09/2020	**Action Plan Rating**	Moderate Progress Made Moderate Progress Made

Title Of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 October 2020**
Agenda Item	**TB151/20**	**FOI Exempt**	**No**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	EXECUTIVE MANAGEMENT TEAM (EMT)		
Lead Officer	Michael Lightfoot, Head of Information		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update on the Trust's performance against key national and local priorities.

Executive Summary

The performance report includes the Trust indicators relating to the NHS Constitutional standards, the 19/20 SOF and internal performance indicators, which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework. Each indicator has a Statistical Process Control (SPC) chart and commentary. Whilst this executive summary provides an overall view of the organisational improvements and risks, some indicators are also included as improvement measures for the four QI priorities and are covered in detail in the relevant reports.

The Executive summary highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work.

Recommendation

The Board is asked to receive the Integrated Performance Report detailing Trust performance in August.

Previously Considered By:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	**Presented By:**
Michael Lightfoot	Executive Management Team

Indicator Name	August 2019	July 2020	August 2020	Trend
Overall Trust A&E attendances	10,396	8,251	8,861	
SDGH A&E Attendances	5,169	4,407	4,634	
ODGH A&E Attendances	1,955	1,211	1,333	
SDGH Full Admissions Actual	1,242	1,306	1,233	
Stranded Patients AVG	165	135	144	
Super Stranded Patients AVG	64	43	44	
MOFD Avg Patients Per Day	65	42	36	
DTOC Unconfirmed Avg Per Day	6	-	-	
GP Referrals (*Exc. 2WW*)	2,267	1,135	818	
2 Week Wait Referrals	741	890	732	
Elective Admissions	162	96	121	
Elective Patients Avg. Per Day	5	3	4	

Indicator Name	August 2019	July 2020	August 2020	Trend
Elective Cancellations	22	20	25	▼
Day case Admissions	1,941	1,114	1,111	▼
Day Case Patients Avg. Per Day	63	36	36	▼
Day Case Cancellations	40	16	10	▼
Total Cancellations (EL & Day Case)	62	36	61	▼
Total Cancellations (On or after day of admission, non clinical reasons)	2	4	3	▼
Outpatients Seen	21,165	19,387	17,183	▼
Outpatients Avg. Per Day	683	625	554	▼
Outpatients Cancellations	4,546	5,025	4,088	▲
Theatre Cases	620	350	359	▼
General & Acute Beds Avg. Per Day	365	444	445	▲
Escalation Beds Avg. Per Day	2	0	0	▼
In Hospital Deaths	52	54	59	▼

Trust Board - Integrated Performance Report

Head of Information Summary

There are 88 indicators in the Board IPR. 18 of these are failing to provide assurance, 2 are fully assured and the majority (68) are neither fully assured nor are consistently failing, so are unstable.

Of those which are failing to provide assurance the Board should pay particular attention to those which are also showing negative variation as not only are these failing they are also deteriorating. These are;

- % Deaths screened
- ODGH Theatre utilisation
- Personal Development Reviews
- Vacancy rate – Medical
- ODGH Bed Occupancy
- Expenditure on bank/ agency staff
- Staff turnover (rolling)
- Sickness (12 month)

There are also a number of indicators which are not assured and are showing no significant recent variation, so these need corrective action in order to improve. These are;

- Induction rate
- % Agency staff (Cost)
- Sickness – Nursing
- Theatre utilisation SDGH
- Vacancy Rate – Nursing
- Sickness – Non Clinical

It is also important to highlight to the Board those indicators which are not assured but are showing significant recent positive variation, which, if continues will move them from the 'failing' assurance flag to intermittent compliance. These are;

- A&E 4 hour compliance
- TIA
- Ambulance handovers 30-60 minutes
- Distance from agency spend cap

There are two indicators which are assured in their performance – Timely Identification of Sepsis and the A&E conversion rate. However, it should be noted that the A&E conversion rate is showing negative variation in recent months so this may change if current trend continues.

More than three quarters of indicators (77%) are intermittent in their assurance measure, which means that 'this indicator is inconsistently passing and falling short of the target.' In order to reach the assurance goal these indicators need to demonstrate the ability to consistently meet their target over a period of time. The first step to achieving this is to show positive variation in the most recent time period and the Board should be advised to acknowledge that of these 68 indicators, 22 (32%) are showing recent positive variation, with all key areas included;

- Quality – 7
- Finance – 4
- Operations – 10
- Workforce - 1

There are 14 indicators in this section which are showing recent negative variation, several of these are related to the RTT waiting list and are expected to continue in this trend until the end of the current financial year. The other will require corrective action to prevent them from establishing a 'failing' assurance measure in future reports.

Integrated Performance Report

Board Report

August 2020

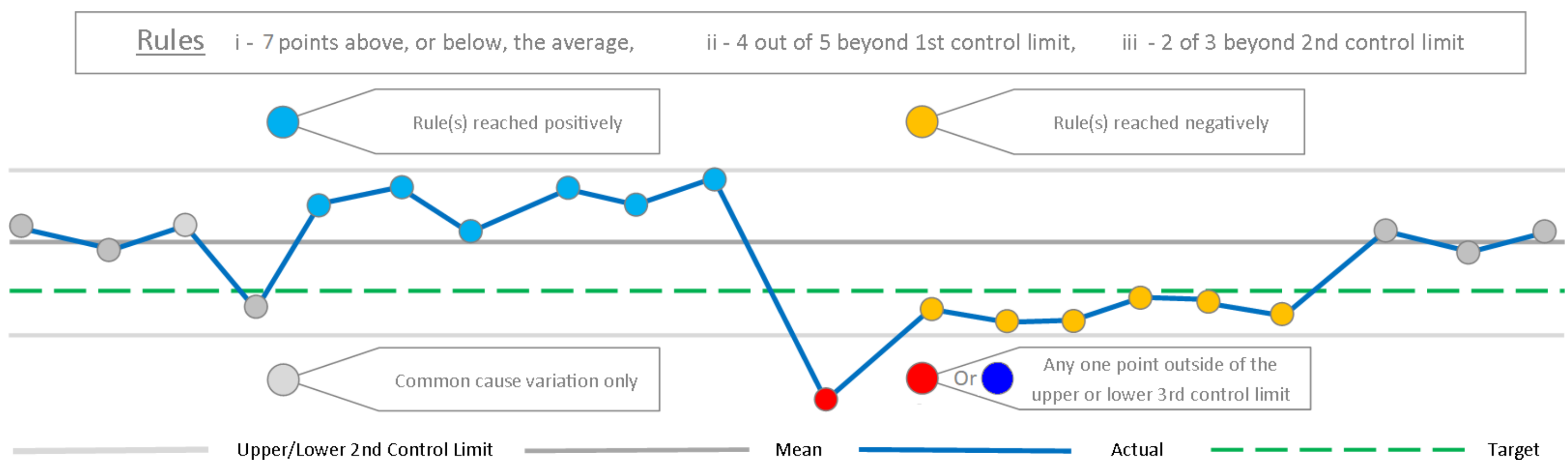
Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **http://www.improvement.nhs.uk/resources/making-data-count**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre reference line (**dark grey**) is the mean, and the two light grey lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.



Executive Summary

		Assurance			Variation				
		F	P	?	H (orange)	L (orange)	H (blue)	L (blue)	No variation
Quality	Harm Free	0	1	12	0	2	2	1	8
	Infection Prevention and Control	0	0	4	0	0	0	0	4
	Maternity	1	0	7	0	0	0	2	6
	Mortality	1	0	2	0	1	0	1	1
	Patient Experience	0	0	10	0	1	2	1	6
Operations	Access	3	0	10	4	1	2	4	2
	Cancer	0	0	3	0	0	1	0	2
	Productivity	3	1	6	1	2	0	6	1
Finance	Finance	2	0	8	1	1	3	2	3
Workforce	Agency	1	0	0	1	0	0	0	0
	Organisational Development	1	0	1	0	1	0	0	1
	Sickness, Vacancy and Turnover	6	0	5	3	0	0	1	7

Assurance	
Measures the likelihood of targets being met for this indicator.	
?	Indicates that this indicator is inconsistently passing and falling short of the target.
F	Indicates that this indicator is consistently passing the target.
	consistently falling short of the target.

Variation (Past 3 Months)	
Whether SPC rules have been triggered positively or negatively overall for the past 3 months.	
(grey)	Indicates that there is no significant variation recently for this indicator.
L H (blue)	Indicates that there is positive variation recently for this indicator.
L H (orange)	Indicates that there is negative variation recently for this indicator.

Page **3** of **3**

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY AND SAFETY COMMITTEE (Q&S)**
MEETING DATE:	**28 SEPTEMBER 2020**
LEAD:	**DR DAVID BRICKNELL**

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The risk of harm to patients because of the absence of follow-up over a number of years requires a sustained effort to both review the backlog and to set up a robust programme for the future.
- The Trust's measures to cope with this year's exacerbated winter pressures relies on significant actions by the System, which are yet to be ratified or funded.
- Intended closure of Ophthalmology to new referrals for 3 months leaves us with the capacity to deal with the backlog and contribute to System solutions for this fragile service.

ADVISE

- Some topics within mandatory training are challenging to bring up to the compliance targets, but are subject to detailed review and specific, tailored solutions.
- Over the last 12 months, there have been a significant number of formal (section 42) complaints alleging unsafe discharge, specifically increase since COVID. A detailed review will report in October.
- The level of Hospital Acquired Pressure Ulcers (HAPU) reported are consistent. The Committee agreed there is opportunities to reduce and a concerted programme of action is being implemented to address this key indicator of safe care.
- The backlog of actions arising from STEIS reviews is being addressed.

ASSURE

- Gases policy and training require formal approvals, but the practical issues have been addressed.
- The extensive programme to address the issue of Fragile Services is proceeding at pace to mitigate this extreme risk.
- The Insight Report from CQC is being used to guide action to be taken by the Trust in addition to the CQC required actions, which will improve our responsiveness to key issues.
- The issues raised by the MIAA report on key indicators have been explored and the follow up review by MIAA will be carried out shortly.
- The Trust was one of the leading implementer of the flu jab last year and plans are in place to repeat the success.
- The SONASS scheme of internal peer review of standards has now produced two Gold Awards, and a continued enthusiasm for teams to be reviewed.

New Risk identified at the meeting	• No new risks were identified at the meeting.
Review of the Risk Register	

Quality

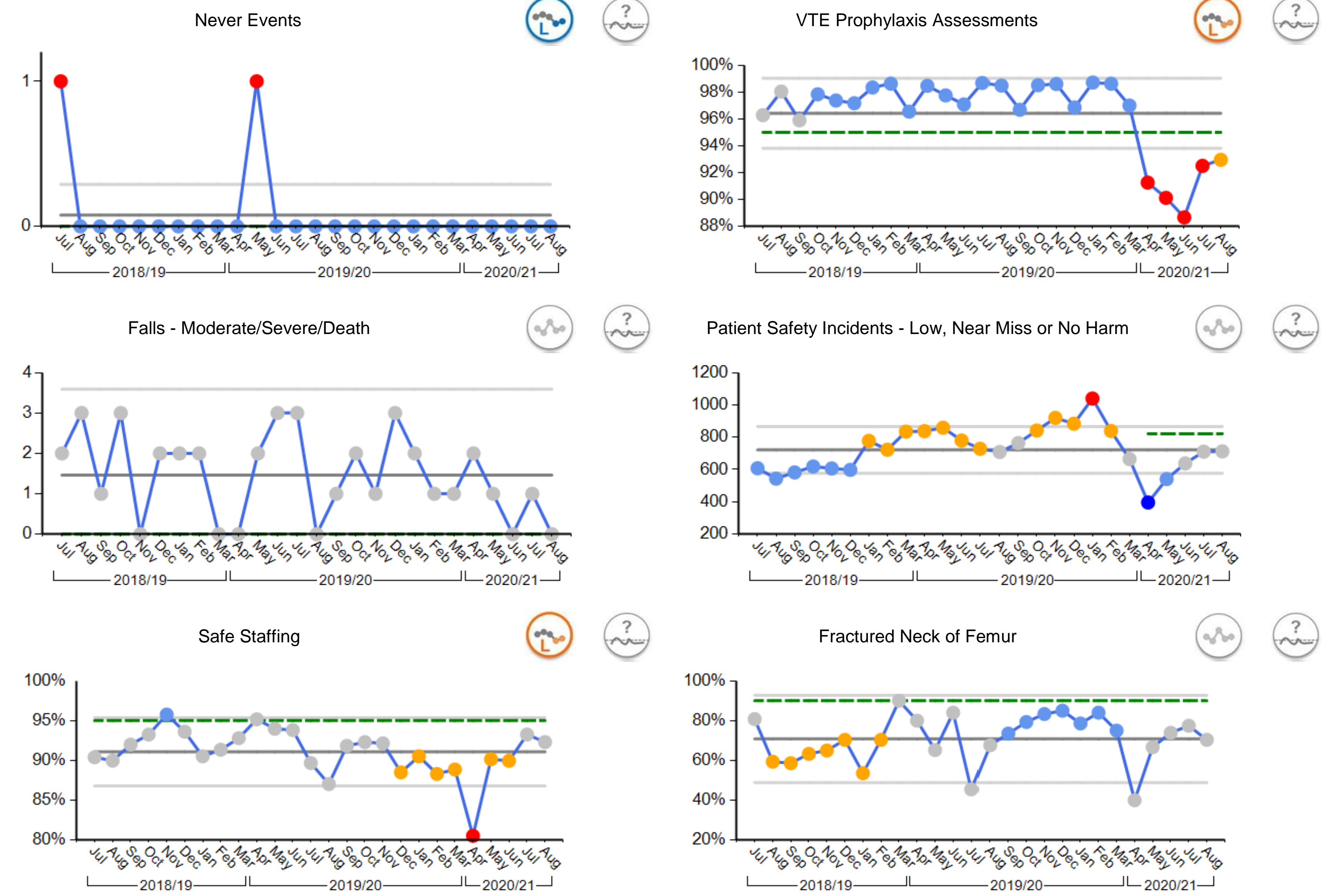
Harm Free

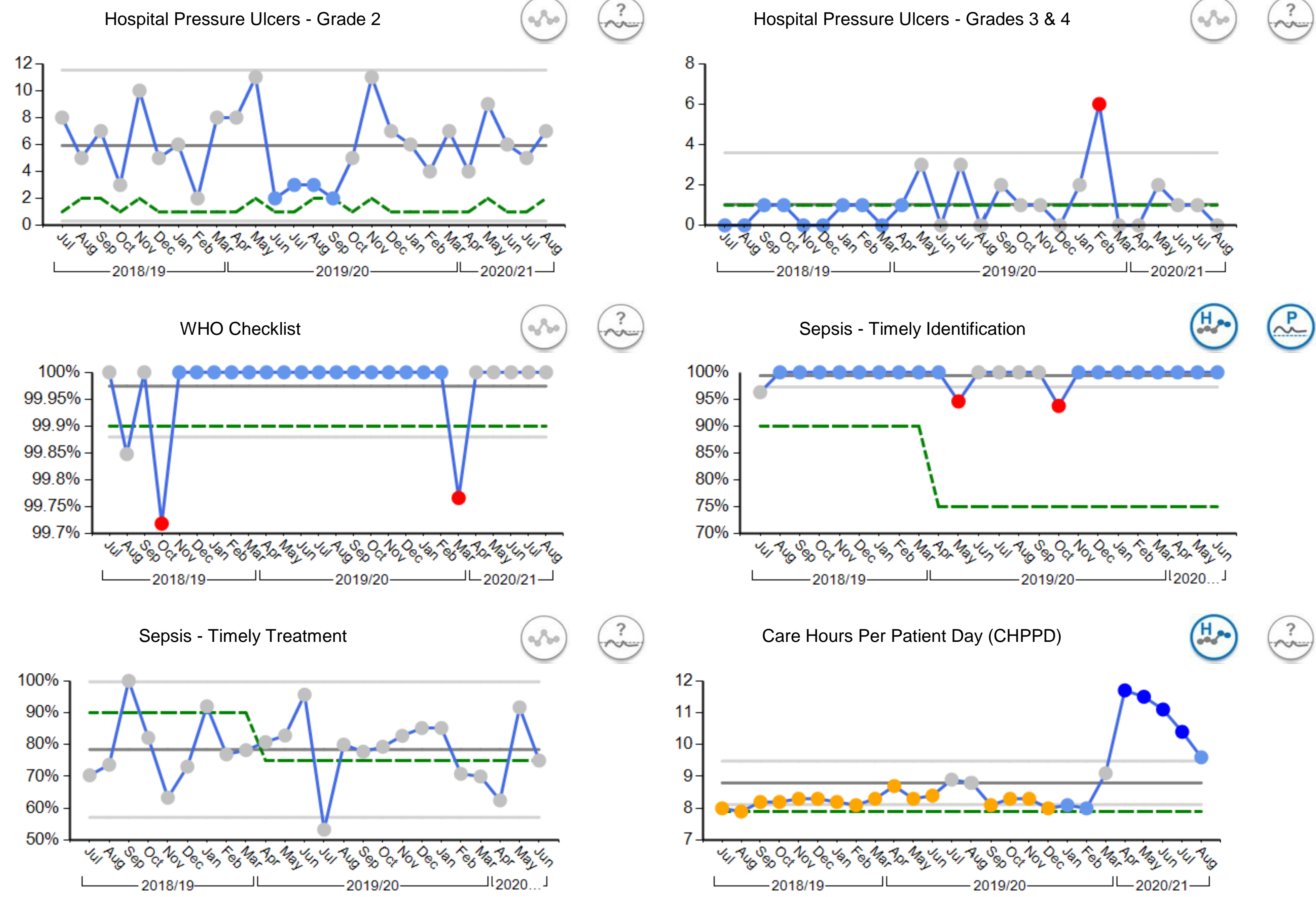
Analyst Narrative: Of the 12 indicators in this section 1 is assured (Sepsis - Timely Identification). It is also positive to note than none are completely failing to provide assurance. Recent performance for VTE and Safe Staffing is statistically significant enough to flag it as having recent negative variation; however, there are 3 indicators with recent positive variation - Never Events, Sepsis - Timely Identification and CHPPD.

Operational Narrative:

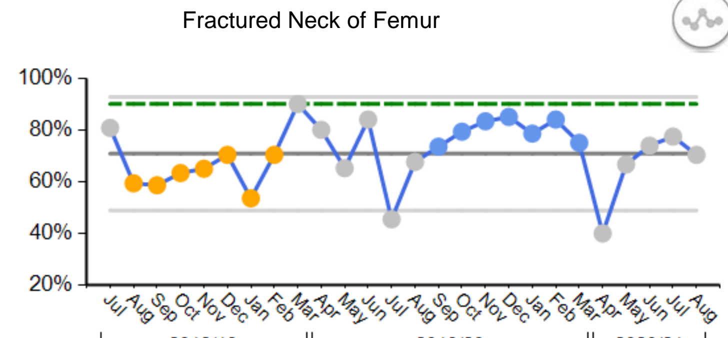
- **Never Events** - No never events recorded in month
- **Steis** - Five reported in month, Pressure Ulcer- 1 grade 3 pressure ulcer which had been reported in July but delays in review had meant this was not reviewed and reported until August. - Lapses in care identified. Sub optimal care - related to an invasive procedure; Accident – resulted in deterioration; 2 Diagnostic incidents reported - delay in follow up.
- **VTE Prophylaxis Assessments** – 1 patient was identified that had not had VTE prophylaxis assessment in July; the department remains above target for the month at 99.5% and is achieving 98.2 % YTD against a target of 95%. This target has been either achieved or surpassed since December 2019 and has seen only 1 month below target in the last 16 months.
- **Safe Staffing** - The target % for safer staffing has not been achieved in month or year to date, the in-month % is 83.1% with a YTD figure of 85.4%, this is a drop in performance from last month. Some issues are related to Midwives returning to work under risk assessments due to shielding, risks and pregnancy, but in the main Paediatrics and NNU. As stated last month these areas appeared to have low fill rates. This is because staff are moved to cover the areas due to low activity therefore there has been no need to cover vacant shifts. Also with the closure of A&E at night there have been some alterations to the rosters to change the shifts. The Matron is now removing unused shifts which will better reflect the fill rate.
- **Pressure Ulcers Grade 3 /4** - No pressure ulcers category 3/ 4 reported in month.
- **Pressure Ulcers Category 2** - There were 5 category 2 pressure ulcers reported in month (3 urgent care, 1 planned care and 1 Specialist Services. All cases have been reviewed and 4 out of the 5 showed there were lapses in care.
- **Moderate Harm incidents.** There were five reported moderate harm incidents: Infection Prevention Control (E coli), Two women and children's incidents relating to complications during a procedure - themed review taking place in the Business unit. Sub optimal care - related to an invasive procedure (also reported above in STEIS section). Access - delay in access to treatment
- **Incident Reporting** - Incident reporting remains under expected limits but has increased month on month since the drop we experienced in incident reporting during the COVID pandemic. We continue to encourage staff to report incidents across the Trust.

