NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 09.45 – 13.00 on Wednesday 7th February 2018
Seminar Room, Clinical Education Centre, Southport District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Time
PRELIMINARY BUSINESS			
TB018/18 (V)	**Chair's welcome & noting of apologies** To **note** the apologies for absence	**Chair**	**09.45**
TB019/18 (V)	**Declaration of Directors' Interests** To **review and update** declarations of interest relating to items on the agenda and/or any changes to the register of directors' declared interests	**Chair**	
TB020/18 (D)	**Minutes of the Meeting held on 10th January 2018** To **approve** the minutes of the Board of Directors	**Chair**	
TB021/18 (D)	**Matters arising action Log** To **review** the Action Log and receive relevant updates	**Chair**	
STRATEGIC CONTEXT			
TB022/18 (D)	**Interim Chief Executive's Report** To **note** key issues and update from the ICEO	**ICEO**	**09.55**
QUALITY & SAFETY			
TB023/18 (P)	**A staff member's Story: *From Volunteer to Qualified Nurse*** To note and **discuss** learning from the above	**Michelle Kitson/ Carol Fowler**	**10.00**
TB024/18 (D)	**Quality & Safety Committee (Q & S) : Alert Advise & Assure Report and Minutes of Meeting** To **receive** a summary report from the Committee	**Chair of Q & S**	**10.10**
TB025/18 (D)	**Integrated Governance Report** To **receive** the report for quarters 1 and 2	**DoN**	**10.15**
TB026/18 (D)	**Quality Improvement Strategy 2017-2019** To **receive** an updated version of the Strategy that went to November 2017 Board incorporating timelines and milestones.	**DoN**	**10.25**
TB027/18 (D)	**CQC Action Plan Update** To **receive** the monthly update report	**DoN**	**10.35**

Ref No.	Agenda Item	Lead	Time
TB028/18 (P)	**Care For You** To **receive** an update report and Presentation on the Frailty Pathway	**ICEO/Dr Fraser, Geriatrician/ D Bradbury**	**10.45**
TB029/18 (D)	**Workforce & Organisational Development Committee: Alert Advise & Assure Report and Minutes of Meeting** To **receive** a highlight report including any escalated risks from the Committee	**Chair of W&OD**	**10.55**
TB030/18 (D)	**Monthly Safe Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**11.00**
TB031/18 (D)	**National Guardian's Office – Freedom to Speak Up (FTSU)** To **receive** an updated FTSU action plan with input from NHS Improvement and quarter 2 report	**DoN**	**11.10**
TB032/18 (D)	**Learning from Deaths** To **receive** an update on mortality performance data	**MD**	**11.20**
TB033/18	**Merger of the Quality & Safety Committee and the Mortality Assurance & Clinical Improvement Committee** To **approve** the merger	**Mrs Gorry / ICoSec**	**11.30**
TB034/18 (D)	**Guardian of Safe Working** To receive a report for Quarter 3	**Dr Ruth Chapman**	**11.40**
PERFORMANCE			
TB035/18 (D)	**Finance Performance & Investment Committee: Alert Advise & Assure Report and Minutes of Meeting** To **receive** a highlight report including any escalated risks from the Committee	**Chair of FP&I**	**11.50**
TB037/18 (D)	**Emergency Care Performance Report** To **receive** a monthly update report	**COO**	**11.55**
TB038/18 (D)	**Integrated Performance Report (IPR)** To **receive assurance** from the current position in relation to national performance targets and integrated governance.	**DoF**	**12.05**
TB039/18 (D)	**Director of Finance Report** To **receive** the current financial position at Month 9 and progress on the Cost Improvement Programme / Internal Sustainability	**DoF**	**12.15**
GOVERNANCE / WELL LED			
TB040/18 (D)	**Risk Management: Board Assurance Framework and Risk Register** To **receive** a quarterly report on the BAF and Risk Register	**Executives**	**12.25**