Indicator	Latest					Previous			Year to Date		
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Never Events	0	0	0	Aug 20		0	0	Jul 20	0	0	
VTE Prophylaxis Assessments	95%	93%	233	Aug 20		95%	92.5%	Jul 20	95%	91.2%	
Falls - Moderate/Severe/Death	0	0	0	Aug 20		0	1	Jul 20	0	4	
Patient Safety Incidents - Low, Near Miss or No Harm	822	713	713	Aug 20		822	711	Jul 20	822	2999	
Safe Staffing	95%	92.3%	N/A	Aug 20		95%	93.3%	Jul 20	95%	89.2%	
Fractured Neck of Femur	90%	70.4%	19	Aug 20		90%	77.4%	Jul 20	90%	67.2%	
Hospital Pressure Ulcers - Grade 2	2	7	N/A	Aug 20		1	5	Jul 20	18	31	
Hospital Pressure Ulcers - Grades 3 & 4	1	0	0	Aug 20		1	1	Jul 20	1	4	
WHO Checklist	99.9%	100%	0	Aug 20		99.9%	100%	Jul 20	99.9%	100%	
Sepsis - Timely Identification	75%	100%	N/A	Jun 20		75%	100%	May 20	75%	100%	
Sepsis - Timely Treatment	75%	75%	N/A	Jun 20		75%	91.7%	May 20	75%	77.8%	
Care Hours Per Patient Day (CHPPD)	7.9	9.6	N/A	Aug 20		7.9	10.4	Jul 20	7.9	10.9	


Never Events
1
0
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
VTE Prophylaxis Assessments
100%
98%
96%
94%
92%
90%
88%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Falls - Moderate/Severe/Death
4
3
2
1
0
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Patient Safety Incidents - Low, Near Miss or No Harm
1200
1000
800
600
400
200
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Safe Staffing
100%
95%
90%
85%
80%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Fractured Neck of Femur
100%
80%
60%
40%
20%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21



Hospital Pressure Ulcers - Grade 2
Hospital Pressure Ulcers - Grades 3 & 4
WHO Checklist
Sepsis - Timely Identification
Sepsis - Timely Treatment
Care Hours Per Patient Day (CHPPD)
2018/19
2019/20
2020/21


Fractured Neck of Femur
100%
80%
60%
40%
20%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
2018/19
2019/20
2020/21

Quality

Infection Prevention and Control

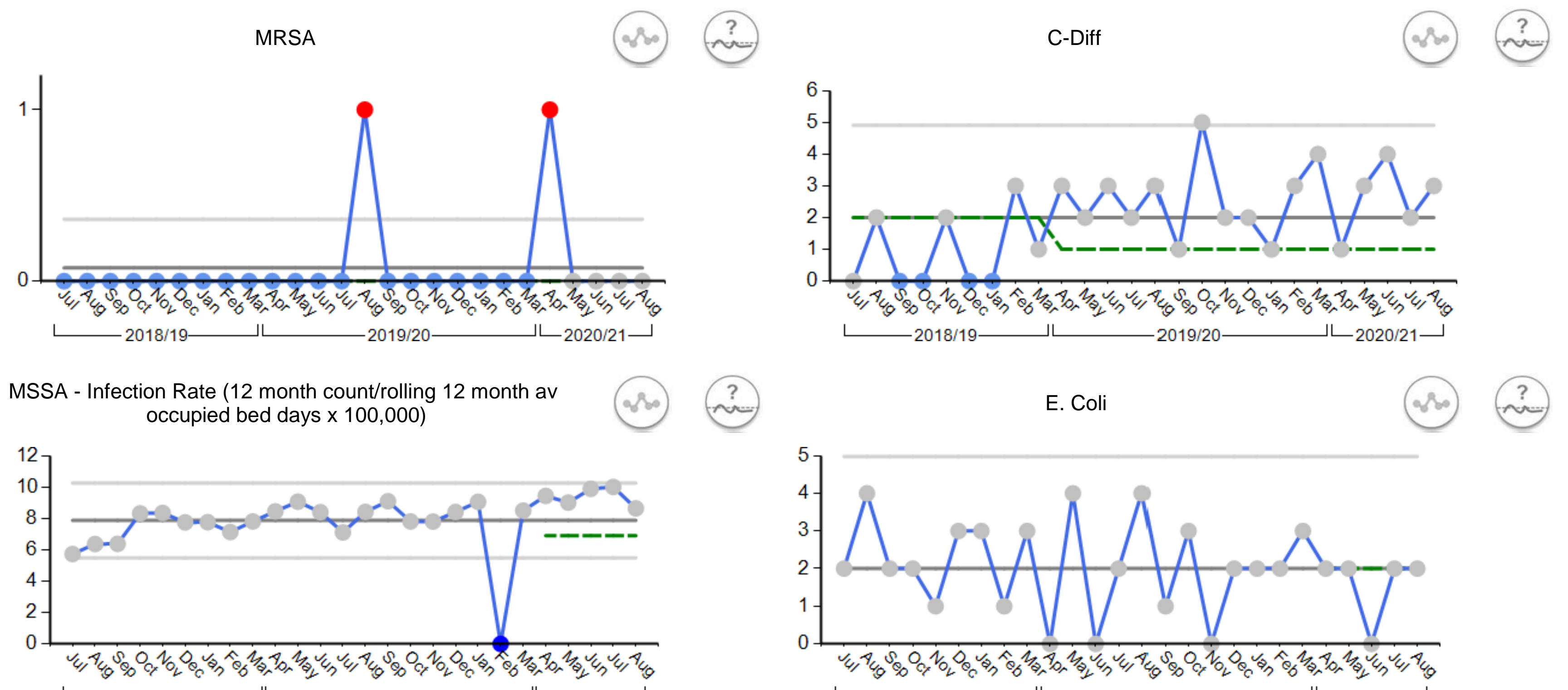
Analyst Narrative: All the IPC indicators are showing intermittent assurance - so neither consistently assured or failing. Recent performance is also not showing any significant positive or negative variation.
3 C diff cases in August, two of these cases HOHA and one case COHA .
The COHA case had been an in-patient on ward 11B prior to being discharged home and being tested by their GP within 28 days of discharge – there were no apparent lapses in care. The other 2 HOHA cases had both been in-patients on SSU; typing has been requested on these specimens, there were no apparent lapses in care on one of these cases and the 2nd case is scheduled for an RCA meeting to identify any lapses.
The C diff year to date total is now 13, however 8 of these cases had no lapses in care and are therefore likely to be successfully appealed when submitted to the CCG review panel.

E coli - 2 E coli cases on ward 7A. These cases were actually the same patient but the bacteraemias occurred in excess of 14 days apart and required a readmission. The infection was initially treated with antibiotics as agreed by the clinicians and the Consultant Microbiologist, however the source of the infection wasn't clearly identified even though the patient responded initially to treatment.
Low level infection rate for August.

MSSA - There was one MSSA infection in August on ward 11B. The source of this infection was pneumonia which was identified and treated.

MRSA - No MRSA bacteraemia in August the last case was in April 2020.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
MRSA	0	0	0	Aug 20		0	0	Jul 20	0	1	?
C-Diff	1	3	3	Aug 20		1	2	Jul 20	15	13	?
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)	6.9	8.6	N/A	Aug 20		6.9	10	Jul 20			?
E. Coli	2	2	2	Aug 20		2	2	Jul 20	2	8	?


MRSA
C-Diff
MSSA - Infection Rate (12 month count/rolling 12 month av occupied bed days x 100,000)
E. Coli
2018/19
2019/20
2020/21

Quality

Maternity

Analyst Narrative: Most indicators are inconsistent in their assurance, only the Induction rate is failing which appears to be due to an isolated incident last year. Two indicators are showing recent positive performance which is statistically significant enough to trigger the highlighting rule.

Operational Narrative: Caesarean Rates - Caesarean section rate for July was 31.38% this is higher than the plan of 24% and is slightly higher than the average rate for the year. 12.77% were elective caesareans, which is a slight reduction on June 2020. New Consultant leads for Antenatal Care and Delivery Suite are now in post, discussions to take place with the new Consultants their plans to evaluate and where possible reduce the rate. Variance with Trust and other providers in C/Section performance plan in that our KPI has a lower threshold Head of midwifery providing brief at October PIDA with proposal to amend to fit with other providers across C&M.

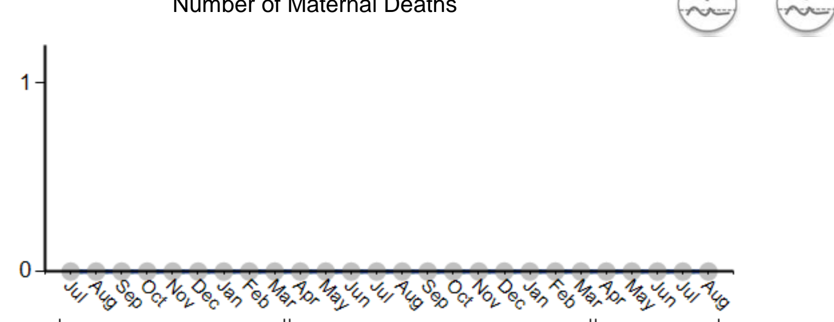
Induction Rate - 38.3% against a target of 33.3% with a YTD performance of 45.7% This has seen a reduction of almost 10% against last month. Increased awareness of the poor fetal outcomes associated with reduced fetal movements and fetal growth problems have led to a significant increase in early Induction of Labour. HOM and Consultant MW completed audit of 25 cases giving full assurance for decision making against guidance. Work now in progress looking at inputting and extracting of data to assure of accuracy. HOM reporting back to PIDA in October

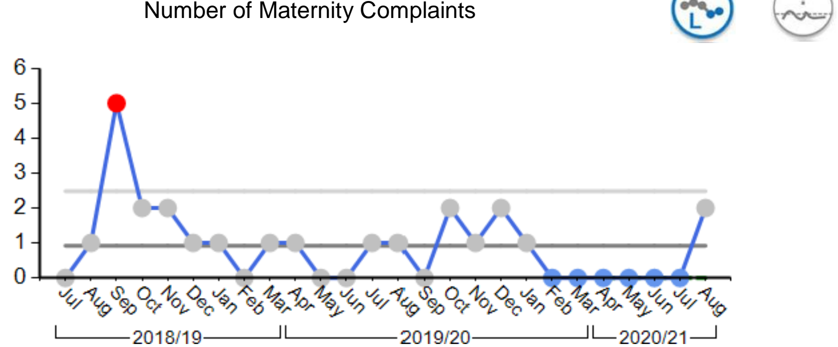
Breastfeeding Initiation - The department achieved 54.01% in July and is 60.28% YTD against a target of 60%, this metric does show some fluctuation month to month anecdotal evidence suggests that COVID has impacted on women choosing to breastfeed, and is in line with findings of other providers Work is ongoing with the BFI towards full accreditation for the service

No 3rd/4th Degree Tears in Unassisted and assisted Vaginal Births although usually small numbers this is positive.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Caesarean Rates	24%	24%	42	Aug 20		24%	31.4%	Jul 20	24%	28.7%	?
Induction Rate	33.3%	40%	70	Aug 20		33.3%	38.3%	Jul 20	33.3%	43%	F
Breastfeeding Initiation	60%	59.8%	70	Aug 20		60%	54%	Jul 20	60%	60.2%	?
Percentage of Women Booked by 12 weeks 6 days	90%	91.7%	17	Aug 20		90%	96.5%	Jul 20	90%	94%	?
Number of Occasions 1:1 Care Not Provided			0	Aug 20	L			Jul 20			?
Percentage of 3rd/4th Degree Tears	0	3	3	Aug 20		0	0	Jul 20	0	9	?
Number of Maternal Deaths	0	0	0	Aug 20		0	0	Jul 20	0	0	?
Number of Maternity Complaints	0	2	2	Aug 20	L	0	0	Jul 20	0	2	?

Caesarean Rates
45%
40%
35%
30%
25%
20%
15%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Induction Rate
55%
50%
45%
40%
35%
30%
Breastfeeding Initiation
100%
90%
80%
70%
60%
50%
Percentage of Women Booked by 12 weeks 6 days
100%
98%
96%
94%
92%
90%
88%
86%
Number of Occasions 1:1 Care Not Provided
Percentage of 3rd/4th Degree Tears
10
8
6
4
2
0





TB152_20b - Integrated Performance Report (Quality & Safety)

Quality

Mortality

Analyst Narrative: The screening rate is failing its assurance target and recent performance is also negative using the 2 out of 3 months rule. The SHMI and HSMR are showing recent positive variation however the forecast for these indicators would suggest a decline in coming months.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
SHMI (Summary Hospital-level Mortality Indicator)	100	103.9	N/A	Apr 20		100	103.8	Mar 20	100	103.9	?
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	79.6	N/A	May 20	L	100	80.9	Apr 20	100	79.6	?
Percentage of Deaths Screened	100%	75.9%	13	Jul 20	L	100%	14.8%	Jun 20	100%	28.6%	F

SHMI (Summary Hospital-level Mortality Indicator)

HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)

Percentage of Deaths Screened

Quality

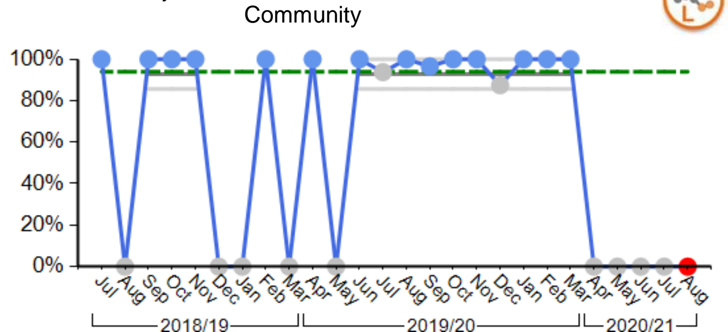
Patient Experience

Analyst Narrative: No indicators are assured in this section but no indicators are classed as consistently failing. There is one indicator with negative variation - Friends & Family - Antenatal. There are two indicators with positive variation - Complaints turnaround time and DOC - Evidence of discussion. All other indicators are showing no significant variation.

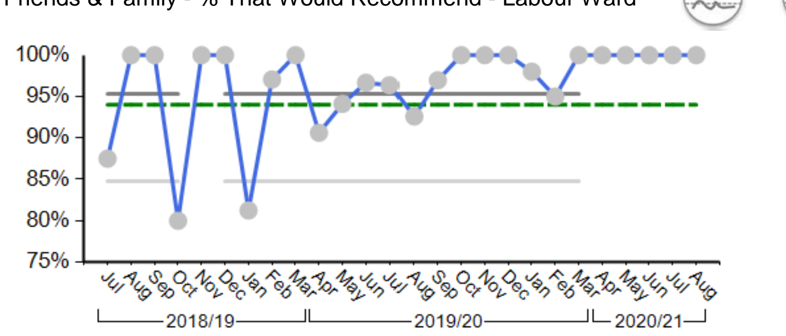
Operational Narrative:
FFT – Trust overall % patients that would recommend is under plan by 5%. The four maternity touch points have been reviewed and automation for delivery, post-natal ward and post-natal community has now gone live.
Duty of Candour - The Trust compliance remains at 100% for both written and verbal duty of candour.
Compliments - A total of 44 compliments have been received in month, they have been received by all Business units. Planned care received the most compliments with 31 being received, 10 from patient feedback in theatres. Urgent care received 9 compliments. Specialist Services received 3 compliments
Complaints - Complaints average timescale for closure remains under the target of 40 days with this month's average at 35.1 days. 13 complaints have been received in month the breakdown is: 3 in planned care related to different services, 1 in vascular service, 2 for trauma and orthopaedic s, 1 of the 2 complaints for trauma and orthopaedic is related to the Royal college review in orthopaedics. 6 in Urgent care: 4 general medicine, 1 cardiology, and 1 related to rehabilitation. 4 Specialist Services, 1 in midwifery and 3 in obstetrics.

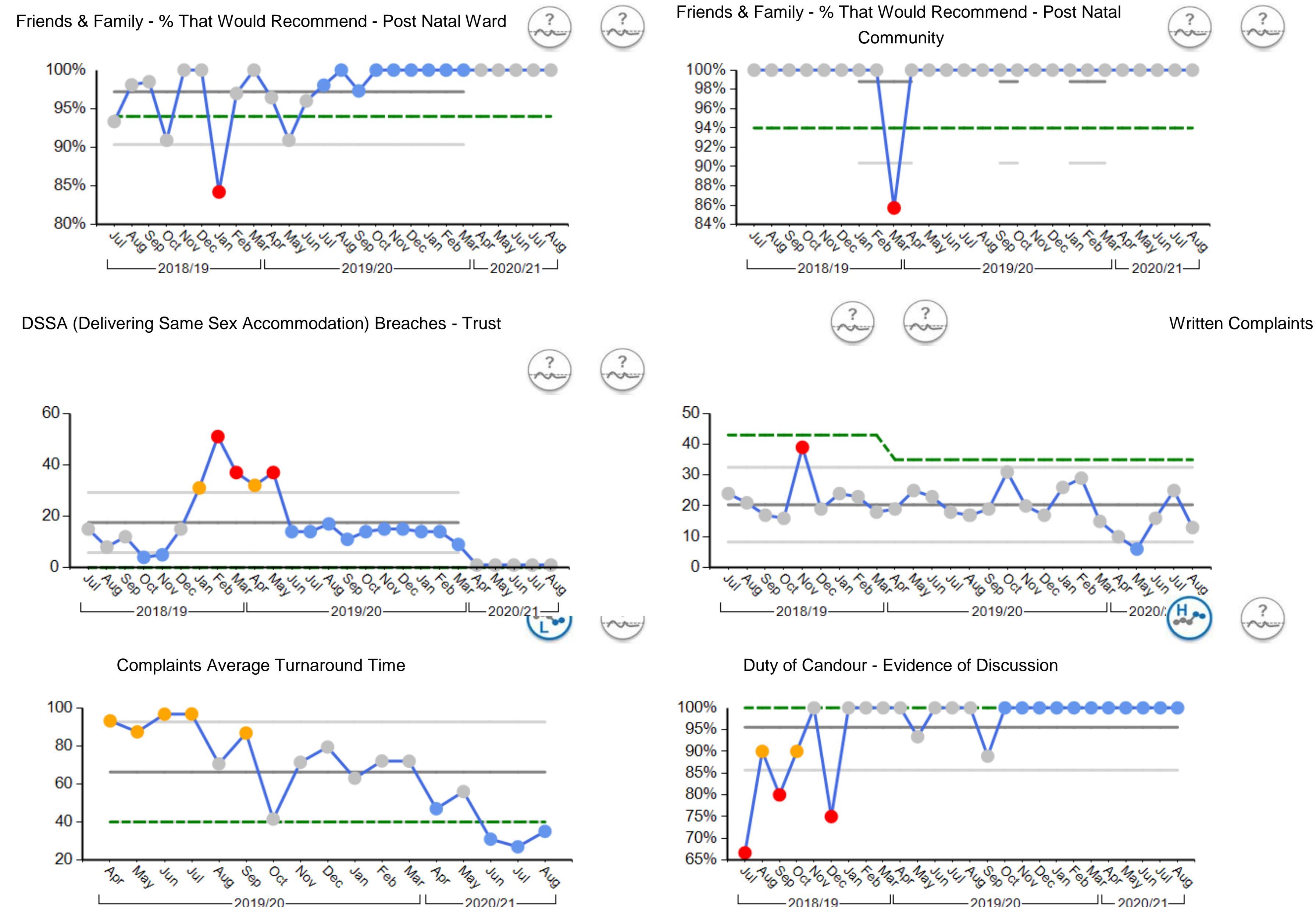
Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Friends & Family - % That Would Recommend - AnteNatal Community	94%	0%	1	Aug 20		94%	100%	Mar 20	94%	0%	
Friends & Family - % That Would Recommend - Labour Ward	94%	100%	0	Mar 20		94%	95%	Feb 20	94%		
Friends & Family - % That Would Recommend - Post Natal Ward	94%	100%	0	Mar 20		94%	100%	Feb 20	94%		
Friends & Family - % That Would Recommend - Post Natal Community	94%	100%	0	Mar 20		94%	100%	Feb 20	94%		
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	1	1	Jul 20		0	9	Mar 20	0	1	
Written Complaints	35	13	13	Aug 20		35	25	Jul 20	537	70	
Complaints Average Turnaround Time	40	35.1	N/A	Aug 20		40	27	Jul 20	40	39.2	
Duty of Candour - Evidence of Discussion	100%	100%	0	Aug 20		100%	100%	Jul 20	100%	100%	
Duty of Candour - Evidence of Letter	100%	100%	0	Aug 20		100%	88.9%	Jul 20	100%	94.4%	
Friends and Family Test - Staff - % That Would Recommend - Trust Overall		65.3%	124	Sep 19			69.2%	Jun 19		66%	

Friends & Family - % That Would Recommend - AnteNatal Community

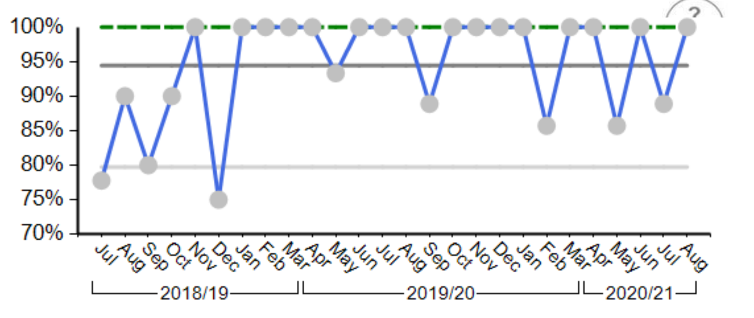


Friends & Family - % That Would Recommend - Labour Ward

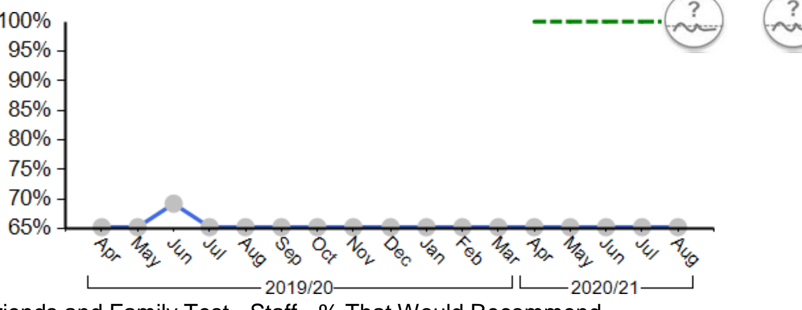




Friends & Family - % That Would Recommend - Post Natal Ward
Friends & Family - % That Would Recommend - Post Natal Community
DSSA (Delivering Same Sex Accommodation) Breaches - Trust
Written Complaints
Complaints Average Turnaround Time
Duty of Candour - Evidence of Discussion
2018/19
2019/20
2020/21



Duty of Candour - Evidence of Letter



Friends and Family Test - Staff - % That Would Recommend - Trust Overall

Title of Meeting	BOARD OF DIRECTORS	Date	7 October 2020
Agenda Item	TB153/20	FOI Exempt	NO
Report Title	CQC IMPROVEMENT PLAN UPDATE		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery, Therapies and Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ To Approve ✓ To Assure	☐ To Note ☐ To Receive	

Purpose
This report provides an update on the progress of the CQC Improvement Plan, governance arrangements and assurance processes to ensure a continuous cycle of sustainable improvement.
Executive Summary
Following the inspection in 2019, CQC identified 31 'must do' actions relating to breaches of regulation and 92 actions the CQC recommend we 'should do' to prevent further breaches. The Deputy Director of Quality, Risk & Assurance is currently undertaking a review of all the actions, evidence and the governance and assurance process and as a result, none of the BRAG (Blue, Red, Amber, Green) ratings for the must or should Do's have been updated since the last report. Since the inspection, there have been some changes to senior management and also to executive portfolios following the departure of the Director of Strategy/Deputy Chief Executive. As a result, there is a need to review action owners as well as the alignment with Executive portfolios and arrange appropriate review/sign off where actions are considered complete. In line with the Board Assurance Framework, we are aiming to complete all actions by the end of January 2021.
Recommendations
The Board is asked to note key actions and progress against the CQC Improvement Plan.
Previously Considered By:
✓ **Quality & Safety Committee**
Strategic Objectives
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
☐ **SO3** Efficiently and productively provide care within agreed financial limits
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Jo Simpson	Bridget Lees

Care Quality Commission (CQC) Update – September 2020

1. PURPOSE OF REPORT

The Care Quality Commission (CQC) carried out an inspection at the Trust between 10 July 2019 and 1 August 2019 and a well-led inspection between 20-22 August 2019. The subsequent inspection report was published on 29 November 2019 where the Trust received a rating of Requires Improvement (RI).

An improvement plan was developed following the outcome of the inspection and the purpose of this report is to provide an update on progress with completion of the actions.

This report also outlines the assurance processes going forward to ensure a continuous cycle of sustainable improvement.

2. EXECUTIVE SUMMARY

Following the inspection in 2019, CQC identified 31 'must do' actions relating to breaches of regulation and 92 actions the CQC recommend we 'should do' to prevent further breaches.

The Deputy Director of Quality, Risk & Assurance is currently undertaking a review of all the actions, evidence and the governance and assurance process and as a result, none of the BRAG (Blue, Red, Amber, Green) ratings for the must or should Do's have been updated since the last report.

Since the inspection, there have been some changes to senior management and also to executive portfolios following the departure of the Director of Strategy/Deputy Chief Executive. As a result, there is a need to review action owners as well as the alignment with Executive portfolios and arrange appropriate review/sign off where actions are considered complete.

3. PROGRESS TO DATE

Trust Must and Should Do BRAG ratings (not yet reviewed by Quality Assurance Panel)

Rating	Must Do	Should Do	Total
Completed	2	4	6
Progressing on schedule	17	43	60
Slightly delayed and/or of low risk	12	45	57
Significantly delayed and/or of high risk	0	0	0
TOTAL	**31**	**92**	**123**

4. CQC ENGAGEMENT MEETINGS

Our monthly engagement meetings with CQC have continued virtually, this provides us with an opportunity to discuss any themes or trends in relation to serious incidents, complaints, safeguarding and discharge. It is also an opportunity for us to highlight any new initiatives and innovations.

We have received feedback from our Emergency Support Framework' Infection prevention control Board Assurance Framework' (ESF IPC BAF) engagement call with CQC, this found that

- Through the IPC BAF there is assurance that the trust has effective infection prevention and control measures in place
- There are systems in place to manage and monitor the prevention and control of infection
- Risks and gaps identified have planned mitigation in place that is monitored. Ongoing monitoring on none gaps as well to ensure that standards and quality remains.
- No further risks or gaps were identified by CQC following the ESF IPC BAF engagement call

5. CHANGES TO THE CQC IMPROVEMENT PLAN GOVERNANCE PROCESSES

Since the inspection, there have been some changes to senior management and executive portfolios following the departure of the Director of Strategy/Deputy Chief Executive. As a result, there is a need to review the alignment of CQC actions with Executive portfolios and arrange appropriate sign off where actions are considered complete.

The new Deputy Director of Quality, Risk and Assurance is in the process of arranging meetings with all Executive Directors to review the evidence where actions they are accountable for are considered complete. A further update will be provided on progress in October 2020.

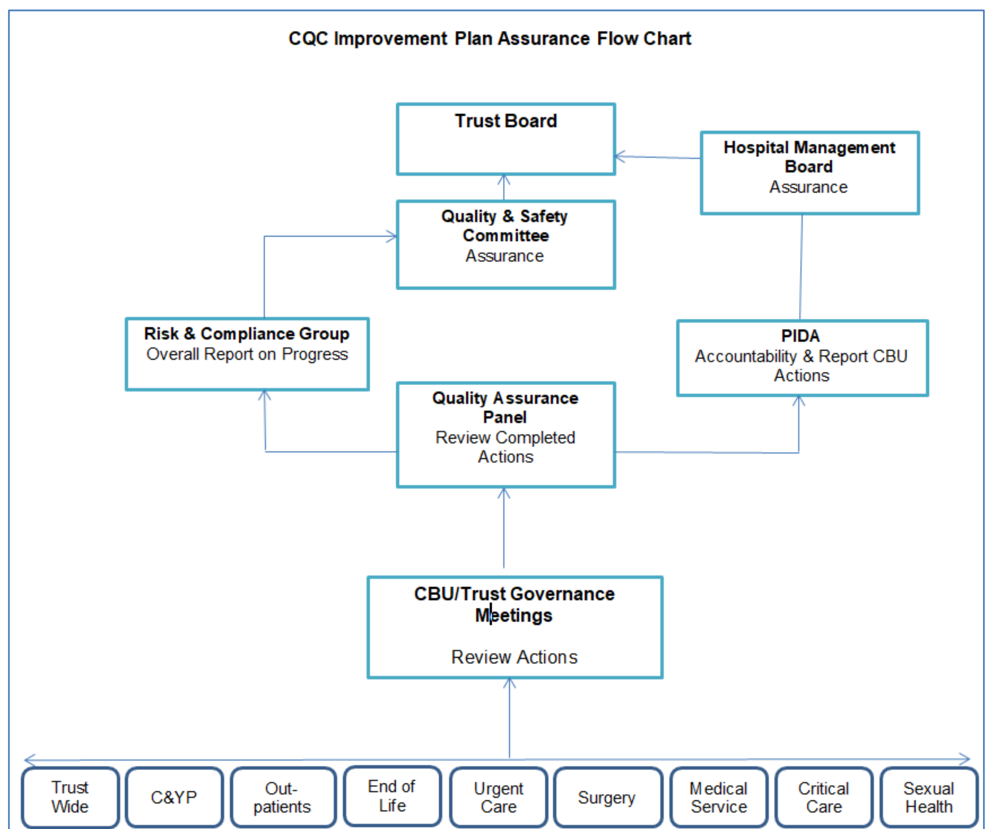
The governance framework in relation to the CQC Improvement Plan has been reviewed to realign responsibility between the operational, nursing and medical management. The framework will enable clear lines of accountability for the CBUs and corporate services.

Quality Assurance Panels have not been held as frequently as they should have been. However, from October 2020, in order to escalate pace in improving progress, the Quality Assurance Panels will be held twice per month, chaired by the Director of Nursing (or Deputy). This will be a 'confirm and challenge' meeting for CBUs and corporate services to review the evidence and confirm BRAG status of the must and should do actions.

The CQC assurance process will include:

- Overview of progress at CBU and corporate governance meetings.
- Quality Assurance Panels to review completed actions and evidence
- CBU performance to be monitored at Performance, Improvement, Delivery and Assurance Boards (PIDA) as part of the single accountability framework.
- Overall progress report to be reported to Risk and Compliance and then Quality & Safety Committee for Assurance
- Progress report to be presented to Trust Board as per reporting cycle.

The flowchart below highlights the proposed process for CQC governance framework



6. RECOMMENDATIONS

The Board of Directors is asked to note the current position against the CQC Improvement Plan and the updated process to monitor completion of actions.

Alert, Advise, Assure (AAAs) Highlight Report

Committee/Group:	FINANCE, PERFORMANCE & INVESTMENT COMMITTEE
Meeting date:	28TH SEPTEMBER 2020
Lead:	GRAHAM POLLARD

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The committee received a presentation that provided an update on the revised funding allocation for month 7-12. Whilst the funding allocation for S&O NHS Trust remains unclear, the funding envelope for the STP has been announced. There is a gap between the forecast costs across the system and the available STP budget, which is a concern. It is anticipated that we will have clarity of the Trusts funding allocation, including monies for winter, service restoration and COVID, by the end of October. In the meantime FP&I supports the recommendation to plan on the basis of the Trust receiving 50% of the bids that have been put forward.
- The System Winter Plan was presented to the Committee, during which substantial risks were highlighted in regards to the uncertainty of funding that is required to implement the plan. Specifically, any slippage in implementing the out of hospital schemes in the community and primary care settings will place additional risk upon the Trust's own winter plans. Mitigation measures that the Trust might ordinarily consider like, for example, maximizing ward 1, will be complicated by the potential impact of COVID.
- The IPR highlighted an increase in staff turnover and sickness absence during July and August, which can, in part, be attributed to COVID-related causes. The reintroduction of a COVID testing programme for Trust employees will help provide some mitigation, but associated staff absences linked to child care, self-isolation and shielding will remain an increased risk across multiple services, as the number of COVID cases continues to rise.

ADVISE

- The Committee received an action plan in response to the NHSI Use of Resources assessment report that was carried out in November 2019. The action plan focuses upon three areas, which are: to establish a 2 Year Financial Recovery Plan for the Trust; to develop a new Financial Management Framework; and to develop and implement a Recruitment and Retention Strategy. The committee were supportive of the overarching plan but requested the development of a more detailed delivery plan.
- The Committee approved a new terms of reference for the Business Development and Investment Group (BDIG), which will report in to FP&I. BDIG will be able to approve business cases up to a financial threshold of £200K, and consider business cases above that value for escalation to FP&I and Board. BDIG will also be responsible for reviewing the impact of all historic business cases.
- It was reported in the month 5 finances report that Agency staffing costs were at their lowest within the last 12 months
- It was reported that Trust expenditure on medicines in Quarter 1 was 30% lower than Q1 2019-20 and this correlates with a substantial fall in activity during this period.
- The Committee supported the virement of funds from the obstetrics medical budget to the paediatric medical budget to appoint two paediatric consultants, which would help respond to feedback from a previous CQC visit, and bring staffing provision closer to Royal College standards.

ASSURE

- An update was provided on the Committee's chosen deep dive topic, which is 'The use of benchmarking data and costing information to improve productivity'. The Committee were given assurance that the work is on track to be completed by February 2021.

New Risks identified at the meeting: None
Review of the Risk Register: *No action taken*

Operations

Access

Analyst Narrative:

Of the 13 indicators measured none are showing assurance but only 2 are failing. These are 4 hour compliance and Ambulance waits 30-60 minutes, both of these are demonstrating recent positive variation however this is not expected to continue next month. From the remaining indicators 12 hour trolley waits, 60 minute handover times and the total RTT waiting list size are all showing positive variation which is good. RTT ongoing, diagnostic waits and multiple measures related to long waiters are all showing statistically significant negative performance of late so will require additional monitoring.

Operational Narrative:

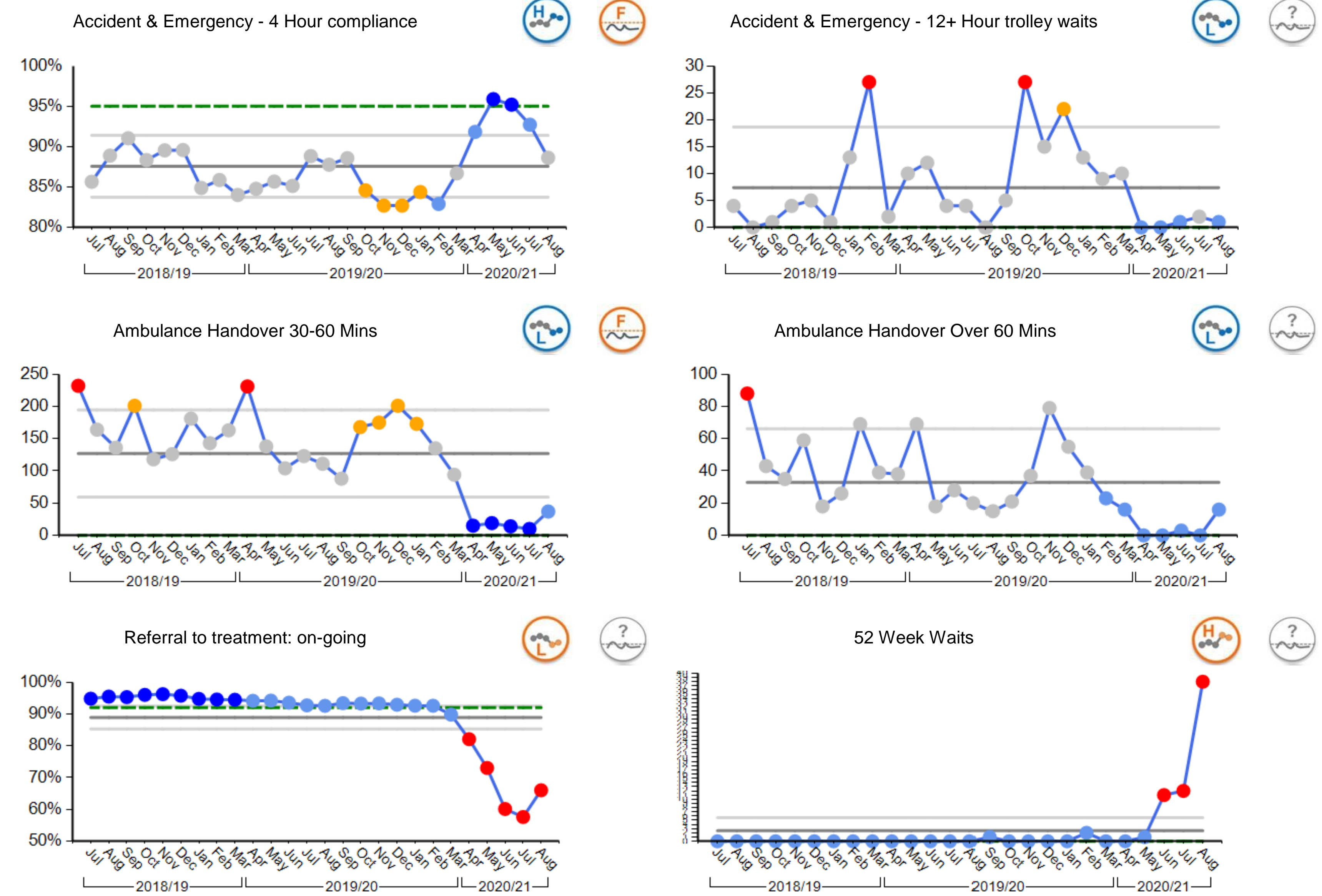
- **Ambulance Handovers** - Ambulance arrivals at Southport are still marginally lower than pre-Covid levels (approx. 42 per day compared to 50 per day). Current handover times have seen an increase in 60 minute or longer wait – 16 in August whereas there were 5 in the previous 4 months combined. These incidents occurred on specific days when demand far outweighed capacity resulting in high occupancy.

- **4 Hour Compliance** - Performance has decreased due to issues surrounding high occupancy levels in ED, delays in transfers to wards, and reliance on specialties to undertake reviews down in ED instead of in assessment areas.

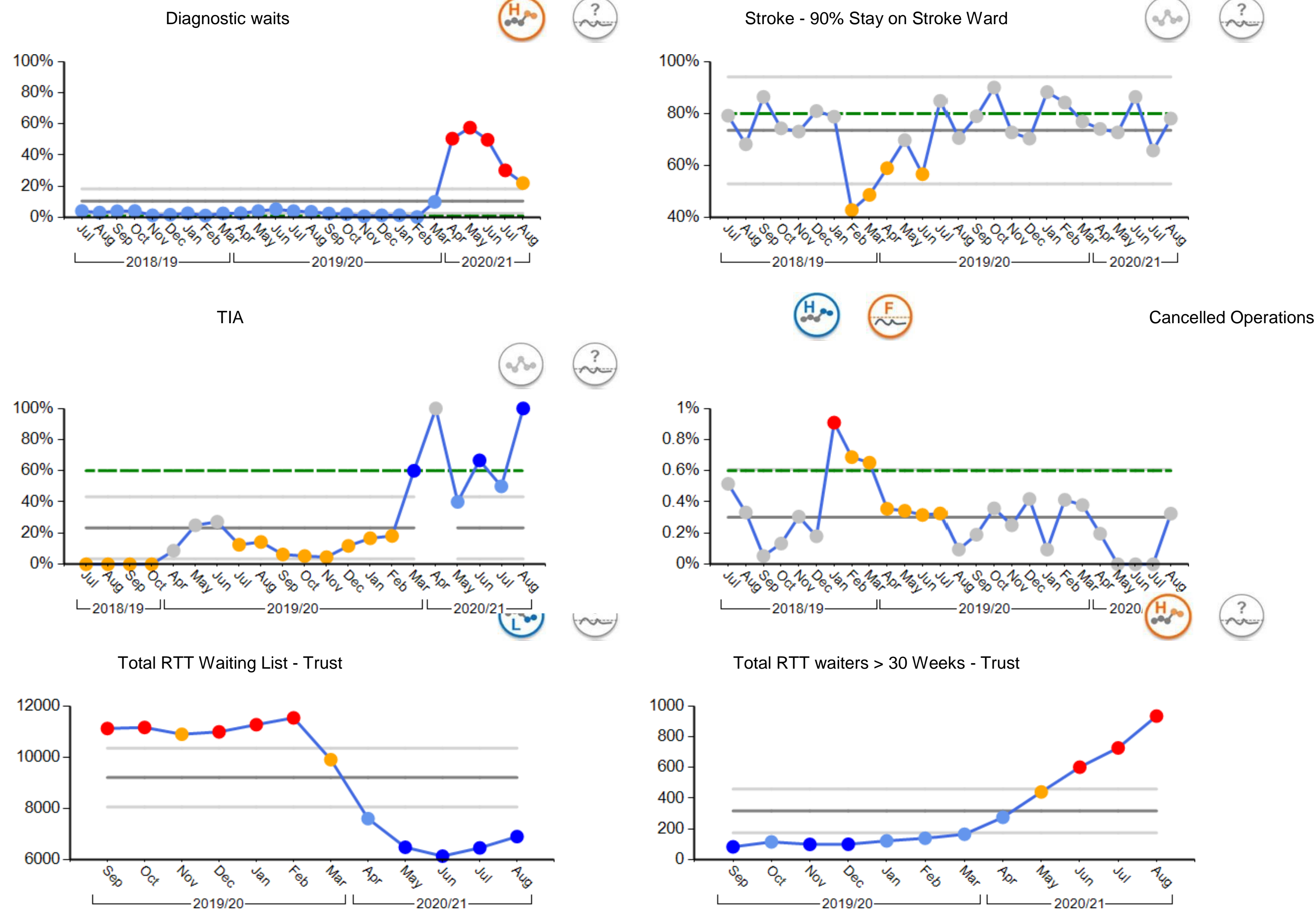
- **Diagnostic Waits** - August has seen an improved performance due to opening up of services and Royal Colleges easing of guidance. Endoscopy still having issues as delivering against 2/3 reduced capacity whilst MDU occupy Treatment Room estate. MDU move to a temporary home in B ward at Ormskirk which will allow the Endoscopy unit to expand capacity with the aim to returning to pre-Covid activity levels.

- **Referral To Treatment** - Performance improving month on month after the lows through the first stages of Covid. Referral numbers have started to increase as patients start to visit the GPs. In spite of a focus in treating long waiters – due to the waiting list profile over 30 week waiters and above continue to grow whilst activity restrictions are in place in OP and Theatres. The month has seen an increase in 52 week waits to 38. It is expected that this profile will continue. The Trust is still experiencing numbers of patients deferring their treatments due to Covid fears. As has been stated previously – these long waiters remain on the Waiting List. The trauma/emergency list that was put in place at Ormskirk through Covid has been returned to elective lists from mid-September to improve throughput. From 5th October the Trust will aim to deliver 5 elective theatres per day.

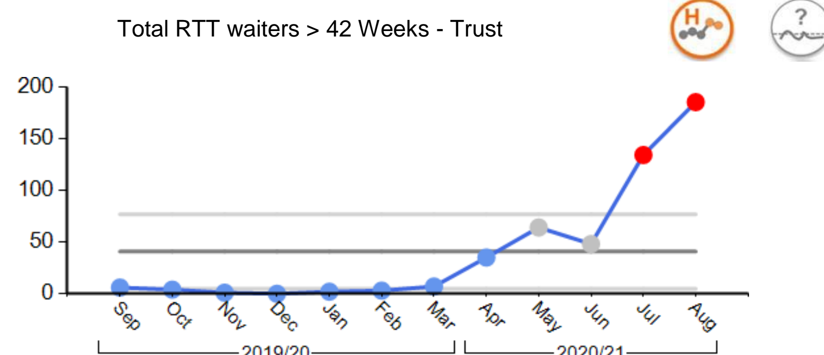
Indicator	Latest					Previous			Year to Date		
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Accident & Emergency - 4 Hour compliance	95%	88.6%	1006	Aug 20	H	95%	92.7%	Jul 20	95%	92.7%	F
Accident & Emergency - 12+ Hour trolley waits	0	1	1	Aug 20	L	0	2	Jul 20	0	4	?
Ambulance Handover 30-60 Mins	0	37	37	Aug 20	L	0	10	Jul 20	0	95	F
Ambulance Handover Over 60 Mins	0	16	16	Aug 20	L	0	0	Jul 20	0	19	?
Referral to treatment: on-going	92%	66%	2345	Aug 20	L	92%	57.6%	Jul 20	92%	68.3%	?
52 Week Waits	0	38	38	Aug 20	H	0	12	Jul 20	0	38	?
Diagnostic waits	1%	22.1%	670	Aug 20	H	1%	30.2%	Jul 20	1%	40.9%	?
Stroke - 90% Stay on Stroke Ward	80%	78%	9	Aug 20		80%	65.8%	Jul 20	80%	74.7%	?
TIA	60%	100%	0	Aug 20	H	60%	50%	Jul 20	60%	57.1%	F
Cancelled Operations	0.6%	0.3%	4	Aug 20		0.6%	0%	Jul 20	0.6%	0.1%	?
Total RTT Waiting List - Trust		6905	6905	Aug 20	L		6465	Jul 20		6905	?
Total RTT waiters > 30 Weeks - Trust		934	934	Aug 20	H		727	Jul 20		934	?
Total RTT waiters > 42 Weeks - Trust		185	185	Aug 20	H		134	Jul 20		185	?