Ref No.	Agenda Item	Lead	Time
TB041/18 (D)	**Items for Approval / Ratification:** • **Ratification of a Resolution taken under Emergency Powers for Approval of an Uncommitted Revenue Support Loan taken under Emergency Powers (to be tabled).** • **Board and Committees' Meeting Dates**	**DoF/ Chair** **ICoSec**	**12.35**
TB042/18 (V)	**Questions from Members of the Public**	**Public**	**12.40**
CONCLUDING BUSINESS			

TB043/18 (V)	**Any Other Business**
	To **consider** any other matters of business
	• Letter from the Secretary of State for Health
	• Confirmation of Non-Executive Director Leads for:
	  • End of Life,
	  • Freedom to Speak Up &
	  • Medical Education
		Chair	**12.50**

TB044/18 (V)	**Items for the Risk Register/changes to the BAF** To **identify** any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting	**Chair**	
TB045/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**	**13.00 CLOSE**
TB046/18 (V)	**Date and time of next meeting** Wednesday 7th March 2018, 10.00 Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**	

ACTIONS REQUIRED:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

Chair: Richard Fraser

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Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 10th January 2017

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

Present

Richard Fraser, Chair
Carol Baxter, Non-Executive Director
Jim Birrell, Non-Executive Director
Ged Clarke, Non-Executive Director
Julie Gorry, Non-Executive Director
Sheila Lloyd, Director of Nursing, Midwifery & Therapies
Paul Mansour, Acting Medical Director
Therese Patten, Chief Operating Officer
Jane Royds, Associate Director or HR*
Steve Shanahan, Director of Finance

In Attendance

Audley Charles, Interim Company Secretary
Rachel Flood-Jones, Temporary PA to the Company Secretary
Sue Hillyard, Improvement Director (NHSI)
Caroline Griffiths, Improvement Director (NHSI)

Apologies:

Pauline Gibson, Non-Executive Director*

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
TB001/18	**CHAIRMAN'S WELCOME AND NOTE OF APOLOGIES**	
	The Chair, Mr Fraser, opened the meeting by welcoming board members and members of the public. He noted apologies from Pauline Gibson, Non-Executive Director. He thanked Mrs Lloyd and her team for the outstanding efforts put into the preparation and on-going work for the CQC Inspection. He also recognised the dedication of Mr Shanahan, Ms Patten and Dr Mansour who had worked on call over the extremely busy Christmas period, to ensure that the Trust provided the best care possible for patients. The Chair asked that these thanks were to be extended to all members of staff who had shown great commitment in these two areas.	

	He reiterated that as discussed in the Private Board, Mrs Jackson had now left the Trust and that the new Interim Chief Executive Officer, Ann Farrar was to start on 17th January 2018. The length of her tenure had not yet been confirmed but it was likely to overlap with the new substantive Chief Executive Officer, Silas Nicholls who it was hoped would start with the Trust at the beginning of April 2018 (subject to confirmation).	
TB002/18	**DECLARATION OF DIRECTORS' INTERESTS CONCERNING AGENDA ITEMS**	
	The Chair asked that any changes or additions to the Register of Interests declared by the Board of Directors should be submitted to the Company Secretary.	
TB003/18	**MINUTES OF THE MEETING HELD ON 6th December 2017**	
	The Chair asked the Board to approve the Minutes of Meeting of 6th December subject to the following changes which were noted for amendments: Dr Mansour to be added to those present at the December 2017 Public Board. **TB259/17 Workforce & Organisational Development Committee AAA Highlight Report and Minutes and TB260/17 Bi-annual Nurse Staffing Establishment Report:** Mrs Lloyd reported that she had expected to see a number of points delivered by Mrs Fowler against these agenda items. It was agreed that only items discussed in the meeting could be minuted as a record of the meeting, anything that should have been discussed but that had been missed could be added as addendum. **TB266/17 Director of Finance Report:** an amendment to be made to read " Mr Birrell advised that the funds allocated to the IT programme should be ring fenced as far as possible from a patient safety perspective, as the progress in this area was slow and that delivery should not be hindered in any way." **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the noted amendments.	
TB004/18	**MATTERS ARISING ACTION LOG**	
	The Board considered the following matters arising in turn: **TB116/17 Staff Engagement Plan:** This is an ongoing piece of work; item to remain on the log. **TB174/17 Workforce & Organisational Development:** Update to be brought to the February Board.	ICEO/ ADHR ADHR