TB154_20b - Integrated Performance Report (Operational Performance)



Diagnostic waits
Stroke - 90% Stay on Stroke Ward
TIA
Cancelled Operations
Total RTT Waiting List - Trust
Total RTT waiters > 30 Weeks - Trust
2018/19
2019/20
2020/21


Total RTT waiters > 42 Weeks - Trust
200
150
100
50
0
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
2019/20
2020/21

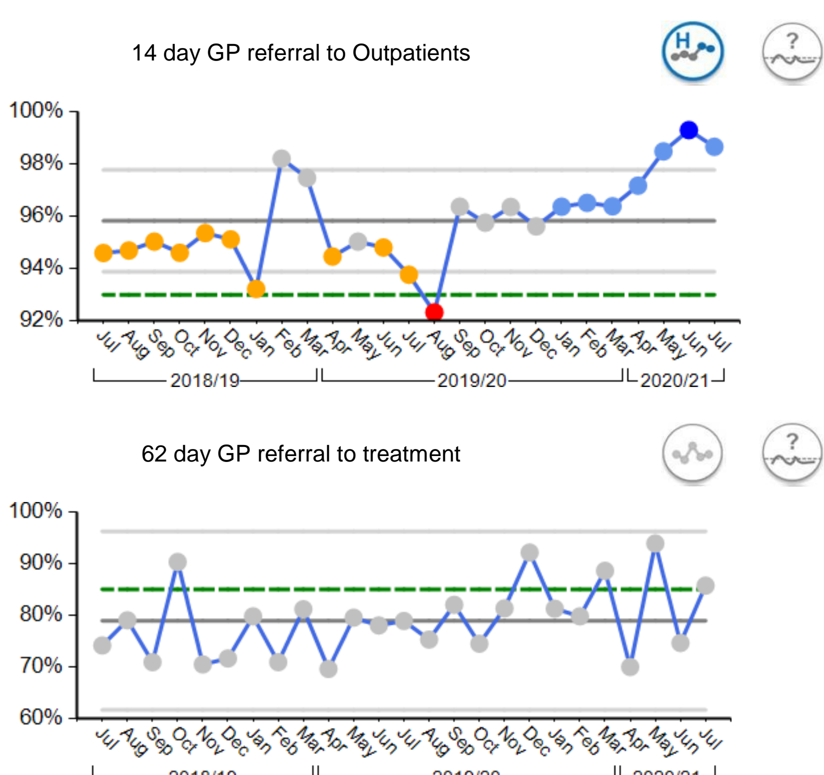
Operations

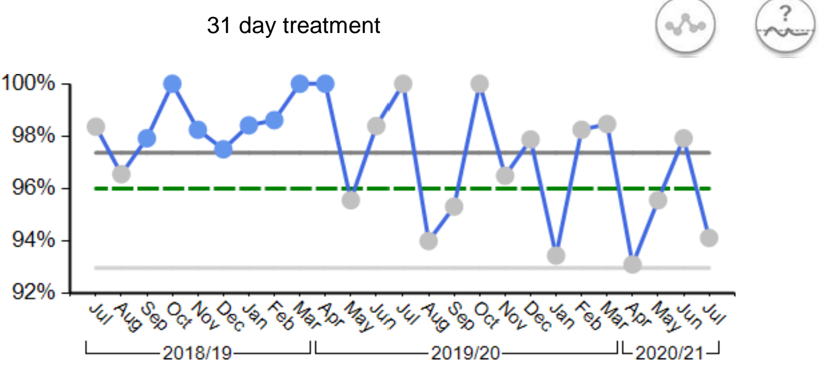
Cancer

Analyst Narrative: None of the cancer measures are fully assured or failing. Only the 14 day measure is showing recent positive performance which is the best performance this measure has seen for a number of years.

Operational Narrative: All tumour groups continue to feed into cancer improvement plan.
Key focus has been to set recovery trajectories in place for 62, 31 and 104 days, this includes managing in line with cancer alliance guidance. New trajectories set for diagnostic modalities that support cancer pathways.
Patients continue to be prioritised by clinicians as capacity in areas reduced, specific areas of concern theatre access due to reduced capacity in theatres, areas that this has impacted on are urology and ENT.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
14 day GP referral to Outpatients	93%	98.6%	12	Jul 20	H	93%	99.3%	Jun 20	93%	98.6%	?
31 day treatment	96%	94.1%	3	Jul 20		96%	97.9%	Jun 20	96%	95%	?
62 day GP referral to treatment	85%	85.7%	6	Jul 20		85%	74.6%	Jun 20	85%	80.4%	?


14 day GP referral to Outpatients
100%
98%
96%
94%
92%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul
2018/19
2019/20
2020/21
62 day GP referral to treatment
100%
90%
80%
70%
60%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul
2018/19
2019/20
2020/21


31 day treatment
100%
98%
96%
94%
92%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul
2018/19
2019/20
2020/21

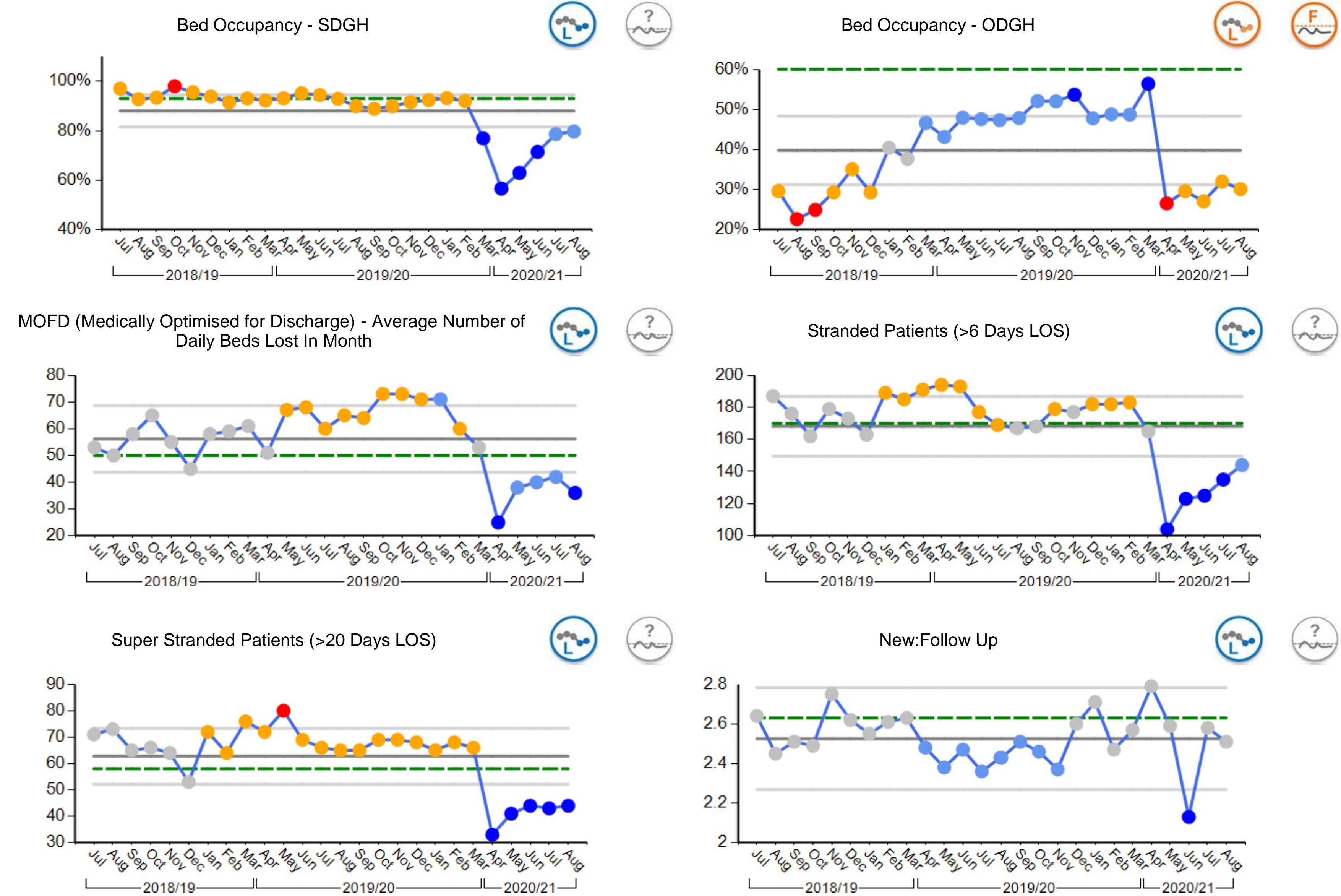
Operations

Productivity

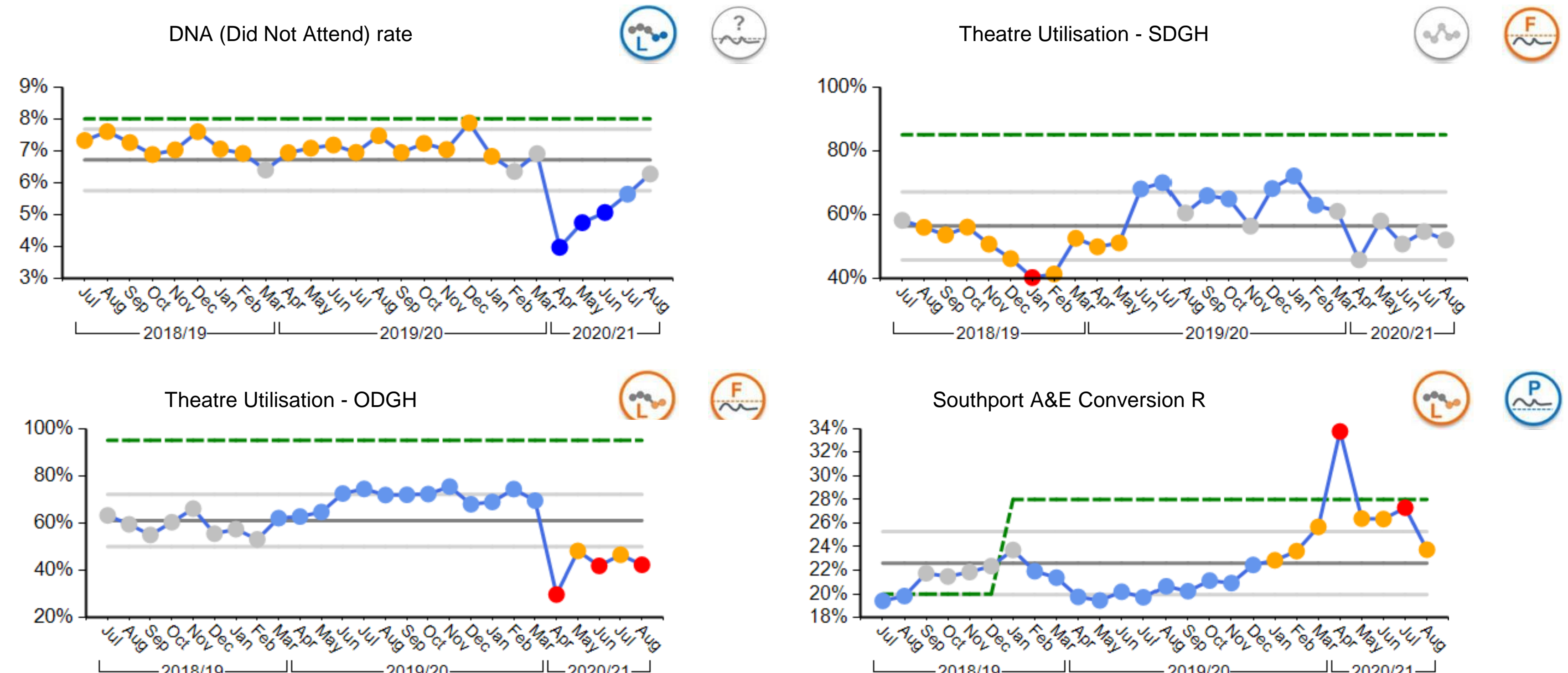
Analyst Narrative: Three indicators failing - ODGH bed occupancy and theatre utilisation at both sites. A&E conversion rate is assured despite a recent increase giving negative variation. ODGH bed occupancy and theatre use is also showing recent negative variation so is statistically a concern. There are a number of indicators showing recent positive variation so all showing improvements.

Operational Narrative: No major outliers in performance against previous month.
There will be a push as part of the Phase III response to covid to increase elective activity pre-winter with the focus on outpatients, theatre, endoscopy and radiology. Trust has set performance targets in line with NHS Guidelines however major caveat is around workforce and any further spike in covid infections seen as winter approaches. The Trust continues to utilise Renacres for surgery and Endoscopy activity under the National Contract. It is expected this will continue until March 2021.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	93%	79.7%	N/A	Aug 20	L	93%	78.6%	Jul 20	93%	70%	?
Bed Occupancy - ODGH	60%	30.1%	N/A	Aug 20	L	60%	32%	Jul 20	60%	29.1%	F
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month	50	36	36	Aug 20	L	50	42	Jul 20	50	36	?
Stranded Patients (>6 Days LOS)	170	144	144	Aug 20	L	170	135	Jul 20	170	631	?
Super Stranded Patients (>20 Days LOS)	58	44	44	Aug 20	L	58	43	Jul 20	58	205	?
New:Follow Up	2.63	2.5	N/A	Aug 20	L	2.6	2.6	Jul 20	2.63	2.5	?
DNA (Did Not Attend) rate	8%	6.3%	1153	Aug 20	L	8%	5.6%	Jul 20	8%	5.3%	?
Theatre Utilisation - SDGH	85%	52.1%	N/A	Aug 20		85%	54.7%	Jul 20	85%	52.6%	F
Theatre Utilisation - ODGH	95%	42.3%	N/A	Aug 20	L	95%	46.6%	Jul 20	95%	42.9%	F
Southport A&E Conversion Rate	28%	23.7%	1096	Aug 20	L	28%	27.3%	Jul 20	28%		P



Bed Occupancy - SDGH
100%
80%
60%
40%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Bed Occupancy - ODGH
60%
50%
40%
30%
20%
MOFD (Medically Optimised for Discharge) - Average Number of Daily Beds Lost In Month
80
70
60
50
40
30
20
Stranded Patients (>6 Days LOS)
200
180
160
140
120
100
Super Stranded Patients (>20 Days LOS)
90
80
70
60
50
40
30
New:Follow Up
2.8
2.6
2.4
2.2
2



DNA (Did Not Attend) rate
9%
8%
7%
6%
5%
4%
3%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Theatre Utilisation - SDGH
100%
80%
60%
40%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Theatre Utilisation - ODGH
100%
80%
60%
40%
20%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Southport A&E Conversion R
34%
32%
30%
28%
26%
24%
22%
20%
18%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21

Finance

Finance

Analyst Narrative: 2 indicators failing to provide assurance - % Agency Staff (Cost) and Distance from Agency Spend Cap - however the latter is showing a recent improvement in variation.

Of the remaining indicators 4 are showing improvements (I&E surplus or deficit/total revenue, Distance from Control Total, Capital Service Capacity & Use of Resources (Finance) Score). Two are deteriorating (Liquidity & Non Pay Run Rate - Trust)

Operational Narrative:

COVID-19 led to the suspension of the 2020/21 Operational Planning process and a new financial framework was introduced for the period 1st April to 31st July (this has now been extended to September 2020). The framework enables all NHS organisations to break even in the first six months of the financial year through monthly block contracts and "top up" funding. The I&E break-even plan for August has been achieved although a higher top up figure was required due to higher monthly expenditure than previously incurred. Non pay expenditure rose in July reflecting the impact of the restart of the elective programme and this has been maintained in August. Bank and agency spend – a marginal reduction on July's performance with a high level of vacancies and absences relating to COVID-19 contributing. Agency costs have reduced in August (7.3% of the pay bill relates to agency staff).

Capital service capacity -there has been a step change in this metric from last year and this has been driven by the fact that the Trust is now in a breakeven position and has a positive EBITDA.

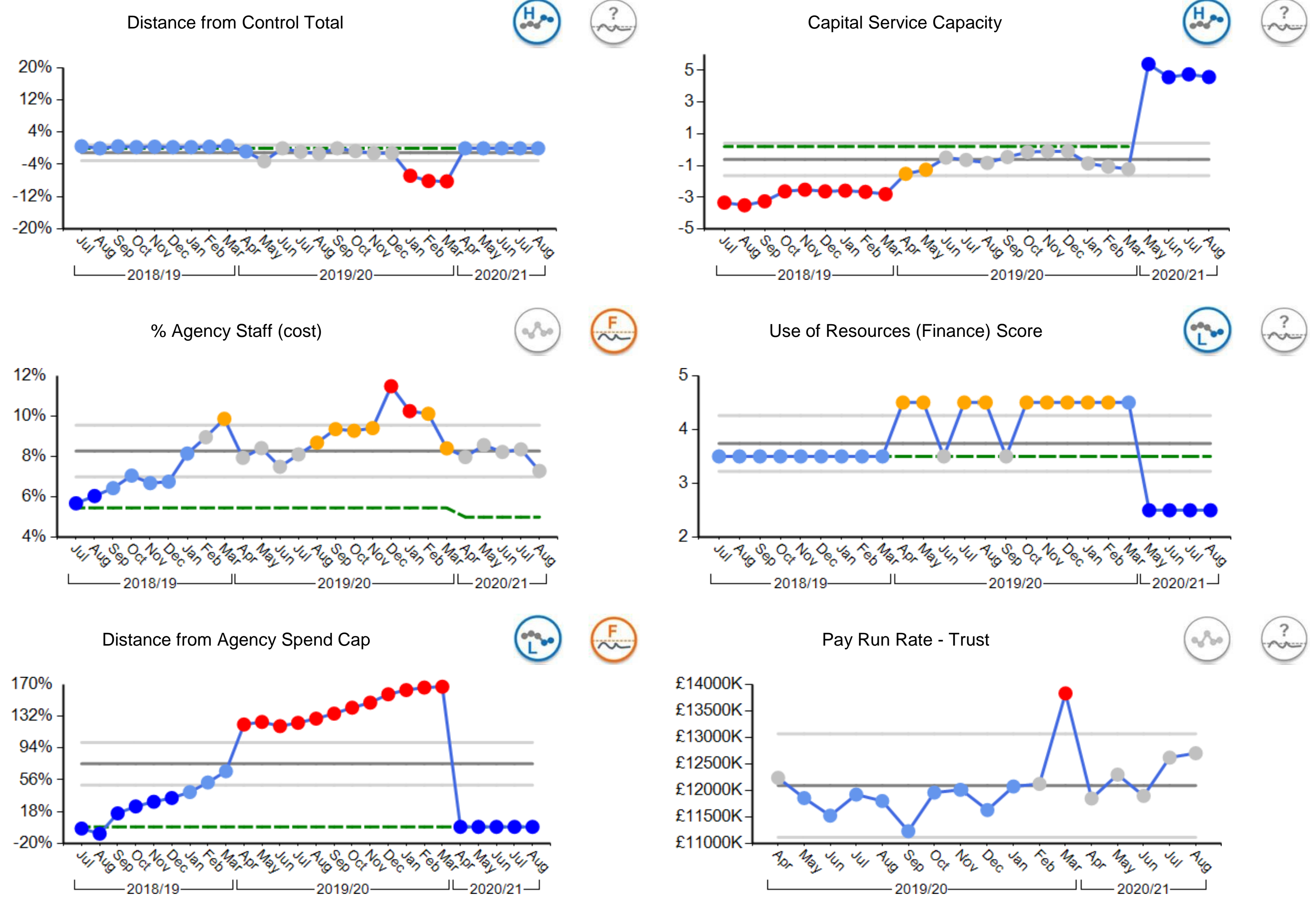
Liquidity -again there has been a step change in this metric as all our DHSC loans have been classified as current liabilities. DHSC will be converting the loans into public dividend capital (PDC) in September and at that point the liquidity calculation will significantly improve. In practical terms there are no cash flow issues as the Trust is being paid in advance by the Commissioners and also receiving a monthly top up. The Trust's liquidity situation is likely to change after month 6 following the expected change in the financial framework in the second half of the year. There is a possibility that the new framework will result in a monthly deficit position which would require a cash solution

Use of Resources – currently a score of 2 but this reflects the current artificial break even position of all NHS organisations.

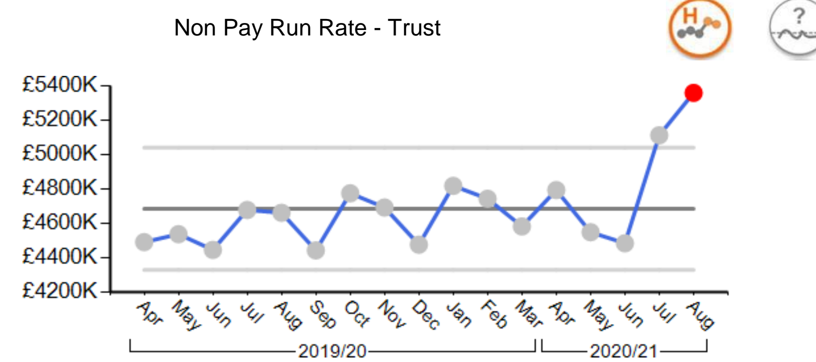
Indicator	Latest: Plan	Latest: Actual	Latest: Patients	Latest: Period	Latest: Variation	Previous: Plan	Previous: Actual	Previous: Period	Year to Date: Plan	Year to Date: Actual	Assurance
I&E surplus or deficit/total revenue		0%	N/A	Aug 20	H	-4.2%	0%	Jul 20		0%	?
Liquidity		-248	N/A	Aug 20	L	-106	-249	Jul 20		-248	?
Distance from Control Total	0%	0%	N/A	Aug 20	H	0%	0%	Jul 20	0%	0%	?
Capital Service Capacity		4.59	N/A	Aug 20	H	0.2	4.76	Jul 20		4.59	?
% Agency Staff (cost)	5%	7.3%	N/A	Aug 20		5%	8.4%	Jul 20	5%	8.1%	F
Use of Resources (Finance) Score	3	2	N/A	Aug 20	L	3	2	Jul 20		3	?
Distance from Agency Spend Cap	0%	0%	N/A	Aug 20	L	0%	0%	Jul 20	0%	0%	F
Pay Run Rate - Trust		£12,702K	N/A	Aug 20			£12,619K	Jul 20		£61,368K	?
Non Pay Run Rate - Trust		£5,357K	N/A	Aug 20	H		£5,111K	Jul 20		£24,295K	?
Bank & Agency Run Rate - Trust		£2,015K	N/A	Aug 20			£2,033K	Jul 20		£10,579K	?

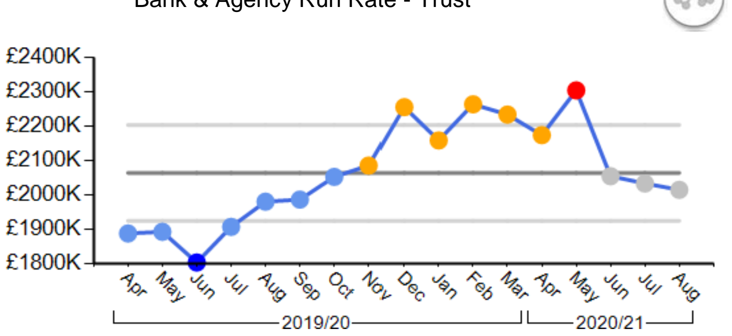
I&E surplus or deficit/total revenue

Liquidity



TB154_20c - Integrated Performance Report (Financial Performance)


Non Pay Run Rate - Trust
£5400K
£5200K
£5000K
£4800K
£4600K
£4400K
£4200K
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
2019/20
2020/21


Bank & Agency Run Rate - Trust
£2400K
£2300K
£2200K
£2100K
£2000K
£1900K
£1800K
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
2019/20
2020/21

Title of Meeting	BOARD OF DIRECTORS	Date	7 OCTOBER 2020
Agenda Item	TB154/20d	FOI Exempt	No
Report Title	FPI Committee Terms of Reference		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
Action Required	✓ To Approve ☐ To Assure	☐ To Note ☐ To Receive	

Purpose

To purpose of this report is to present the Finance, Performance and Investment Committee Terms of Reference for ratification following approval by the Committee.

Executive Summary

The Board previously ratified the Finance, Performance and Investment Terms of Reference (ToR) in July 2019.