	TB185/17 Items for Approval, Standard Operating Procedure for the Administration of Meetings: To be brought to the February Board for sign off.	ICOSEC
	TB214/17 Items for Approval – Risk Strategy: Deferred to the January 2018 Board.	
	TB216/17 Any Other Business: The Orientation Programme for Non-Executive Directors is to be circulated ahead of the February Board	CHAIR
	TB226/17 Highlight Report for the Quality & Safety Committee – Lock Down Policy: Update on activities to be brought to the February Board.	COO
	TB230/17 Workforce & Organisational Development Plan – Organisational Development Strategy and Plan: To be brought back to the February Board.	ADHR
	TB323/17 Quarterly Integrated Governance Report – Content: To remain on the log.	
	TB232/17 Quarterly Integrated Governance Report – MRSA Case: Mrs Lloyd to circulate before the February Board.	DoN
	TB254/17 Patient Story: An update to be brought to the February Board.	ICEO/ DoN
	Quality & Safety AAA Highlight Report (without Agenda Item) – Paediatric Mortality Review: An update to be brought to the February Board and Dr Chris Goddard to be invited to speak to the Board.	ICoSec
	Quality & Safety AAA Highlight Report (without Agenda Item) – Overdue Follow Up Appointments: Mrs Hillyard reported that discussions with NHS England (NHSE) and the network lead to clear the backlog of 2,020 diabetic eye screening appointments. Discussions are underway with Aintree Hospital. An update to be brought to the February Board.	COO
	TB256/17 Quality Improvement Plan: To be added to the February agenda.	DoN
	TB258/17 Care for You: Dr Fraser to be invited to give an update; to be added to the February agenda.	ICoSec
	TB259/17 Workforce Committee AAA Report – E-learning: Two items under this reference, both to be brought to the February Board.	ADHR
	TB259/17 Workforce Committee AAA Report – E-Rostering: Mrs Fowler to meet with Mrs Farrar to discuss how more people can be trained.	DoN
	TB262/17 Audit Committee AAA Highlight Report - MIAA Workshop: The 7th March has been confirmed. To be removed from log.	
	TB269/17 Items for Ratification and Approval – Freedom to Speak Up: To be removed from log.	
TB005/18	**CHIEF EXECUTIVE'S REPORT**	
	Mr Shanahan introduced the Chief Executive's Report as Acting Chief Executive Officer. He noted the following parts of the report which had been prepared by Karen Jackson prior to her departure: • **CQC Core Area Inspection Visit:** feedback would be given under	

	agenda item TB010/18 • **The Financial Position:** to be discussed under agenda item TB007/18. It was to be noted however that the Trust's financial position had not changed since the summer and that the organisation continued to be under the financial scrutiny of the regulator. Financial Turnaround Director from NHS Improvement (NHSI), Steve Leivers had started with the Trust on Monday 8th January. • **A&E Performance over the winter:** to be reported under agenda item TB008/18. • **Local Issues:** 'Care for you' which had previously come under NHSI was now formally a part of the Cheshire and Merseyside Sustainability and Transformation Partnership, chaired by Andrew Gibson. Mr Clarke asked whether general surgery had been cancelled at the Trust (in line with the Department of Health's requirement that Trusts nationally cancel all elective surgery in order to increase capacity in case of an influenza epidemic). Ms Patten explained that cancer and urgent operations had not been subject to cancellation but that they were still going ahead. A working plan was being put together (on the back of meetings with doctors) to understand what they were doing with their time and where they could be repatriated. There had been some concern from regarding the reallocation of surgeons into patient clinics however it had been agreed that they would be sent to support teams at the Ormskirk site. Mrs Griffiths confirmed that she would be picking this up with colleagues nationally to understand how other Trusts were approaching the situation. The Chair explained that the Trust had received the report from the Clinical Senate the previous day and that a copy would be circulated to the Board after the meeting. **RESOLVED:** The Board **received** the Chief Executive's Report.	
TB006/17	**MORTALITY ASSURANCE & CLINICAL IMPROVEMENT COMMITTEE (MACIC): ALERT, ADVISE & ASSURE (AAA) HIGHLIGHT REPORT**	
	Mrs Gorry, as Chair of the Mortality and Clinical Improvement Committee presented the report and alerted the Board that the Learning from Deaths implementation plan required confirmation of the following: • Funding of the Outreach Team • The recruitment of the 'Care of the Elderly' posts • Project management support	

	Dr Mansour reported that he had met with Dr Chris Goddard, (Consultant Anaesthetist and lead on Safe at All Times and the Deteriorating Patient) who had reported that there was a lot of work going on relating to mortality which was not necessarily apparent. Mrs Gorry reported that the the new Mortality Operational Group would take operational matters out of the Mortality Assurance and Clinical Improvement Committee (MACIC). Mortality related matters were already triangulated with the Quality and Safety Committee such as the 'Safe at all Times' work and the Paediatric Mortality Review. In view it was proposed subject to further discussions that the Mortality Assurance and Clinical Improvement Committee be discontinued. Ms Patten stated that the Trust had been granted £830k of winter funding monies, £98k of which was to be allocated for a Geriatrician who would start on 15th February 2018. This would be a short term arrangement for which long term funding would still be required. She reported that Project Managers Dave Fillingham and his Team (from Advancing Quality Alliance (AQuA) had been engaged to work with Jo Simpson, Assistant Director of Quality on service improvement. Two further posts were required to support the project would be going out to advert. Mr Shanahan stated that the increase in the number of patients being admitted through ambulatory care was having an adverse impact on our mortality numbers. Dr Mansour explained that this had been discussed with Mike Lightfoot (Head of Information) who had been in contact with NHS Digital to understand how this was to be measured. **RESOLVED:** The Board **received** the report.	
TB007/18	**FINANCE PERFORMANCE & INVESTMENT COMMITTEE ALERT, ADVISE & ASSURE (AAA) HIGHLIGHT REPORT**	
	Mr Birrell as Chair of the Finance Performance and Investment Committee stated reported that the late date of the Board had provided an opportunity for an unscheduled meeting on the 4th January; because of the comparatively short notice provided to the Directors the meeting focused on the Trust's financial position. He verified that whilst the recovery of income had improved, the consistent but high level of expenditure coupled with disappointing Cost Improvement Programme (CIP) had resulted in a further £2m deficit in	