Following a periodic review in August 2020 and in line with best practice, the FP&I ToRs have been reviewed to ensure they clearly define the Committee's functions and duties and that they remain aligned to the Trust's Corporate Governance policies. The ToRs have also been refreshed to ensure they are consistent in style with those of other Board Committees. Notable changes from the previous versions are listed on the Version Control Document and are identifiable in the document through red font where there have been deletions and blue font for insertions.

The FPI Committee ToRs were presented and endorsed for final approval by the Committee in September 2020.

Recommendations

The Board is asked to review ratify the FP&I Terms of Reference following approval by the Committee.

Previously Considered By:

✓ **Finance Performance and Investment Committee**

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards

✓ **SO3** Efficiently and productively provide care within agreed financial limits

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values

☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Sharon Katema, ADCG	Sharon Katema, ADCG

Finance, Performance and Investment Committee

Terms of Reference Document Control Sheet

MEETING	Finance, Performance and Investment Committee
ESTABLISHED BY /REPORTING TO:	Board of Directors
Reviewer:	Sharon Katema, Associate Director of Corporate Governance
REVIEW:	August 2020
ASSOCIATED DOCUMENTS:	Scheme of Reservation and Delegation Standing Financial Instructions Standing Orders CIP Process IM&T Strategy Risk Management Strategy Extreme Risk Register Board Assurance Framework
RELATED FORUMS /COMMITTEES/ GROUPS	Trust Board Quality and Safety Committee Remuneration & Nomination Committee Audit Committee Charitable Funds Committee Workforce Committee Hospital Management Board **Sub Committees** • Business Development and Investment Group • IM&T ~~Programme Board~~ Group • ~~Finance, Procurement & Information Governance~~ • Finance, IM&T and Procurement Group • Capital Investment Group • Estates and Facilities Governance Group • ~~Patient Level Income Cost (PLICs) Steering Group~~ • ~~Activity & Income Assurance Group~~ • ~~Information Governance Steering Group~~ • ~~Transformation Committee~~

Document Control	
Document Name	Finance Performance & Investment Committee ToR – Aug 20
File Name	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2020 Statutory and Assurance Committees\ Finance Performance and Investment Committee ToR – Aug 20
Version/Revision Number	**V4.1**

Version Control Document			
Version Ref	**Amendment**	**Committee Review & approval**	**Ratified by Board**
V2.0	1.1 Added authority and responsibility diagram 1.2 Added more information on the purpose of the committee 1.3 Deleted *"by exception"* and added "*twice annually*" 1.4 Added that *the CEO is ex officio a member of the committee* and not a standing member Added: *An officer acting up for a member will count towards a quorum and will be allowed to vote* as though he or she is a member 1.5 Added that the Committee should review its performance and effectiveness twice annually-mid and year end 1.6 Added that the Committee will oversee the implementation of the IM&T and Estates Strategies 1.7 Added meeting attendance information 1.8 Added information regarding the agenda and distribution of papers	**2017**	**2017**
V3.0	2.1 Related Committees/Forums, added Remuneration and Nominations Committee, Charitable Funds Committee and Workforce Committee	**2018**	**2018**
V3.1	Added new governance structure showing reporting arrangements	**2019**	**2019**
V3.2	1.Changed name to read Finance & Investment 1.2 (b) Removed Patient flow- includes activity levels, AED and waiting time performance AND (d) Annual review of the Performance Framework 3.5 Removed Performance Section 3.6 Removed Information Governance Section 3.7 Removed Data Quality Section 4.3 Edited membership of Executives attending to read: Director of Finance and Deputy CEO/Director of Strategy and remove Chief Operating Officer 4.4 Edited Quorum to reflect change of membership	**April 2019**	**April 2019**
V3.3	• Added 'Risk' to Audit Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure 4.3 Updated membership to exclude NED with recent financial experience and removed Chair of Audit being a member 4.4 Added that rotating NED will count towards a Quorum if needed. 4.5 Removed Deputy CEO and reinstated COO 3.5 Reinstated Performance Section 3.6 Reinstated Information Governance Section 3.7 Reinstated Data Quality Section		**June 2019**

V.4	• Removed Risk from Audit & Risk Committee • Added Risk and Compliance Group • Added Hospital Management Board • Added Performance to Committee name throughout • 3.6 - replaced DPA 1998 with GDPR and DPA 2018 • 4.2 - added The members of the Committee shall be appointed by the Board in accordance with the *Standing Orders* • *7.2 added the subgroups to the list* • *8.2 added Committee Secretary*	**August 2020** *(approval deferred)*	-
V.4.1	• 3.1(a) amended to make recommendations to the Board on proposed revenue and capital budgets. • 3.3 (b) amended to 'On behalf of the Board the Committee should oversee the Trust's contract strategy, negotiation of contracts and monitoring of contractual performance • *4.1 removed "but not the Chair of the Audit Committee"* • *4.3 removed 'All Board members may attend any Committee meeting'* • *5.2 amended rotated NED to alternative NED will be asked to fulfil the quorum requirement* • S.7.4 Removed Transformation Committee, AIAG and PLICS Steering Group • Renamed Finance. Procurement and Information Governance Group as Finance, IM&T and Procurement Group.	**September 2020**	

Finance, Performance and Investment Committee

Terms of Reference

1. Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Finance, Performance and Investment Committee, herafter referred to within this document as the *Committee.* The accountability and responsibility structure is set out in Diagram 1.

1.2 The Committee has no executive powers, other than those limited to these Terms of Reference.

1.3 The Committee has the delegated authority to monitor and scrutinise:

a) Financial performance – includes monthly performance and CIP
b) Patient flow- includes activity levels, AED and waiting time performance
c) Capital Programme, including IT
d) Annual review of the Performance Framework
e) Investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee.

1.4 The Committee operates within the Trust's *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.*

1.5 The Committee will operate at a strategic level as the executives are responsible for the day to day operational delivery and management.

1.6 The Committee can obtain, within the limits set out in the Trust's Scheme of Reservation and Delegation, legal or other independent professional advice on any matter within its terms of reference and to secure the attendance of external persons with relevant experience and expertise if it considers this necessary

1.7 Any changes to these Terms of Reference must be approved by the Trust Board.

2. Purpose

2.1 The Committee is established to provide the Board with assurance regarding the Trust's finances, performance against national key financial indicators and approval of investment cases.

2.2 The Committee will oversee the implementation of the IM&T and Estates Strategies.

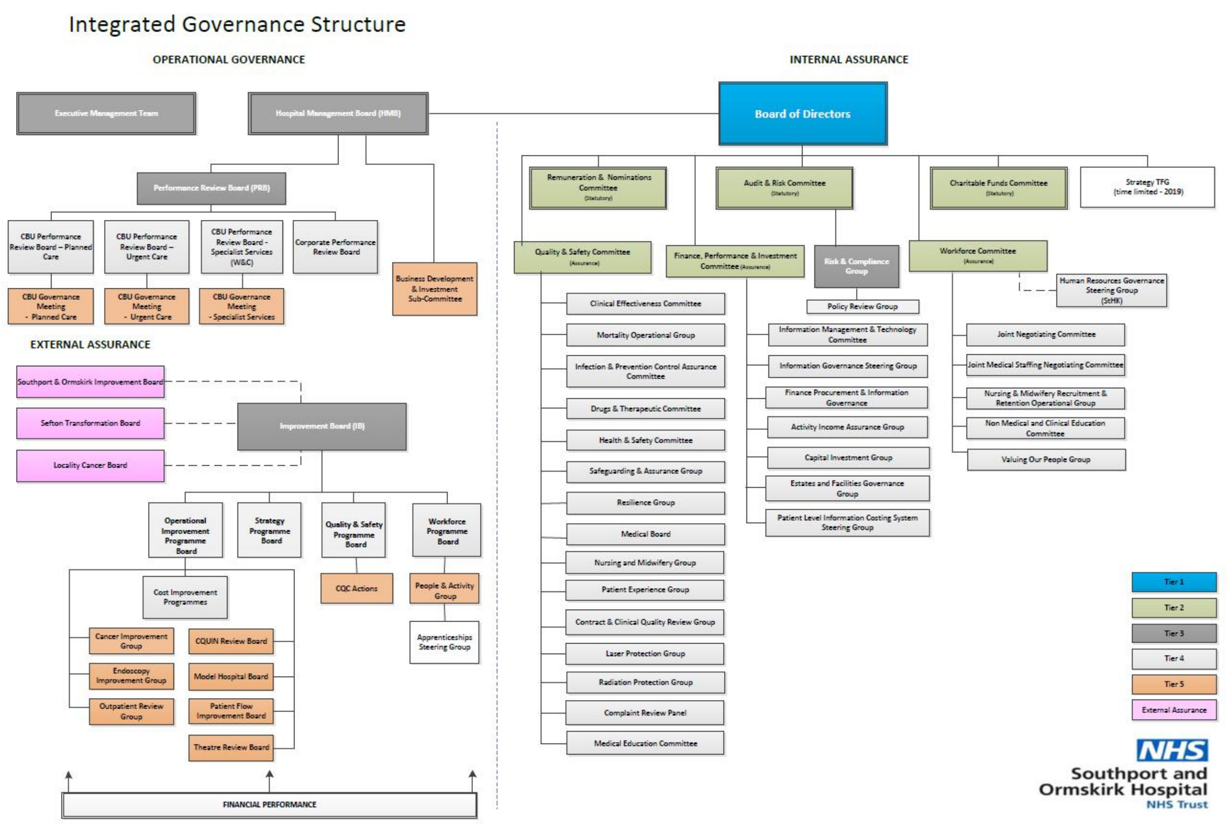


Diagram 1. The relationship between the Finance, Performance & Investment Committee, the Board and other Trust committees

3. Principal Duties

The duties of the Committee are as follows:

3.1 Financial planning and monitoring

a) Consider the Trust's financial plans (both revenue and capital) and approve key underpinning assumptions. Approve both revenue and capital budget.

b) Monitor monthly and year to date financial information including:-
- Performance against revenue budget at both Trust and Business Unit level.
- Run rate performance to date and forecast.
- Performance against the Cost Improvement Programme (CIP).
- Cash, liquidity and working capital.
- Performance against capital budget.
- Ensure the committee is advised of any significant variation in activity and its impact on income.
- Monitor compliance with contractual issues impacting on the Trust finances eg CQUIN performance targets and contract penalty issues, and consider the financial implications.

c) Consider the appropriateness of any corrective actions and undertake detailed scrutiny of the financial forward projections.

d) Review the Trust's Service Line Reporting (SLR) performance on a quarterly basis and consider implications for future viability.

e) Oversee the long term financial model.

3.2 Cost Improvement Programme

Where CIP schemes are at risk of delivery the Committee will seek assurance from Executive Director Leads that a plan is in place and being implemented to bring the schemes back on track.

Ensure that there is a CIP Programme in place for the financial year in line with the Trust's Annual Business Plan.

3.3 Contract monitoring

a) Approve the Trust's Contract Strategy and oversee the negotiation of contracts with the organisation's commissioners.

b) Review the systems in place to ensure compliance with the contract terms and monitor any impact of non-compliance on penalties.

3.4 Investment

a) Consider the recommendations of the Executive Management Team (EMT) when considering business cases for both capital and revenue investments.

b) Scrutinise all business cases for proposed investment that require Board approval, ensuring that outcomes and benefits are clearly defined, are measurable and support delivery of the Trust's key objectives.

c) Approve investment and expenditure on behalf of the Board as delegated to it.

d) Receive post implementation reviews to ensure benefits realisation.

3.5 Performance

Have oversight and review the national key performance indicators relevant to the remit of the Committee, paying particular attention to areas of deterioration and the potential financial impact of actions taken to address issues.

3.6 Information Governance

The Committee will receive at least twice annually, reports relating to the Trust's Compliance with the Freedom of Information Act 2000, GDPR and Data Protection Act 2018.

To receive and review the Trust's submission of the Information Governance Toolkit

3.7 Data Quality

To ensure that the Trust has in place effective arrangements for assuring the quality of its performance data

3.8 Procurement

Ensure the Trust has adequate oversight of procurement arrangements to ensure compliance with regulations and maximise value for money.

Have oversight of how the Trust's procurement of goods and services compare to others using national appropriate benchmarking.

Receive, on a quarterly basis, the Trust's register of tenders and contracts

3.9 Risk

Consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the Committee, as part of the reporting requirements, and report any areas of significant concern to the Audit & Risk Committee or the Board as appropriate.

Review all other significant–risks across finance, performance, IM&T, IG and data quality as highlighted in the monthly report

4. Business Conduct

4.1 Chair

The Chair of the Committee will be a Non-Executive Director. ~~, but not the Chair of the Audit Committee.~~

In the absence of the Chair, one of the other Non-Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 Membership

The members of the Committee shall be appointed by the Board in accordance with the *Standing Orders* and shall consist of the following members:

- Three (3) independent Non-Executive Directors
- Director of Finance
- Chief Operating Officer

~~4.3 All Board Members may attend any Committee meeting.~~

4.4 The Associate Director of Corporate Governance is required to attend meetings of the Committee in a non-voting capacity

4.5 The following persons shall be expected to normally be in attendance at meeting:

- Deputy Director of Finance
- Head of Information
- Deputy Director of Performance

4.6 Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.7 To ensure that the Non-Executive Directors have the majority vote, only the Director of Finance and Chief Operating Officer will have a vote at the Finance, Performance & Investment Committee. The Chair of the Committee will have a casting vote in the event of a tie.

4.8 All members are required to attend at least 75% of meetings held. Each member is required to nominate a deputy to attend in their absence. However, deputies shall not count towards the quorum of a meeting.

4.9 An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member.

5. Quorum

5.1 In order for the decisions of the Committee to be valid the meeting must be quorate. A quorum will be no less than three Members including two Non-Executive Directors and one Executive Director who must be either the Director of Finance or the Chief Operating Officer.

5.2 In the event there are insufficient regular NED members, a rotating NED will count toward the Quorum.

6. Frequency of meetings

6.1 The Committee will meet no less than ten times a year, usually once a calendar month.

6.2 The Chair of the Committee may arrange extraordinary meetings at his/her discretion or at the request of Committee members.

7. Organisation and Reporting Structure

7.1 The minutes of Finance, Performance & Investment Committee meetings shall be formally submitted to the Board of Directors.

7.2 The Chair of the Committee shall produce an Alert, Advise, Assurance (AAA) highlight report to draw the attention of the Trust Board to any issues that require disclosure to the full Board or require executive action

7.3 The Committee will produce an annual workplan for the Board to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

7.4 The following sub-groups of the Committee will report via the formal submission of a AAAs report:

- IM&T ~~Committee~~ Group
- Capital Investment Group
- Estates and Facilities Governance Group
- Business Development and Investment Group
- ~~Finance, Procurement & Information Governance~~
- Finance, IM&T and Procurement Group
- ~~Patient Level Income Cost (PLICs) Steering Group~~
- ~~Activity & Income Assurance Group~~
- ~~Information Governance Steering Group~~

8. Conduct of Meetings

8.1 The PA to the Director of Finance shall provide administrative support to the meeting and duties with include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

8.2 The agenda for the meeting shall be drawn up by the Committee Secretary and the Chair of the Committee in consultation with the Director of Finance. The agenda and papers for the meeting shall be distributed no less than four days in advance of the meeting

8.3 Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practicable.

8.4 Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper and the key issues. Committee members may question the presenter.

8.5 Meetings are not open to members of the public

9. Review of Terms of Reference

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

10. Review of Performance and Effectiveness

The Committee shall undertake a review of its performance and effectiveness at least once annually.

Approved by FP&I Committee	**28 September 2020**
Ratified by Board of Directors:	**[ENTER DATE]**
Date for next review:	**August 2021**

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

Committee/Group	WORKFORCE COMMITTEE
Meeting date:	29 SEPTEMBER 2020
Lead:	PAULINE GIBSON

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Sickness Absence
The sickness absence rates in month for medical, nursing and non-clinical is 1.8%, 6.4% and 4.9%, respectively; which apart from medical are higher than the planned targets. The Workforce Committee are expecting a review paper of these targets with an accompanying proposal. The Chair requested that there needs to be more narrative to support these metrics within the IPR. It was noted that these figures are expected to increase as the second wave for COVID-19 commences.

PDRs
Compliance for PDRs is at 63.4% in August 2020 from the figure of 62.6% in July 2020, against the target of 90%. Whilst there is improvement, there is still significant concern around this area. Whilst a number of comments were made on the Appraisal deep dive analysis, the Committee signed it off. The analysis is due to be completed by December 2020.

Medical Vacancy Rate
Whilst the medical vacancy rate for August 2020 has dropped from 14.5% to 8.2%, this figure is still off its target of 8%.

Clinical Education – Workforce Improvement Group (WIG) workstream
It was noted that the Clinical Education workstream in the WIG has been progressing slower than others with little evidence of good progress. The Committee were informed that area of the workstream is a significant risk to the Trust anyway but support is further required for traction.

ADVISE

Mandatory Training
Compliance for Mandatory Training has increased to 86.9% in August 2020 from 85.4% in July 2020, against the target on 85%. Whilst rates are increasing, this is still an area of concern for the organisation to deliver an excellent service to patients.

Supporting Attendance Policy
The PERS 12 Supporting Attendance policy is due to be launched in January 2021, following agreement between management and Staff Side. The Committee were informed that HR are continuing to review risk assessments; have launched a staff swabbing service to support staff; and two Executives are meeting with Merseycare around Just Culture. Furthermore, the organisation is fourth for the best sickness absence rate in the region relating to living with COVID-19.

Nursing Recruitment
There are currently many varieties of recruitment and retention activities being undertaking within nursing. There is due to be further information on what is in the pipeline in the next month. The senior nursing team are additionally further engaging in Training Nursing

Associate and Nursing Associate programmes, as well as the nursing care support working programmes.

HEE Self-Assessment
The HEE self-assessment report was approved by Executive Team Meeting and sent to the Workforce Committee for sign off before Board. The report was signed off for submission to the Board following no comments.

Employee Relations (ER)
There have been a number of cases paused during COVID-19 as per agreements with the Social Partnership Forum, however HR are continually working with Staff Side so this arrangement does not negatively impact on any staff in those processes.

ASSURE

Time to Hire (TTH)
The average TTH in month is 37 days from 51 days in July 2020, against the target of 55. The Committee were very impressed by the hard work, focus and effort of those involved to achieve such a stretched figure.

Apprenticeships
The Trust has still not lost any funding for apprenticeships despite the errors seen in the Digital Apprenticeship System. The Trust are expecting an expiration of funds in January 2021 unless more registrations commence.

International Recruitment
Currently five international nurses have arrived in Southport and are currently quarantining as per national guidelines. A further five nurses will be arriving on week commencing 12 October 2020. The pipeline for new starters remains robust.

Workforce Disability and Racial Equality System (WDES & WRES)
The annual WDES and WRES reports were presented to the Committee. Whilst it was noted that some of the data isn't wholly reliable due to lack of sample size, the actions agreed were meaningful such as: establishing robust staff network groups or further research into the root cause of why disabled and Black, Asian and Minority Ethnic staff less frequently are employed into higher bands.

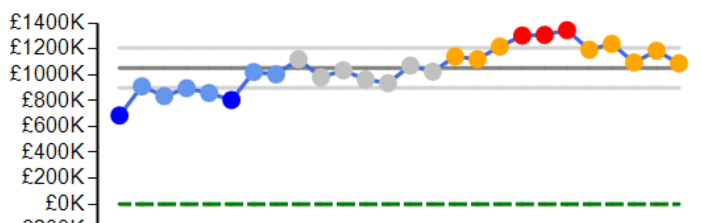
New Risk identified at the meeting	None.
Review of the Risk Register	

Workforce

Agency

Analyst Narrative: Expenditure on bank/ agency staff is failing its target by a considerable margin. Recent performance is also showing a worsening position.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Expenditure on Bank / Agency Staff	£00K	£1,089K	N/A	Aug 20		£00K	£1,186K	Jul 20		£5,803K	



Workforce

Organisational Development

Analyst Narrative: Personal Development Reviews are failing to provide assurance and recent variation is also negative. Workforce Committee have commissioned a deep dive analysis to address this.

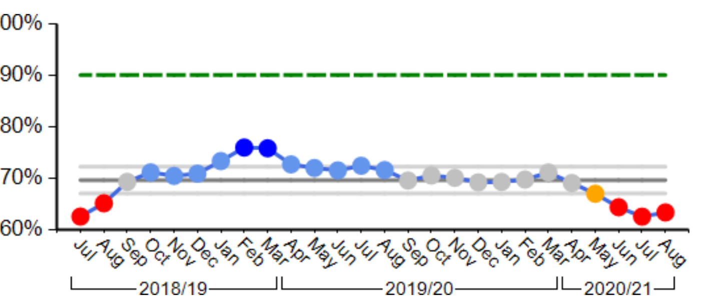
Mandatory Training assurance is inconsistent and recent variation is also not statistically significant.

Operational Narrative: Mandatory Training - The Trust core mandatory training figure has overall shown a slight increase in the last month to 86.9%. All core mandatory training remains online via ESR 24/7 with the exception of hand hygiene, moving & handling and basic resus. Both core mandatory and role specific training are reported monthly via the Board IPR, CBU PIDA meetings and are circulated to managers to monitor. All staff member have access to review their own competence profile via ESR with automatic prompt emails to staff and managers commencing 3 months prior to flag areas to update. The Director of Nursing is working with the senior nursing teams to deliver improved compliance in the following key areas: blood transfusion, resuscitation and local fire training. A review of the training needs analysis for blood transfusion is underway to be approved by the Blood Transfusion Committee, which aims to target key groups and improve compliance, this exercise has already been undertaken for resuscitation. The Clinical Competency Working Group continues to meet 3-4 weekly to progress TNA work for further subjects and develop an overarching “at a glance” training matrix. The 3 x high risks in relation to clinical education are reviewed monthly at the Risk & Compliance Group and managed weekly by the Exec led Clinical Education Oversight Group.

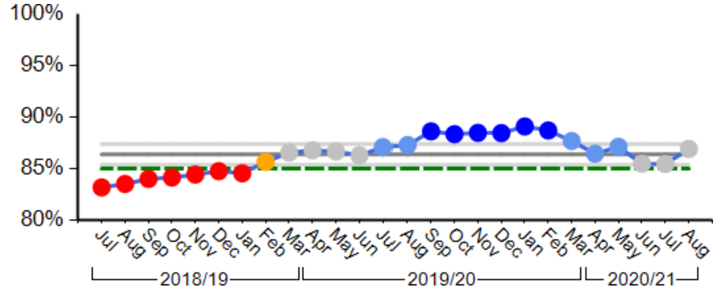
PDR - An appraisal deep dive analysis has been commissioned by the Workforce Committee Members. The purpose of the analysis is two-fold: 1) to review the data management process to provide assurance of accuracy and 2) to work with staff and management to define the purpose of appraisals and understand the contributing factors that make a quality appraisal. Work commenced in August with Board interviews to seek views to inform the analysis and an initial appraisal of the data management process is underway to identify gaps and take steps to amend. In the meantime, HRBP’s continue to work with CBU’s and managers to progress and improve compliance.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Personal Development Review	90%	63.4%	N/A	Aug 20	L	90%	62.6%	Jul 20	90%	66%	F
Mandatory Training	85%	86.9%	N/A	Aug 20		85%	85.4%	Jul 20	85%	86.3%	?

Personal Development Review



Mandatory Training



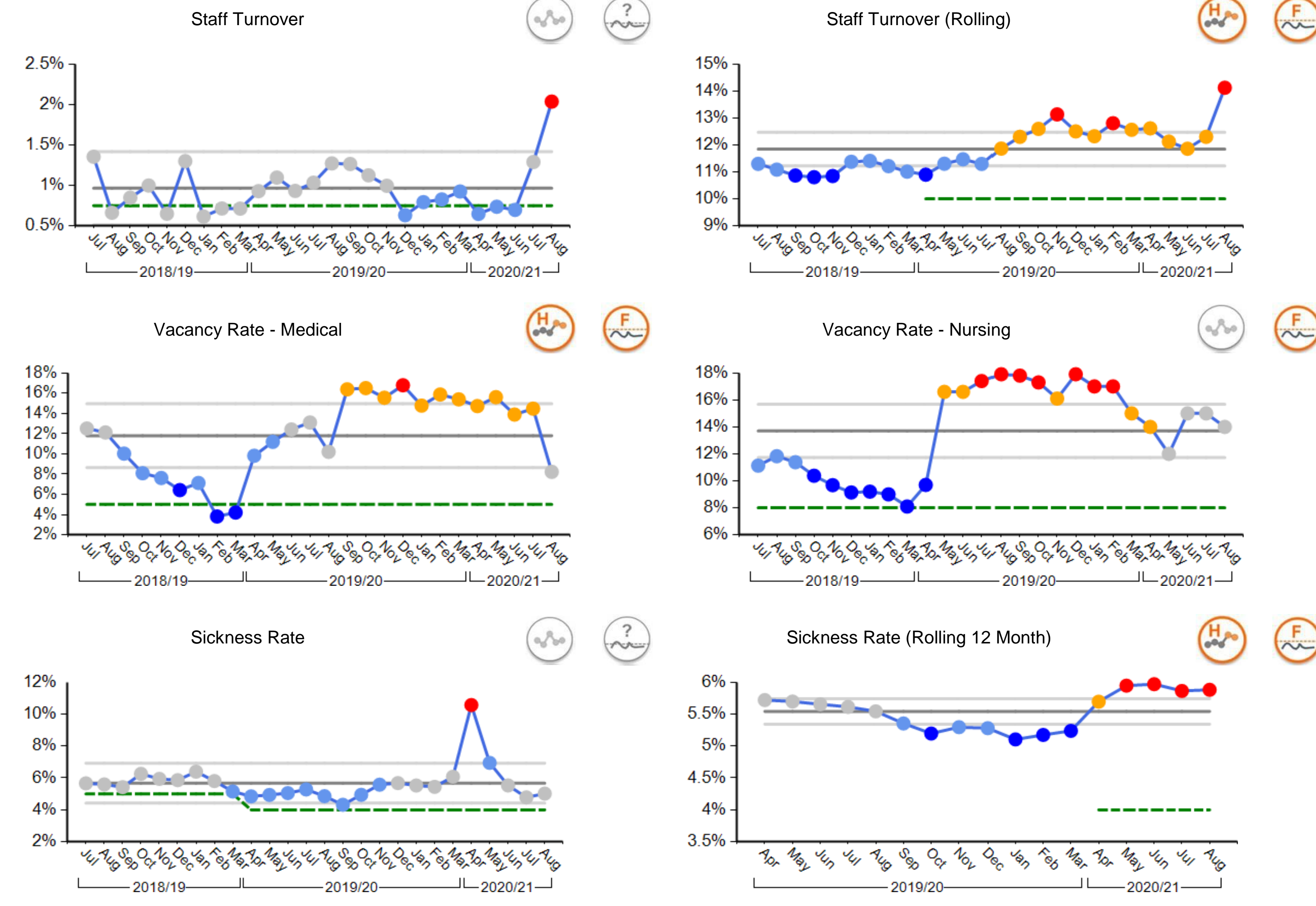
Workforce

Sickness, Vacancy and Turnover

Analyst Narrative: There are 11 indicators in this section none are assured in performance. There are a number of indicators failing to provide assurance, these include Staff Turnover, Medical and Nursing vacancy rates and Sickness - in particular Nursing and non-clinical. Of these it is worth highlighting that Turnover, Medical vacancies and overall sickness are actually showing recent negative variation as well so need particular attention. The time to recruit, although showing intermittent assurance is the only indicator with recent positive variation so this is a good.

Operational Narrative:
Medical vacancies - The positive reduction reflects a number of consultant vacancies that have been recruited to permanently in August 2020.
Sickness rate – nursing – With the rising infection rate, there has been an inevitable increase in the number of nursing staff reporting absent.

	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Turnover	0.75%	2%	N/A	Aug 20		0.8%	1.3%	Jul 20	9%	6.8%	?
Staff Turnover (Rolling)	10%	14.1%	N/A	Aug 20	H	10%	12.3%	Jul 20			F
Vacancy Rate - Medical	5%	8.2%	N/A	Aug 20	H	5%	14.5%	Jul 20	5%		F
Vacancy Rate - Nursing	8%	14%	N/A	Aug 20		8%	15%	Jul 20	8%		F
Sickness Rate	4%	5%	N/A	Aug 20		4%	4.8%	Jul 20	5%	6.5%	?
Sickness Rate (Rolling 12 Month)	4%	5.9%	N/A	Aug 20	H	4%	5.9%	Jul 20	4%	5.9%	F
Time to Recruit	55	37	N/A	Aug 20	L	55	51	Jul 20	55	47	?
Sickness Rate - Medical Staff	4%	1.8%	N/A	Aug 20		4%	1.9%	Jul 20	4%	3.6%	?
Sickness Rate - Nursing Staff	3.7%	6.4%	N/A	Aug 20		3.7%	5.5%	Jul 20	3.7%	8.1%	F
Sickness Rate - Non-Clinical Staff	4%	4.9%	N/A	Aug 20		4%	5.1%	Jul 20	4%	5.8%	F
Sickness Rate (not related to Covid-19) - Trust		4.6%	N/A	Aug 20			4.1%	Jul 20		4.3%	?



TB155_20b - Integrated Performance Report (Workforce)

Time to Recruit
100
80
60
40
20
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Sickness Rate - Medical Staff
10%
8%
6%
4%
2%
0%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Sickness Rate - Nursing Staff
14%
12%
10%
8%
6%
4%
2%
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug
2018/19
2019/20
2020/21
Sickness Rate - Non-Clinical Staff
7.5%
7%
6.5%
6%
5.5%
5%
4.5%
4%
3.5%
Apr May Jun Jul Aug
2020/21
Sickness Rate (not related to Covid-19) - Trust
4.6%
4.4%
4.2%
4%
3.8%
Apr May Jun Jul Aug
2020/21

Title Of Meeting	BOARD OF DIRECTORS	Date	7 October 2020
Agenda Item	TB156/20	FOI Exempt	Yes
Report Title	Guardian of Safe Working – Quarterly report		
Executive Lead	Terry Hankin, Medical Director		
Lead Officer	Sharryn Gardner, Guardian of Safe Working		
Action Required	☐ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

This report provides an update on issues affecting working hours / rotas / working conditions of trainees

Executive Summary

- Trainees on the whole, have a positive experience in the Trust when compared to other organisations.
- There are workforce pressures from clinical workload in General Medicine at Foundation level particularly in respiratory wards.
- There are ongoing reviews on the rotas which breach the maximum 1 in 3 weekends in the BMA 2016 contract.
- There is a tendency for nursing staff who escalate patients to the most junior medical staff. The rationale is believed to be due to the reliance on temporary and bank staff on wards.

Recommendation

The Board is asked to note breaches of 1 in 3 weekend frequency in 3 rotas, be aware of ongoing clinical pressures in respiratory (pre-COVID) and be aware that reliance on agency nursing staff is likely impacting inappropriate escalation procedures.

Previously Considered By:

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

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ☐ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Sharryn Gardner, GOSW	Sharryn Gardner, GOSW

THE GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT

1st November 2019 – 31st July 2020

Introduction

As Guardian of Safe Working I am responsible for collating information with regard to safe working for trainee doctors. This information is produced from Hours, Pattern and Service Support Exception Reports generated by trainees and I disseminate an anonymised overview to the Executive Medical Director, Assistant Medical Directors, Clinical Directors, trainees and Departmental Managers on a monthly basis. Education Exception Reports are monitored by Director of Medical Education and he will report on these to Board.

1. EXCEPTION REPORT OVERVIEW (1st August 2019 – 31st July 2020)

	01/08/2019 – 31/10/2019	1/11/19 – 31/1/20	1/2/20 – 30/4/20	1/5/20 – 31/7/20
Exception Reports ERs	24	7	11	4
Completed ERs	9	7	11	4
Trainees	7	5	4	3
Episodes	24	7	11	4
Review Interview Held	9/24	5	1	2
A&E	0	0	0	0
Medicine	10	7	3	1
Surgery	14	0	8	3
Trauma & Orthopaedics	0	0	0	0
Anaesthetics	0	0	0	0
Ophthalmology	0	0	0	0
Paediatrics	0	0	0	0
Obs & Gynae	0	0	0	0
GP	0	0	0	0

Medicine continues to be busy and while there are a number of ERs these probably still underestimate the number of true exceptions. We SHOULD expect **some** reports here are it is the nature of the post.

Surgery issues have tended to focus on anticipated unfilled gaps as well as cross-covering other firms and having one or more tiers of doctor missing. This in one particular week with issues with a particular locum resulted in 2 Immediate Safety Concerns and a number of escalations after the event.

Completion rate rose in Nov-Jan and then plummeted. Lack of interviews and the process around lack of payment have led trainees to dismiss the Exception Report system.

Most Exception reports have been closed with payment (partly around the non-completion of supervisor interviews).

1a. MEDICINE

Workload across the organisation remains high and particularly in respiratory. During the COVID peak trainees did not rotate and workload was particularly heavy. Trainees tended during this period to support each other and the Trust well. The rotas did alter within BMA temporary guidelines and these new rotas were well received by trainees. No-one was moved to an area they had not worked in or trained to be competent in previously.

1b. SURGERY

There were more ERs in surgery in the middle of the 3 quarters. Trainees are frustrated that gaps are not always filled when anticipated and that there can be gaps at other levels due to rotas / leave.

2. PAYMENT AND FINES

There have been no GoSW fines levied in either of the last three quarters.

3. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

All Trust Rotas are 2106 compliant.

The BMA provided additional guidance during the COVID peak which enabled changes to rotas temporarily. The changes were generally well received and trainees generally felt supported by the Trust and by meal provision, free car parking and universally available PPE.

There were no Work schedule reviews during this period.

A number of rotas are not compliant with the maximum 1:3 weekends and this should be in place across the board by August 2020. GoSW in contact with CDs in these areas to look at planning for this.

4. DOCTORS NOT ON THE NEW CONTRACT

All trainees are now on the 2016 contract for the first time.

No concerns about safe working from non-trainee doctors have been escalated to the GoSW.

5. VACANCIES (as of 1st September 2020)

SOHT are actively recruiting and therefore vacancy rates are changing frequently, so I cannot guarantee complete accuracy. Doctors are also leaving often out of sync with normal staff changeover dates.

The current vacancies have been largely unchanged for the last 12 months.

6. TRAINEE CONCERNS

Attendance at the TDF continues to be a feast or a famine despite the provision of pastries.
We continue to try different strategies to improve this.

A further issue is a degree of lack of ownership from the trainees where trainees present agree to gauge opinions or get additional ideas / information and then do not attend the next meeting or provide feedback such that we effectively tread water on a number of issues.

The longest running issue has been the continuing practice of ward nursing staff contacting the most junior ward doctor for patients identified as likely to be very sick by early warning scores. There is significant work going on in the background to address this and it is felt to be historic and exacerbated by a lot of bank staff. Trainees have perceived no improvement in this are despite raising it at each Trainee Doctor Forum for 6 months.

7. FACILITIES

Facilities funding of over £60 000 has been made available for the Trust’s Trainee doctors to improve rest and related facilities. The majoriy of the funds will be spent at SDGH CEC providing sleeping areas as well as new toilet / shower areas. Different funds have been used to improve things at ODGH.

8. ADDITIONAL GOSW CONCERNS

The trainees were not being paid for exception reports and took around 1 year for trainees to articulate this. Looking into processes in HR and how to automate system.

The trainees have continually raised the issue around being escalated to (alone) for the sickest patients and have seen no change as a result of continually highlighting this. Work is ongoing to improve this and has not (yet) seen those improvements make a difference at ward level.

The changes are not all rota-based and will need planning to be implemented (such as provision for transport home if not safe to drive after night-shift). Accommodation is available (should be booked in advance where possible, is limited in capacity and available to all staff on call). If not available transport home and back is paid.

Dr Sharryn Gardner
Guardian of Safe Working
1st September 2020

Title Of Meeting	BOARD OF DIRECTORS	Date	7 October 2020
Agenda Item	TB157/20	FOI Exempt	No
Report Title	Health Education England Self-Assessment Report (SAR) 2020		
Executive Lead	Jane Royds, Director of HR & OD		
Lead Officer	Tracy Gunn, Head of Education, Training & OD		
Action Required	☐ To Approve ☐ To Assure	√ To Note ☐ To Receive	

Purpose

To inform the Board Members of the responses to the HEE Multi-Professional Self-Assessment Report (SAR) prepared by the Medical & Nurse Education Teams submitted online on the 18 September 2020, prior to the deadline 30 September 2020

Executive Summary

This report is for the Board Members to note as requested by Health Education England in the HEE Self-Assessment Report 2020. HEE has confirmed that the report can be submitted online prior to being seen at Board. The Executive Team approved this report on 14 September 2020 and the online submission was completed on 18 September 2020.

The last HEE SAR was submitted in 2018 and it is anticipated that this will move to an annual response in view of the new NHS Education Contract in September 2020. This report forms Southport & Ormskirk NHS Trust's self-assessment of how it is meeting the quality standards of the current HEE Learning & Development Agreement and flags areas where standards are not met. The responses are provided by the Medical and Nurse Education Teams supplemented with responses from the subject matter experts in relation to education governance arrangements in their respective appendix.

A separate document has also been submitted which shows the Trust's current education governance structure. The Trust recognises that there is a need to improve its overarching education governance structures to ensure a multi-professional approach to education and training and provide Board assurance. In recognition of this, an Executive led Clinical Education oversight Group has been established.

Recommendation

The Board members are asked to note the report.

Previously Considered By:

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

Strategic Objectives

☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards

☐ **SO3** Efficiently and productively provide care within agreed financial limits

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel

valued and motivated	
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Tracy Gunn, Head of Education, Training & OD	Jane Royds, Director of HR&OD

Southport & Ormskirk NHS Trust
Self-Assessment Report (SAR)2020

Declaration

Trust Name

Southport & Ormskirk NHS Trust

Name of Board Level Director responsible for Education and Training within your organisation:

Terry Hankin, Medical Director

Report compiled by (responsible for completion):

Director of Medical Education SAS Leads Patient Safety Consultant Lead PEF Team / Assistant Director of Nursing (Workforce) Library & Knowledge Management Services Manager EDI Lead Assistant Director of Governance & Risk Deputy Chief Pharmacist

Date seen at or scheduled for Board meeting	07-10-2020
Approved by/ on behalf of the trust Board (Name):	Terry Hankin, Medical Director
Date approved by/ on behalf of the trust Board:	14-09-20

HEE Domain 1: Learning Environment and Culture

1. ***In your organisation, in which clinical service areas does clinical workload regularly impact adversely on your ability to deliver clinical training?***

Medical Education Response
The Department of Medicine and Surgery within the trust had significant red outliers in the 2019 GMC Trainee Survey. Further analysis of these two departments highlighted significant gaps on the resident rotas, which suggested the service delivery pressures were impacting on the quality of training provided.

Educational Supervision was also highlighted as an issue with both the 2019 GMC Trainee and Trainer Survey in the Department of Medicine. The department had a number of locum consultant appointments, some of whom were trained and job planned to provided clinical and educational supervision, some of whom weren't. So again the clinical service delivery had an impact on the quality of training provided.

Nurse Education Response
Where clinical workload has been highlighted on occasion as potentially affecting training, these have been managed collaboratively with the nurse education team and departments to resolve the issue, in the majority of cases in advance, to support individuals in their training requirements.

2. ***What strategies do you employ to maintain clinical service and training on a daily basis?***

Medical Education Response
Organisationally, the trust recognises that it currently doesn't have an overarching clinical education and training strategy. A process mapping event is ongoing within the trust senior management team to develop one.

The current senior management team, in conjunction with the Director of Medical Education, have been developing a culture within the organisation where medical education and training is valued. Following appointment to the role in December 2018, the Director of Medical Education met with the lead clinicians in individual departments, at their departmental meetings. This was to highlight the educational and training needs of the students and doctors within their department and to help identify the barriers in delivering them and support understanding within the operational teams as core business of the trust.

The model for job planning for educational roles, was re-designed by the Director of Medical Education, so the department was given allocated time, job planning objectives and a Departmental profile to implement. This will necessitate discussion between the Clinical Director/ Lead Clinician and Lead Educators on the model of educational and clinical supervision within the department. Thus, the operational team will have responsibility for both clinical and educational service delivery within the department. This will provide accountability at a departmental level for the delivery of undergraduate and postgraduate medical education and training. This is further re-enforced by the Supervision of Doctors in Training Policy, which makes the Clinical Director jointly responsible with the lead educators for the Learning Environment and Culture within the department.

The Director of Medical Education undertook regular safety huddles with the foundation doctors. This allowed specific issues where there was a tension between service delivery and educational delivery.

The Director of Medical Education, Medical Director and Guardian of Safe Working, have an excellent working relationship. Issues identified or raised with one are discussed with the others, to identify solutions, particularly if/when exception reports are submitted. The aim of the working relationship is to address both specific issues, but also identify trends and themes, which need a wider organisational solution.

Nurse Education Response
Each clinical area has an assigned Practice Educator that works hard to ensure all training is accessible and available to all members of staff whilst maintaining clinical services. Drop in sessions and opportunistic training is also utilized which makes effective use of available time between providing clinical services.

Clinical educators also provide essential hands on training and support which can be delivered alongside the provision of clinical care.

Training to support our future workforce and education to support staff in the supervision of trainees is provided by the Practice Education Facilitator Team

HEE Domain 2: Educational Governance and Leadership

1. ***Many clinical services are undergoing review and change as part of the NHS Long Term Plan & People Plan, what governance steps have you put in place to ensure the required notification of any change in service is given to both HEE and the HEIs to ensure continued clinical placements within your organisation?***

Medical Education Response
The Director of Medical Education is a Member of the Clinical Board, which is held monthly. This is a forum for the departmental Clinical Directors/ Lead Clinicians and the Medical Director to discuss both operational delivery and the service and strategic planning objectives of the trust.

They are also a member of the Associate Medical Director forum, which meets weekly with the Medical Director. Again, operational and strategic matters are also discussed.

Thus, through understanding the service delivery model and the future likely service configurations, the Director of Medical Education can consider the impact this may have on the clinical learning opportunities within the organisation. In turn, this would allow consultation with the local HEIs and HEE NW, to determine the possible impact on the medical education and training delivered within the trust.

Nurse Education Response
Outcomes of formal quality assessments i.e. CQC inspections which may lead to notifications of changes in service and learner placements, are formally notified to HEE and HEI's. Further organisational notification of changes would be undertaken via the PEF Team's in liaison with the HEI's as required.

2. ***Please describe how your organisation ensures the governance of education. Please email a copy of the organisational diagram or visual that describes the governance and team structures relating to education and training to the North Quality Analyst Team at nqat@hee.nhs.uk.***

Description and organisational diagram sent to the North Quality Analyst Team via email as above

Medical Education Response
The Trust Clinical Tutors
They will oversee the educational governance arrangements within the CBU, which they are aligned with. The quarterly educational KPI report will be jointly owned by the Trust Clinical Tutor and the AMD responsible for the CBU. Any Action Plan necessary will be agreed jointly between the Trust Clinical Tutor and the AMD.

In addition to be being assigned to a CBU, each of the Trust Clinical Tutors will have an educational portfolio area for which they will be responsible:

1. **Simulation Lead**
   They will develop a simulation strategy for the trust moving forward, in the initial instance focusing on ensuring the current programmes which need to be delivered have a sustainable faculty. Ultimately the strategy will be extended to include the use of simulation and clinical skills within the trust, to support the clinical learning needs of the organisation
2. **Educator Development Lead**
   They will be responsible for maintaining the trust trainer database and monitor the trust educational appraisal process. In addition, they will have responsibility for devising the trust strategy on supporting trainees whose performance has given cause for concern
3. **Educational Governance Lead**
   They will be responsible for overseeing the development of the routine monitoring processes within the department. These need to be aligned with the clinical governance structures within the organisation and ensure that education and training is embedded as part of the development of the trust's safety culture

College Tutors
They will oversee the educational governance arrangements within their department for postgraduate medical education. They will be jointly responsible for the quarterly KPI report for their department with the Clinical Director and/or Lead Clinician. Any Action Plan necessary, will be agreed jointly.

Specialty Leads for student doctors
They will oversee the educational governance arrangements within their department for undergraduate medical education.

Structure and function of the Committees/ Groups within Medical Education overview
The Trust has a service level agreement with local Higher Education Institutions to provide clinical placements for student doctors and student Physician Associates. Additionally, via the Learning Development Agreement, it has a contract to provide postgraduate education and training for doctors in training.
The trust also has a responsibility to support the personal and professional development of SAS doctors. Support and develop those who undertake and supervise medical learners, to ensure they have the appropriate capabilities for their roles.
Oversee the administration of Study Leave to Foundation Doctors, Consultants, SAS and locally employed doctors.

Postgraduate Medical Education Committee

The Postgraduate Medical Education Committee (PG-MEC) operates to oversee the delivery and quality management, control and assurance of postgraduate medical education and training delivered within Southport and Ormskirk NHS Trust.
Its function is to oversee the operational delivery of postgraduate medical education and training and provide a forum for faculty development for the postgraduate senior educators in the trust, with the aim of developing excellence in Medical Education

Postgraduate Medical Education Executive Group
The Postgraduate Medical Education Executive Group operates to advise and make recommendations on the delivery, as well as the quality management, control and assurance of postgraduate medical education and training at Southport and Ormskirk NHS Trust.
The Group will provide a forum for the Lead Educators to devise an appropriate strategy to aspire to excellence in the delivery of postgraduate medical education and training in the trust

Undergraduate Medical Education Committee
The Undergraduate Medical Education Committee (UG-MEC) operates to oversee the delivery and quality management, control and assurance of undergraduate medical education and training of Doctors and Physician Associates delivered within Southport and Ormskirk NHS Trust.
Its function is to oversee the operational delivery of undergraduate medical education and training and provide a forum for faculty development for the undergraduate senior educators in the trust, with the aim of developing excellence in Medical Education

Undergraduate Medical Education Executive Group
The Undergraduate Medical Education Executive Group operates to advise and make recommendations on the delivery, as well as the quality management, control and assurance of undergraduate medical education and training at Southport and Ormskirk NHS Trust.
The Group will provide a forum for the Lead Educators to devise an appropriate strategy to aspire to excellence in the delivery of undergraduate medical education and training in the trust

The Medical Induction Working Group
This group was initially established as a Task and Finish Group to pre-plan the medical induction programme delivered to doctors in training who rotate to the trust in August or February each year.
As the operational delivery of induction needs to be agreed and planned with each cohort of trainees rotating to the trust, this is no longer a Task and Finish Group. The function of the Medical Induction Working Group is to support the relevant trust organization required to deliver safe and effective medical induction to doctors in training who rotate to the trust on clinical placement.

The Academic Year Planning Group
The trust needs to ensure effective and efficient use of the resources to support clinical education and training within the trust. In addition to medical learners, the trust is required to support other staff groups within the organisation who require clinical education and training.
The purpose of the Academic Year Planning Group is to provide a forum for the relevant stakeholders to co-ordinate and manage their clinical education and training programmes. In agreeing the organisational needs and forward planning the academic training year, it allows early identification of resource issues, which can then be addressed in a timely manner, thus minimising the risk of adversely affecting the clinical learners within the trust.

<u>HEE Domain 3: Supporting and Empowering Learners</u>

1. ***Please describe how your organisation provides support to medical trainees who submit Exception Reports***

Medical Education Response
The Director of Medical Education, Medical Director and Guardian of Safe Working, have an excellent working relationship. The Guardian of Safe Working speaks to all trainees at induction and outlines the trust exception reporting system. Briefing is also given by the operational team, who are responsible for the software system used for capturing exception reports.

The Director of Medical Education also highlights the importance of exception reporting, as a trust feedback mechanism to support change, if needed, at the Foundation Safety Huddles. Additionally, the Director of Medical Education is a trust Freedom to Speak Up Champion.

2. ***How do you encourage trainees to identify Educational Exception Reports?***

Medical Education Response
The initial briefing at induction highlights the different reasons exception reports may be submitted. However, it is recognised that sometimes trainees may find it a challenge to identify between reasons for submitting exception reports.

The Guardian of Safe Working and the Director of Medical Education both have access to all the exception reports submitted. Both review the individual exception reports regularly and agree who manages what. Thus, if the exception report has been “incorrectly labelled” by the trainee, this will be identified and manage appropriately

Service delivery and additional hours worked are generally dealt with by the Guardian of Safe Working and educational issues by the Director of Medical Education. Patient safety issues are escalated to the Medical Director and managed appropriately. Feedback is provided where appropriate, generally by the Guardian of Safe Working.

Themes around exception reporting are discussed at the Trainee Doctor Forum, which hopefully supports the trainees in understanding what and how an exception report should be submitted.

3. ***How have you used the ‘Rest Monies” allocated to you?***

Plans have been approved to undertake reconfiguration works within the Clinical Education Centre on the Southport hospital site which will result in provision of additional x 2 gender neutral wc’s, shower and change facilities, a fully equipped kitchenette and 2 x sleep pods. This work is expected to commence in quarter 2 of 2020/21.
The new facility will be accessible 24 hours per day, 7 days per week and is ring-fenced for exclusive use of our student and trainee doctors.
Monies have also been used to upgrade existing Doctors Mess facilities on the Ormskirk hospital with the provision of new modular furniture, new PC/study facilities and an increase in the number of lockers available for students and trainees changing pre and post-shift.

4. ***Please describe how your organisation provides support to learners to ensure they can access rest facilities***

Medical Education Response
The importance of rest for personal health and wellbeing is covered during the trust induction for doctors in training. Briefing on the facilities available is covered both at induction and in the doctors in training handbook.

Access to IT facilities is provided at induction. Individual departments are advised to brief and provide orientation to the IT facilities within the department.

The trust has a Well-Being room within the Clinical Education Centre at Southport, with Health and Well-Being noticeboard, with details of how pastoral support may be accessed. Information is also provided in the doctors in training handbook.

The Director of Medical Education and Medical Director both have "open door" policies and these are highlighted at induction. Similarly, the Head of Medical Education and Coordinators also operate an "open-door" policy, readily accessible for enquiries and support at all times.

The Director of Medical Education, through the regular Safety Huddle has been available to the foundation trainees and is now supported in this role by the Foundation Programme Director.

The trust has also a buddy system for the foundation doctors.

5. ***How do you support academic learners?***

Medical Education Response
The trust doesn't currently have any trainees on academic training pathways. Should a trainee be allocated to the trust, discussion would be needed with the Specialty School to identify their academic learning needs which would need to be supported in the trust.

Nurse Education Response
All of our pre-registration students receive a formal induction prior to the start of their clinical placements which is organised by the PEF team. During induction all students complete the IT access request forms so that they have access to the trust intranet and the policies and guidelines contained within. Library access is also arranged for the students at induction.

Pastoral support is provided by the PEF team in a number of ways:
- Regular walk about, visiting students on duty
- Contact record log which identifies students' individual needs and support that has been put in place - this is only available to the PEF team and ensures continuity of support if their named PEF is not on duty.

Introduction of group support for cohorts of students via WhatsApp - this was introduced and trialled in September 2019 with the first year student midwives and has proved a successful way for students to access PEF support whilst on or off placement.

Support for academic learners is provided as part of a partnership agreement with the HEIs. The PEF team also offers support for those undertaking academic learning and further support in resourcing learning materials can be sought from the library team.

HEE Domain 4: Supporting and Empowering Educators

1. ***MEDICAL TRAINING: Please provide details of the specific SPA time you allocate to individual trainers.***

Medical Education Response
The model of clinical and educational supervision may differ from department to department and it has been agreed individuals will not be re-numerated for the role of Named Clinical and Educational

Supervisor for the same trainee. Given the roles may have similar roles and responsibilities this is wholly appropriate.

Thus, 0.25PA per full-time trainee slot and 0.125 PA per student doctor/ PA allocated to the department, should be allocated to each department. It is for the Clinical Director, College Tutor (Trust Specialty Lead) and Specialty Lead for student doctors to decide how this allocated amongst the individuals within the department, depending on the departmental model of clinical and educational supervision for doctors in training and student doctors.

1 PA is allocated to all departments, aside from Medicine, who will be allocated 2 PAs for postgraduate educational governance. It is expected that the College Tutor (Trust Specialty Lead) will be responsible, together with the Clinical Director for the delivery of educational governance at a departmental level. It is expected that the department should have educational leads for each programme they deliver within the department, in line with the Departmental Educational Profile. If the College Tutor wishes to delegate these roles to others in the department, a job description and job planning objectives should be given, together with a PA allocation from that allocated to the department for the College Tutor (Trust Specialty Lead).

0.5PA is allocated to each department for undergraduate educational governance. It is expected that the Specialty Lead for student doctors will be responsible, with the Clinical Director for the delivery of educational governance at a departmental level, for student doctors. This PA allocation would usually sit with the Specialty Lead, but the department can determine how this PA allocation is distributed, depending on the model of clinical and educational supervision for student doctors within the department.

2. ***MULTI-PROFESSIONAL TRAINING: Please provide details of the protected annual time for continued development you allocate those providing educational roles over and above the time required annually for their continuing clinical development. What in-house courses/ support do you provide; what external courses for you regularly use?***

There is currently no formal process for the protection of continued development for those providing educational roles outside of Medical Education. Educators have access to relevant funded apprenticeship programmes in learning & development to develop their educational skills.

In response, the Trust has established an Exec Lead Clinical Education Oversight Group to review all staff with educational roles and look to put in place support structures such as continued development and protected annual time for education as part of the job planning process.

<u>HEE Domain 5: Delivering Curricula and assessments</u>

1. ***With the introduction of new workforce roles (e.g. Physicians Associates) and increased numbers of Advanced Practitioners in training, together with an increased reliance on Locally Employed Doctors on service rotas, how do you ensure that doctors in training receive their required curricular opportunities and where necessary how are these needs prioritised?***

Medical Education Response
Many of the roles created to support the workforce have been done so, as a consequence of gaps on resident medical rotas. Some of this has been done to support changes in working practice and delivery of the EWTD. However, this means that medical roles have been replaced by non-medical

personnel. Thus, the leaning opportunities which were previously available to medical personnel, need to be made available to non-medical personnel.

The department of Medical Education has undertaken a scoping exercise of the clinical learning opportunities available within the trust. It is starting to populate a learning map for the organisation, which highlights where, when and how these clinical learning opportunities can be accessed. This can also link to external learning opportunities, which can be used to supplement those available within the trust.

Additionally, it has reviewed its departmental organisational structure. The role of Clinical Programme Manager has been created and recruited to. This role has been created to oversee all the medical education and training programmes which need to be delivered in the trust.

The Director of Medical Education is a member of the Non-Medical Education Committee which has oversight of the clinical placements for non-medical personnel in the trust. By linking the Clinical Programme Manager with those responsible for timetabling the non-medical clinical placements, the trust is developing oversight of where its clinical learners are placed. The aim is to work more closely together, to develop a "real-time" clinical placement schedule for the trust, so that equitable access to learning opportunities can be provided. This would also support the trust quality assurance framework for clinical education, which is being developed.

The Trust has appointed a Lead ACP, who has oversight of the Advanced Practitioners training and working in the trust. A trust governance framework has been developed for this group of healthcare professionals. The Director of Medical Education and Lead ACP have been in discussion about the learning needs of the ANPs and ACPs within the trust. Through signposting them to the learning map, it is hoped this can support their professional development. As these healthcare professionals have a wealth of experience and valuable skill set, it is hoped that they can be utilised to support medical learners.

The Director of Medical Education has been working on developing a more structured approach to clinical skills teaching and training. Through the creation of appropriate learning materials and the full-time Practice Zones within the Clinical Education Centre, it has increased the capacity available for clinical skills teaching. This has created additional learning opportunities outside the clinical placement environment.

2. ***The NHS People Plan identifies the need for increased placement numbers to accommodate the planned growth in student numbers to meet future workforce demand. What plans do you have in place to accommodate increased student placements? What impact do you envisage this will have on your ability to maintain the learning experience provided to current students and to clinical service provision?***

Nursing Response
In preparation for the increase in student numbers the Trust has ensured that it has enough capacity within the nursing and midwifery teams (AHPs) to support these students. This has involved increasing student capacity on wards and in turn increasing the provision of Supervisor and Assessor preparation training within the trust. The CLIP model will further support provision of supervision to learners in the Trust and is a model we are implementing.

In some specialist areas such as midwifery, it is difficult to increase capacity where care is provided in a one to one setting, for example on delivery suite or out on the community. To address this, a rolling rota is to be introduced to ensure that student numbers in the clinical area are managed and provided with quality placements. This was piloted during Covid with the students that opted in and was successful.

As part of the Pan Mersey Consortium Bid Clinical Placement Expansion Programme in association with Health Education England (HEE) and supported by NHS England/Improvement (NHSE/I) to deliver sustainable placement growth in the NHS workforce, in line with the ambitions of the Long-term Plan, the consortium has been successful in securing funding (£300,000). As part of the Consortium, the Trust will utilise the funding for the delivery of undergraduate placement expansions and growth of education and training across our healthcare professions.

HEE Domain 6: Developing a Sustainable Workforce

1. ***The People Plan identifies as a priority the need to tackle both 'The Nursing Challenge' (Chapter 3) and to create the workforce needed to deliver '21st Century Care' (Chapter 4). What plans for 2019-21 does your organisation have to meet these challenges from an educational and training perspective?***

Nursing Response
The Trust has invested in a Head of Professional Practice Development for Nursing and Midwifery due to commence Q3 2020.

The Trust has commenced a programme of international recruitment in collaboration with NHSP supportive to a recruitment pipeline of 72 registered nurses over the next 12 months. The plan is to recruit to an additional PEF role to support the training and educational requirements i.e. OSCE and clinical skills

The Trust is part of a collective bid for HEE's placement expansion programme funding and has been successful in its bid to support an increase in clinical placements for pre-reg nursing students in our Trust. The aim of increasing the number of students is to build on the number of newly qualified nurses applying for posts in our Trust and reduce the vacancy number.

The Trust plans an increase of 81 more students commencing from September intake 2020 onwards. Work is underway to ensure enough placement areas are available with the appropriate support from practice supervisors and practice assessors. This will be supported by Student Placement Quality Coordinators who will work across the collaborative to lead and ensure increased placement capacity.

Development Opportunities

a. **Pathways into nursing**

The Trust is working hard to increase the numbers of nursing staff, and we are launching three new apprentice training options starting this September 2020. A second intake is also planned for March 2021.

- **Trainee Nursing Associate**
  Against the 10 places offered we have confirmed 6 staff due to commence and a further 2 to be confirmed and all planned to commence at the end of Sept 2020.
- **Nursing BSc Apprentice**

Against the 10 places we have 8 confirmed (5 part 1 and 3 mid-point 2).

- **Nursing MSc Apprenticeship**
  We have 5 staff members confirmed to start September 2021. The MSc programme may commence earlier in Jan-March 2021 pending cohort confirmation with the HEI's.
- **Apprentice ODP**
  Against 3 places we have recruited to all 3 places (external candidates)

The Trust plans with a local FEI to reintroduce the ACORN programme as part of our pipeline for HCA recruitment and then potential NA or RN pathways – these roles were removed by the colleges during COVID.

The Care Support Worker Development programme (CSWD) with NHSP has also recommenced as part of our HCA pipeline and then potential pathways into RN training.

b. Continuing Professional Development

HEE funding of £1000 per head over 3 years or nursing and AHPs has commenced this year our Trust will begin to develop CPD programmes appropriate to the professional needs of the staff groups. Work is underway to deliver development programmes that reflect the needs of our patient population and support new ways of working and upskilling staff. This will be an important factor in retention of staff as development in professional practice is related to increase in feeling valued and staff therefore remaining in the Trust.

Organisation top three successes and top three challenges

Please use this section to summarise three high-level successes your organisation is most proud of achieving, and list any challenges or prominent issues that HEE should be aware of

Description of success	Description of Challenge
Service improvement initiatives have improved the Trust's Emergency Department performance, moving it out of the bottom quartile	A clinical education review is underway to ensure infrastructure & resources, education governance and data assurance measures are in place and effective
Stability of the senior Executive Leadership Team after several years of instability	Below average staff engagement (NHS Staff Survey)
Trust no longer an outlier for patient mortality	Recruitment & retention of staff

Please use this section to summarise three items of Best Practice your organisation is most proud of achieving, and the impact this has had within your organisation. Please Note: Best Practice will be shared with other organisations.

Description of Best Practice	Impact of Best Practice
Use of the apprenticeship levy to enhance current skills, develop new roles and grow our own workforce for the future i.e. Nursing Associates, Physician Associates, Registered Nurse Degree	Creation of a more diverse and flexible workforce for the future, internal promotions to new & higher roles, maintenance of patient safety, more opportunities for career progression to improve staff retention
Working collaboratively with Cheshire & Merseyside LMS and clinical partnerships with a focus on	Development of region wide dashboard to enable benchmarking and check and challenge.

clinical safety, choice, mental health and partnership working	Development of Special Interest Groups to share best practice standards. By the multidisciplinary teams working collaboratively, there is a joined up approach to new initiatives and equity across providers
Included in Part of Wave 2 National Mat Neo Safety Collaborative. Maternity team focused on deteriorating patient. Team presented in London to the National Maternity & Neonatal Safety Collaborative on the improvements they have made regarding the deteriorating patient	Sustained improvement of recording of Maternal Early Warning Scores using Quality Improvement Improvements in patient Safety

Nursing and Midwifery Students (NMC)

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met. If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- Not Applicable
- **Applicable** ✓

Domain 1: Learning Environment and Culture

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	[x]	[ ]	[ ]
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	[x]	[ ]	[ ]
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	[x]	[ ]	[ ]
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	[x]	[ ]	[ ]
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	[x]	[ ]	[ ]
1.6 The learning environment promotes inter-professional learning opportunities.	[x]	[ ]	[ ]

Domain 2: Educational governance and leadership

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	■	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	☐	☐	■
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	☐	☐	■
2.4 Education and training opportunities are based on principles of equality and diversity.	■	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	■	☐	☐

Domain 3: Supporting and empowering learners

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	■	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	■	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	■	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	■	☐	☐

	Met	Not Met	Action Plan Available
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	■	☐	☐

Domain 4: Supporting and empowering educators

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	■	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	■	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	■	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	■	☐	☐

Domain 5: Delivering curricula and assessments

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	■	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	■	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	■	☐	☐

Domain 6: Developing a sustainable workforce

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	■	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	■	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	☐	■	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	■	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Adult Nursing	☐	■	☐	☐	☐	■
Child Nursing	☐	■	☐	☐	☐	■
Community Nursing	☐	☐	☐	☐	☐	☐
Health Visitors	☐	☐	☐	☐	☐	☐
Learning Disabilities Nursing	☐	☐	☐	☐	☐	☐
Mental Health Nursing	☐	■	☐	☐	☐	■
Midwifery	☐	■	☐	☐	☐	■
Nursing Associates	☐	■	☐	☐	☐	■

Medical Training (General Medical Council)

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met. If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- Not Applicable
- **Applicable** ✓

Domain 1: Learning Environment and Culture

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	■	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	■	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	■	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	■	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	■	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	■	☐	☐

Domain 2: Educational governance and leadership

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	■	☐	☐
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	■	☐	☐
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	■	☐	☐
2.4 Education and training opportunities are based on principles of equality and diversity.	■	☐	☐
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	■	☐	☐

Domain 3: Supporting and empowering learners

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	■	☐	☐
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	■	☐	☐
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	■	☐	☐
3.4 Learners receive an appropriate and timely induction into the learning environment.	■	☐	☐

3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	■	☐	☐

Domain 4: Supporting and empowering educators

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	■	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	■	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	■	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	■	☐	☐

Domain 5: Delivering curricula and assessments

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	■	☐	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	■	☐	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	■	☐	☐

Domain 6: Developing a sustainable workforce

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	■	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	■	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	■	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	■	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Postgraduate	☐	☐	☐	☐	☐	☐
Undergraduate	☐	☐	☐	☐	☐	☐
Physicians Associates	☐	☐	☐	☐	☐	☐

Pharmacy Training (General Pharmaceutical Council)

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- ○ Not Applicable
- ○ **Applicable** ✓

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where Standards are not met.

Domain 1: Learning Environment and Culture

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	■	□	□
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	■	□	□
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	■	□	□
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	■	□	□
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	■	□	□
1.6 The learning environment promotes inter-professional learning opportunities.	■	□	□

Domain 2: Educational governance and leadership

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	■	□	□
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	■	□	□
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	■	□	□
2.4 Education and training opportunities are based on principles of equality and diversity.	■	□	□
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	■	□	□

Domain 3: Supporting and empowering learners

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	■	□	□
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	■	□	□
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	■	□	□

3.4 Learners receive an appropriate and timely induction into the learning environment.	■	☐	☐
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	■	☐	☐

Domain 4 Supporting and empowering educators

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	■	☐	☐
4.2 Educators are familiar with the curricula of the learners they are educating.	■	☐	☐
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	■	☐	☐
4.4 Formally recognised educators are appropriately supported to undertake their roles.	■	☐	☐

Domain 5: Delivering curricula and assessments

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	☐	■	☐
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	☐	■	☐
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	☐	■	☐

Domain 6 Developing a sustainable workforce

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	■	□	□
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	■	□	□
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	■	□	□
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	■	□	□

Where a standard is 'not met', please select which professional groups 'not met' relates to:

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Pharmacy Technicians	□	□	□	□	□	□
Pharmacists	□	□	□	□	■	□
Pharmaceutical Scientists	□	□	□	□	□	□

All Other Learners

If your organisation does not provide education and training to this professional group, please select 'Not Applicable' and move on to the next section.

- Not Applicable
- **Applicable** ✓

Organisation assurance statement and exception reporting against HEE Quality Domains and Standards

In this section, we are asking you to consider HEE Quality Domains and Standards and declare any areas where standards are not met

Domain 1: Learning Environment and Culture

	Met	Not Met	Action Plan Available
1.1 Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.	■	☐	☐
1.2 The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.	■	☐	☐
1.3 There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), improving evidence-based practice (EBP) and research and innovation (R&I).	■	☐	☐
1.4 There are opportunities to learn constructively from the experience and outcomes of service users, whether positive or negative.	■	☐	☐
1.5 The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge.	■	☐	☐
1.6 The learning environment promotes inter-professional learning opportunities.	■	☐	☐

Domain 2: Educational governance and leadership

	Met	Not Met	Action Plan Available
2.1 The educational governance arrangements measure performance against the quality standards and actively respond when standards are not being met.	■	□	□
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.	■	□	□
2.3 The educational governance structures promote team-working and a multi-professional approach to education and training where appropriate, through multi-professional educational leadership.	■	□	□
2.4 Education and training opportunities are based on principles of equality and diversity.	■	□	□
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.	■	□	□

Domain 3: Supporting and empowering learners

	Met	Not Met	Action Plan Available
3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	■	□	□
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards or learning outcomes.	■	□	□
3.3 Learners feel they are valued members of the healthcare team within which they are placed.	■	□	□

3.4 Learners receive an appropriate and timely induction into the learning environment.	■	□	□
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.	■	□	□

Domain 4: Supporting and empowering educators

	Met	Not Met	Action Plan Available
4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.	■	□	□
4.2 Educators are familiar with the curricula of the learners they are educating.	■	□	□
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.	■	□	□
4.4 Formally recognised educators are appropriately supported to undertake their roles.	■	□	□

Domain 5: Delivering curricula and assessments

	Met	Not Met	Action Plan Available
5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.	■	□	□
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.	■	□	□
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.	■	□	□

Domain 6: Developing a sustainable workforce

	Met	Not Met	Action Plan Available
6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	■	☐	☐
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.	■	☐	☐
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	■	☐	☐
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.	■	☐	☐

Where a standard is 'not met', please select which professional groups 'not met' relates to:

	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Domain 6
Clinical Psychology	☐	☐	☐	☐	☐	☐
Dieticians	☐	☐	☐	☐	☐	☐
Estates (i.e. clinical engineers)	☐	☐	☐	☐	☐	☐
Healthcare Scientists: Life Sciences, Physiological Sciences, Physical Sciences, Clinical Bioinformatics	☐	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐	☐
ODP	☐	☐	☐	☐	☐	☐
Orthotists and Prosthetists	☐	☐	☐	☐	☐	☐
Ophthalmologists	☐	☐	☐	☐	☐	☐

Orthoptists	☐	☐	☐	☐	☐	☐
Other Apprentice	☐	☐	☐	☐	☐	☐
Other Therapist (art, drama, music etc.)	☐	☐	☐	☐	☐	☐
Paramedics	☐	☐	☐	☐	☐	☐
Physiotherapy	☐	☐	☐	☐	☐	☐
Podiatry	☐	☐	☐	☐	☐	☐
Radiography Diagnostic	☐	☐	☐	☐	☐	☐
Radiography Therapeutic	☐	☐	☐	☐	☐	☐
Sexual Health Advisors	☐	☐	☐	☐	☐	☐
Sonographers	☐	☐	☐	☐	☐	☐
Speech and Language Therapy	☐	☐	☐	☐	☐	☐

19/20 Financial Accountability Report

Details of LDA Funding

A separate copy of the LDA Financial Section (Schedule E) was included in the email sent with the SAR. In this section please describe how the trust has utilised the HEE funding received via LDA payments.

I can confirm that funding listed in the LDA (Schedule E) has been utilised for its intended purpose? (Y/N)

Yes

If you selected No, please specify:

Additional in year funding already provided

Have you received any further funding not included in the LDA?

None

In this section please list any additional funding received from HEE, for example any regional or national funding received outside of the LDA payments. Please state the amount received, provide a high-level description of what this additional funding is for and please describe how the trust has utilised this funding.

1		
2		

3	Please state the amount received	Please describe what this additional funding was for?
4		
5		

SAR 2020 Library Quality Process

Trust Name:

Southport & Ormskirk NHS Trust

Report signed off by (name):

Terry Hankin, Medical Director

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

14-09-20

(dd/mm/yyyy)

1. **Describe how your Trust is implementing the HEE Library and Knowledge Services Policy namely: to ensure the use in the health service of evidence obtained from research, Health Education England is committed to:**

1.1 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.

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.

1.2 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.

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.**

2.1 *Please identify the budget allocated to your Library and Knowledge Service in the current financial year.*

Library Budget (non-pay) 2019-20: £53,022
Library Budget (pay) 2019-20: £103,604

2.2 *If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.*

Funding for external sources 2019-20: £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.**

The LKS has developed a patient information web resource for the Critical Care department. It has a jargon buster section and includes a video tour of ICU for patients which has been shortlisted for a Nursing Times award. http://www.lihnnhs.info/icuknowledge/

The LKS has designed and developed an online Learning Map to support medical education across the Trust. It coordinates and signposts various internal and external learning opportunities for all medical staff and students. https://www.sonhslks.com/learning-map.html

4. **The Learning and Development Agreement that Health Education England has with your organisation states that for 2018-19 the LKS should have achieved a minimum of 90% compliance with the national standards laid out in the NHS Library Quality Assurance Framework. LKS that scored below 90% submitted an action plan to Health Education England in March 2019 describing their planned improvements. If you submitted an action plan, please describe the improvements you have made against the plan.**

LQAF score: 97%

SAR 2020 Equality & Diversity

Trust Name:

Southport & Ormskirk NHS Trust

Report signed off by (name):

Terry Hankin, Medical Director

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

14-09-20

(dd/mm/yyyy)

Name of Trust Equality, Diversity and Inclusion Lead (or equivalent):

Robert Davies - Equality Lead

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 various policies and processes in place to support all learners with protected characteristics in the Trust including the Dignity at Work Policy. The Trust is signed up to:

- NAVAJO charter: LGBT+
- Disability Confident Employers Scheme: Disability
- Young Persons Charter (UNISON)

All learners are required to complete EDI training as part of the induction process

2. **How do you liaise with your trust Equality, Diversity and Inclusion Lead to:**

2.1 Ensure trust reporting mechanisms and data collection take learners into account?

The Trust's Valuing Our People Group provides an opportunity to discuss data etc., information is also provided to Workforce Committee and Joint Negotiating Committee

2.2 Implement reasonable adjustments for disabled learners?

The Trust has the Disability Confident Employer scheme in place that supports people with a disability. Disability Reasonable Adjustment Plans can also be used to support individuals.

2.3 Ensure your policies and procedures do not negatively impact learners who may share protected characteristics?

All policies have equality impact assessments to ensure they will not have a negative impact on any specific groups and appropriate adjustments will be made to remove any barriers

2.4 Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?

This is currently not undertaken

3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?

By using a person-centered approach any concerns can be addressed with appropriately trained staff and appropriate support and equipment can be sourced to remove any barriers to progression

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?

ED&I training and Trust updates are provided. Local information is also promoted on the Trust website, ED&I information - Faith Disability BAME etc

5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?

Staff have a generic understanding of supporting staff with protected characteristics, but additional specific information can be obtained from the Trust various partners i.e. Sensory Visual, ask the person

6. Is there monitoring or strategies in place to look at those accessing progression opportunities, and those progressing into more senior roles?

The Trust monitors progression for staff who have disability & BAME by bands against various reporting processes WDES WRES, monitors shortlisting and hiring etc.

What is the Trust view on data on progression in the trust?
The Trust recognises that further work needs to be undertaken to ensure a robust mechanism for progression for all staff and those with protected characteristics is required underpinned by robust data

Are there any responses or resulting objectives to data held by the Trust?
The WRES & WDES have objectives and action plans against i.e. recruitment disciplinary progression, progression

7. **Does the Trust invest in additional Equality and Diversity training for some or all staff (i.e. more than statutory training)?**

The Trust is in the process of obtaining additional training is Unconscious Bias, Transgender, Disability LGBT and Race. Opportunities are promoted via Trust

Are there any training or initiatives (in place or being considered) to learn from cases that have an E&D theme?
Due to the disproportionate impact on BAME, disabled and LGBT+ staff of Covid 19 – the Trust is in receipt of a successful NHS Charities Together bid to develop a Staff H&W Hub for the above staff groups

SAR 2020 Staff, Associate Specialist, and Specialists Doctors

Trust Name

Southport & Ormskirk NHS Trust

Report signed off by (name):

Terry Hankin, Medical Director

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

14-09-20

(dd/mm/yyyy)

1. Nominated leads for SAS doctors and LEDs

Name of nominated lead for SAS doctor development (*if there is no nominated lead, state "None"):*

Dr Jo Anna Robson & Dr Lesley Kaye

Name of nominated lead for LED development (*if there is no nominated lead, state "None"*):

None

2. Number of SAS doctors and LEDs in the trust

	Answer
Number of Specialty Drs:	
Number of Associate Specialists:	
Number of Staff Grades:	

TOTAL number of SAS doctors:	72
Number of LEDs (e.g. Trust Grade, Clinical Fellow):	12

3. Study leave budgets

	Amount (£)
Trust study leave funding allocation per SAS doctor (£):	1000
Trust study leave funding allocation per LED (£):	1000

How do these allocations compare to the study leave funding allocation for consultants?

Your answer should be no more than 3000 characters long.

Allocations are directly comparable to the study leave funding allocation made for Trust employed consultants

Please outline any examples of good practice or challenges regarding study leave budget allocations:

Your answer should be no more than 3000 characters long.

They are given the same access to time and funding as consultants

4. HEE SAS Development Funding received during the financial year 2018/19

	Amount (£)	Details (if req)
SAS Development Fund – Individual courses (£):	£1,781	
SAS Development Fund – Trust-hosted courses (£):	£27,481	

Funding for SAS tutor/ lead role (£):	£9,601	
Funding for SAS administrator role (£):	£17,562	
Any other funding received from SAS Development Fund (please give details):		
TOTAL funding received from HEE (£):	£56,425	

5. Identification of SAS doctor development needs

	Development needs:
Please describe the process by which the development needs of SAS doctors within your organisation were individually and collectively identified:	SAS National Survey Local Survey Appraisal information BMA Charter
How were priorities decided in regard to applications to the HEE SAS Development Fund?	Canvassed opinion of SAS Doctors regarding development needs, via survey-monkey and meetings. Wider organisational learning requirements and individual CPD needs also factored in.

6. CESR

	Answer
Number of doctors currently being supported by the trust to work towards CESR application:	26
Number of doctors who completed a successful CESR application during the year April 2018 to March 2019:	

7. SAS doctors as Clinical and Educational Supervisors

	Answer
Number of SAS doctors who are GMC-approved Clinical Supervisors:	All are encouraged to be registered as ES
Number of SAS doctors who are GMC-approved Educational Supervisors:	20

Who decides which trainees have a SAS doctor as their named Clinical or Educational Supervisor?

Your answer should be no more than 3000 characters long.

The College Tutor in the department and Clinical Director, as well as FPD, are aware that only those who are on the trust database as a registered trainer should be allocated as CS or ES. SAS doctors are invited to apply to be registered on the database, if they satisfy the HEE NW KSF for a supervisor. Thus, the support of the Lead Educator and Lead Clinician is required for a SAS doctor to be recognised as a trainer

What governance arrangements are in place for SAS doctors who are Clinical and Educational Supervisors?

Your answer should be no more than 3000 characters long.

The appraisal and quality control of SAS supervisors is identical to that of consultant supervisors.

8. SAS doctors in leadership roles

	Answer
Number of SAS doctors who are in leadership roles:	5

Please give details of the roles being undertaken:	AMD, CD, Clinical Sub Dean, Major Incident Lead, Clinical Lead

9. Has the SAS Charter been implemented in the trust?

Yes, it has been embedded as part of the annual appraisal process to facilitate discussion on any areas which the SAS doctors feel still need addressing

Please give details of any examples of good practice or challenges in implementing the SAS Charter:

	Good Practice	Challenge
1	SAS grades appraisers, clinical and educational supervisors.	Office space and admin support
2	Access to developmental budget = to consultants. Regular hosting of HEE funded courses to assist development.	Effective induction with establishing a mentor/ buddy system
3	Small number of autonomous practitioners. Process available for further SAS grades to progress to autonomy	Ensuring patient coding and clinical responsibility given to SAS grade treating the patient when appropriate

10. Please give details of any programmes or initiatives in place to support the development of LEDs:

Your answer should be no more than 3000 characters long.

The trust has recently developed a portfolio for the LEDs to record their achievements within their posts. This has been supplemented by an educational programme developed by the Director of Medical Education, particularly for those new to practice in the UK and/or NHS. Opportunities to access the trust training in clinical skills, if needed, are provided.

Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:

	Good Practice - Please outline any examples of good practice in developing SAS doctors or LEDs which you would like to highlight:	Challenges - Please outline any particular challenges in developing SAS doctors or LEDs:
1	Supporting CESR development with allowing internal rotations that are required to gain skills for sign off.	CESR qualification requiring SAS to attend other hospitals to gain appropriate skills.
2	Supporting college educational roles.	
3	Policy to progress autonomous working	
4		
5		

Any other comments you would like to make regarding development of SAS doctors & LEDs:

Your answer should be no more than 3000 characters long.

SAR 2020 Patient Safety, Simulation and Human Factors

Trust Name:

Southport & Ormskirk NHS Trust

Report signed off by (Name):

Terry Hankin, Medical Director

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

14-09-20

(dd/mm/yyyy)

1. **Who is the Lead for Patient Safety in your organisation?**

Dr Chris Goddard, who is an Associate Medical Director and reports directly to the Medical Director

What support do they receive in delivering this role? e.g. job-planned time, resources etc.

4 PAs are allocated to the role and administrative support is provided for the Mortality Operational Group which is chaired by Dr Goddard. Additionally, project officer support has been provided for projects arising from the workstreams arising from the Action Plan developed following the trust external mortality review

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?**

   1. 24 hour critical care outreach team (CCOT)
      As part of the deteriorating patient project, the CCOT service was transformed from a daytime service focused on education, training and policy to a 24 hour 7 day service focused on detection and response to patients with elevated early warning scores. The team responds to all patients with a NEWS 2 score of 5 or above to ensure that treatment plans are in place and escalation decisions have been reviewed and agreed. Until the beginning of the COVID-19 pandemic the trust has seen a sustained improvement in the numbers of inpatient deaths and a significant reduction in disease specific mortality rates for sepsis, AKI and Pneumonia. The team's response rate to patients with an elevated NEWS 2 score has iteratively improved from over an hour to an average of 30 minutes. Feedback from senior and junior medical staff and ward nursing teams has been universally positive. The team has 500-800 patient contacts per month.

2. Co-ordinated IT strategy focused on improved patient care. The trust has recognised the value of IT projects for patient care and its position behind its peers in this regard. Implementing the Medway PAS and order comms projects has produced a system that produces a wealth of information on processes of care and quality of care which can and is used to improve patient care. Notable success thus far has been to produce a nationally recognised mortality report to identify at risk populations – this has prompted work on pneumonia and AKI. A twice daily e-mail alert for AKI 2 and 3 patients send directly to the critical care outreach team. A system to allow the tracking of post-take medical patients to ensure they are reviewed wherever they are, and, data on patient flow which can be used amongst other things to track and highlight the number of ward moves a patient makes in order to limit these.

3. Investment in the physical estate to provide ward environments with the infrastructure to provide patient care and to reduce the harm from dementia and delirium, to provide handover space for clinical teams which is digitally enabled, to provide an AED facility which is fit for purpose and with enough capacity to vastly reduce care delivered on corridors, and provide assessment facilities with enough capacity to promote flow from AED.

3. In which areas would you like support from HEE? e.g. educational events, funding, specific areas of training such as quality improvement.

Support for ongoing education to support the understanding of the staff into understanding patient safety and their role in delivering safe and excellent patient care.

Simulation

1. What is the governance structure in place within your organisation with regard to simulation- based education training?

See Medical Education Governance Structure

Who is the responsible Simulation Lead within the organisation?

Clare Thompson

2. **Please describe your process for accessing education funding received for simulation and/or TEL bids and who is responsible for this?**

There is no specific funding stream within the trust for simulation-based training. The Simulation Lead is one of the Clinical Tutors within the Department of Medical Education and the simulation programmes delivered within the Clinical Education Centre are funded through the Medical Education budget.
The paediatric department regularly undertakes multi-disciplinary in situ simulation sessions within their department, which is supported by the department itself and the Department of Medical Education provides little input and/or support.
Multi-disciplinary in situ simulation sessions are also delivered within the critical care department, which are supported by the department itself. Those held in the AED and Obstetrics and Gynaecology departments, again which are multi-professional, are supported partly by the department and partly by Medical Education

3. **Does your Trust offer multidisciplinary faculty training including specific simulation-based education debriefing in line with ASPiH standards?**

Where simulation training is delivered, at least one member of the faculty delivering the training has undergone specific simulation-based debriefing in line with ASPiH standards.

Simulation-based training is delivered primarily to medical learners, but the faculty supporting the delivery are from a range of healthcare backgrounds. There have been challenges in recruiting sufficient faculty on a regular basis to deliver the simulation-based training within the trust. The Department of Medical Education has recently undergone a re-structuring process and additional Clinical Educators have been appointed. This is to develop some resilience within the delivery of simulation and clinical skills training.

The trust is currently working to develop a more integrated approach to clinical education and training. It is hoped that this in conjunction with the departmental re-structuring will lead to the delivery of more multi-professional simulation-based training.

4. **Which directorates or inter-professional groups are actively engaged with simulation-based education within your organisation?**

Simulation training is integrated into both the Medical Student and Foundation Training programmes. As highlighted above the Paediatric, Obstetric and Gynaecology, Critical Care and AED departments all deliver multi-disciplinary in situ simulation sessions. Additionally, a multi-professional simulation transfer course is delivered to the anaesthetic and critical care departments. In the last year, the department has supported the training of the student Physician Associates with simulation-based education.

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.

How do you encourage equitable access to simulation for all staff? Add how is this monitored?

The department has developed Academic Year Planning Group. The purpose of the Academic Year Planning Group is to provide a forum for the relevant stakeholders to co-ordinate and manage their clinical education and training programmes, including simulation and clinical skills. In agreeing the organisational needs and forward planning the academic training year, it allows early identification of resource issues, which can then be addressed in a timely manner, thus minimising the risk of adversely affecting the clinical learners within the trust.

Medical education has a clear understanding of its current simulation-based training needs. The lack of an integrated clinical education and training strategy means the wider organisational needs and those of non-medical education and training are less clear. The trust recognises this and is working to develop both the strategy and the governance and operational processes to support it. The aspiration is that through this and the Academic Planning Group, equitable provision can be made for the clinical learners in the trust.

5. **Please describe strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews, quality improvement?**

The Director of Medical Education is a member of the Mortality Operational Group (MOG). The Serious Incident Review Group (SIRG) which meets weekly reports to MOG. Additionally, lessons learnt through the Structured Judgement Reviews (SJRs) are also reported to MOG. The aspiration is that where themes are emerging, which require support through simulation-based training, these can then be embedded within the simulation-based training.

The restructuring within the department of medical education was partly to create some resilience in delivering simulation-based training. This required an additional investment and was supported by the senior management team, including the Medical Director and Chief Executive Officer

Human Factors

Who is the Lead for Human Factors in your organisation?

The trust doesn't have a specific named lead for human factors. However, the organisation recognises the importance of human factors, particularly in relation to patient safety. The current chair of the Board has a background in the aviation industry where an understanding of human factors is critical.

All members of the senior leadership team and have an understanding and a varying degree of training in clinical human factors. All acknowledge they are critical in developing a just culture within the organisation. Thus, the aspiration of the organisation is that they are embedded at all levels.

The governance and learning processes, being implemented in relation to the reducing mortality action plan, led by the AMD for Patient Safety, have been developed using a human factors model.

What support do they receive in delivering this role? e.g. job-planned time, resources etc.

The AMD for Patient Safety has 4 PA for the role

Please describe the extent to which your HF training covers the following domains:

People – the individual & teamwork	Debrief and feedback provided within the simulation sessions, both in situ and within the department, focus on using a human factor template for looking at team working and how the individual within the team interacts
Environment – the physical aspects of a workspace	Nothing specific is delivered around the environment
Equipment and technology	The Volumatic and infusion pumps are all identical across the trust and fitted with a drug library to reduce the risk of medication error
Tasks and processes	The development of LocCSIPs and pathways of care to standardise processes and reduce omission due to human error
Organisation	The trust is looking at equipment replacement and purchase as a whole organization, rather than individual departments, so there is more consistency across the trust. The Medicines Safety Meeting use a human factors model when reviewing trends in medication errors
Ergonomics and research	The trust doesn't have activity within this area currently, but would participate in research and QI projects in this area, if possible

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.	HF training is not delivered separately, but covered within the multi-disciplinary in situ simulation sessions delivered within the trust across the various departments including paediatrics, Obstetrics and Gynaecology, Critical Care and Anaesthesia, and Emergency Medicine.

Frequency of training, or whether ad hoc events.	Foundation Doctors and medical students have it delivered within their respective simulation programmes
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.	The simulation faculty supporting the delivery of simulation training have undergone simulation debrief training, which includes understanding a HF model.
What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis?	Those involved in supporting the risk management processes within the organisation have begun to embed a human factors framework in undertaking SI reviews and RCAs of datixed incidents.
To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process?	All members of SIRG (Serious Incident Review Group) have undertaken training in human factors and are able to utilise the model when reviewing incidents.

What Human Training requirements do you have as a Trust?

The trust will continue to embed human factors in within the organizational culture of the organisation. The aspiration is that they will form an integral part of many of the teaching sessions within the trust. This is to support an organisational culture of continuous learning and improvement, through reflection using a human factors model.

SAR 2020 Incidents and Coroner's Case Support

Trust Name:

Southport & Ormskirk NHS Trust

Report signed off by (name):

Terry Hankin, Medical Director

Date signed off:

Dates need to be in the format 'DD/MM/YYYY', for example 27/03/1980.

14-09-20

(dd/mm/yyyy)

Clinical Incidents

What system is used for reporting clinical incidents?

Datix incident reporting system

How is feedback on an incident given to the reporter?

Automatic email from the system gives feedback to the reporter. Line manager provides feedback

What system is used for reporting Serious Untoward Incidents/ Never Events?

Datix is used and the national Steis database

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Support for learners involved in a Serious Incident:

Question	Response
How does the Trust identify learners involved in a serious incident?	Through the investigation stage of the incident by the Business units.
What is the target timescale for identifying learners involved in a serious incident?	As soon as possible but the total time for an incident to be investigated is 60 days but the learners would be identified during the initial investigation stage.
Who in the education team is notified about a learner involved in a serious incident (e.g. DME, FPD, ES, names CS, Clinical Lead, etc...)?	Clinical Lead and Matron, Head of Nursing, DME.
Who offers support to a learner involved in a serious incident (e.g. DME, FPD, ES, Named CS, Clinical Lead, Manager, PALS, Trust Legal Team, etc...)?	Clinical Lead, Clinical Supervisor, Matron, Head of Nursing, Line Manager
Describe briefly how support to a learner involved in a serious incident is delivered?	Staff are supported by reflection and discussion about the incident. Trust Policy, supporting staff in incidents, complaints and claims Risk Management 17.

Describe briefly arrangements for debriefing/ support for other staff involved in a serious incident?

Feedback is through the line managers within the Business units.

Does your Trust hold Schwartz rounds of similar events?

No – under review for 2020

What guidance does the Trust offer about reflection on serious incidents?

No formal guidance but through informal discussion with line managers and clinical leads.

Writing statements and giving evidence

Who advises and supports learners in the following:

Writing statements for an inquiry into a serious incident, root cause analysis, complaint, etc?	The Risk management team support staff with writing statements, clinical leads and matrons offer support as required.
Giving evidence to an inquiry into a serious incident, root cause analysis, complaint, etc?	Clinical leads and matrons offer support as required.

Coroner's statement and inquests

Support for learners involved in a Coroner's case:

How does the Trust identify learners involved in a Coroner's case?	Through the initial review of the case and identification at statement stages.
What is the target timescale for identifying learners involved in a Coroner's case?	This is undertaken as soon as notified by the coroner.

Who in the education team is notified about a learner involved in a Coroner's case (e.g. DME, FPD, ES, names CS, Clinical Lead, etc...)?	Clinical Lead and supervisor.
Who offers support to a learner involved in a Coroner's case (e.g. DME, FPD, ES, Named CS, Clinical Lead, Manager, PALS, Trust Legal Team, etc...)?	Clinical Lead and supervisor. Trust legal team and risk management team.
Describe briefly how support to a learner involved in a Coroner's case is delivered?	1 to 1 support as detailed in Trust policy.

Who offers advises and supports learners in writing statements for a Coroner's case (e.g. ES, DME, Trust Services, Legal Department, etc...)?	Trust legal services and risk management department.
Who advises and supports learners in giving evidence to a Coroner's case?	Trust legal services and clinical leads
How do the answers to the previous questions differ if the learner has moved to another Trust?	No the offer is still the same.

Do you publicise the advice about Coroner's hearings on the HEE Website?

No

What training does your Trust offer on Duty of Candour?

Initial Duty of Candour training on induction. Training video included on Trust web site and information packs on all the wards.