	December taking the accumulating overspend to almost £21m at the end of month 8. The trend was expected to be consistent into month 9. Consideration was being given to entering into a partnership arrangement for the provision of the Trust's healthcare facilities and services. Whilst the proposal should bring financial benefits, the finance team had been asked to review and bring back to the committee for further consideration. The service and operational impact also needed to be understood before the matter could be progressed further. **RESOLVED:** The Board **received** the report.	
TB008/18	**ACCIDENT & EMERGENCY PERFORMANCE REPORT**	
	Ms Patten gave verbal update on Accident and Emergency Performance. She reported that increased numbers continued to be seen at Accident and Emergency and that the Trust was also receiving increased numbers of major category admissions and those arriving by ambulance. There had been many days in December when the department had been required to evoke the 'full to capacity' protocol with in excess of 70 patients, 79 at most (full capacity being 40). She reported that there had been a decrease in the numbers of day on day discharge patients between June and January and a decrease in the metric of stranded patients (for more than 7 days in the hospital) over the same period. Tracking of 100% occupancy over the Christmas period had however impacted on performance figures. This fact, coupled with the number of 12 hour breaches over December had put the Trust on the national radar. (Ms Patten elaborated that there had been 65 breaches in December of patients not seen in A&E within 12 hours, with a further 51 cases to date in January). Staff had been required to work excessive hours and escalation areas had been opened. Access to a further 37 escalation beds was being organised (at Ormskirk?) for which requests for staff had been put out on Trust News. Support had come the previous week from the A&E Delivery Board, which chaired by Aiden Keogh had been given responsibility for performance in the patch after discussions with NHS England (NHSE) and NHS Improvement (NHSI). Southport and Formby Clinical Commissioning Group (CCG) had helped with additional capacity of 11 beds at Ormskirk District General Hospital with the potential to increase this number to 19. A request for further support had gone to Liverpool Heart and Chest, The Liverpool Womens' Hospital and Walton Hospital, all of which Ms Patten was waiting to hear back.	

	A CEO led System Meeting would be held the following Tuesday 16th January at which improvement plans to support the Trust and improve delivery would be discussed. She explained that despite being told that the Trust was to receive £800k, £490k had been held back for the moment. Multi-Disciplinary Discharge Event (MADE) had been held in the hospital the previous week which had produced great results in moving patients through the system. Senior members from across the system had looked into ways of discharging long staying patients. 50 discharges a day were required with 67 achieved over the weekend. Flow was much improved with only seven patients in A&E the morning of the Board. Ernst and Young were also in the Trust undertaking work on the improvement of flow in conjunction with Aintree and Wirral Hospitals. Mrs Lloyd stated that the MADE events had been extremely successful due to collaborative working across the wider system. Senior leaders from across the system supported wards by actively completing documentation to aid discharge times of patients. She advised that service improvement methodology must be embraced by the Trust. Ms Patten informed the Board that a letter had been received that morning informing the Trust that an additional ward must be opened by Friday. The Fracture Clinic was being moved to the Ormskirk Hospital Site while the existing clinic at Southport Hospital would be used as a Discharge Lounge. Ms Patten informed the Board that 27 cases of flu had been reported and that an outbreak of diarrhoea and vomiting had necessitated the closure of a ward. Mr Birrell asked whether an exercise had been undertaken to correlate staff who became sick with the flu with those who had received the inoculation. Ms Patten said that it had not to date but confirmed that the individual from A&E who had been struck down had been vaccinated. The Chair agreed that clinical staff should continue to be encouraged to have the flu jab. He asked that a communication of thanks was required to the staff who had shown tremendous commitment over the very demanding Christmas period to ensure that the community was well served. He also stated that the Trust was grateful for the support that it was now receiving from the wider community however it had been required sooner.	COMMS

	RESOLVED: The Board **received** the update.	
TB009/17	**CHARITABLE FUNDS**	
	Mr Shanahan asked the Board as Corporate Trustee for the Charity to approve the charitable fund expenditure requests for: 1. Two UVC Disinfector Units: £62,400 2. Critical Care Transfer Trolley: £10,135 3. Six Patient Couches: £19,800 Mr Clarke asked for clarity on the use of the patient couches and justification for their cost. Ms Patten stated that the couches would be used for both pre and post-surgery for use in place of beds for patients brought from Accident and Emergency. Mr Shanahan explained that the couches were purpose built equipment which could be cleaned and not standard seats. Mr Clarke asked whether the requests had been presented to the Finance Investment and Performance Committee in more detail. Mr Shanahan explained that all requests went through a process of scrutiny by the Charitable Funds Team. The Chair explained that the acid test for charitable funds was whether the request was for a minimum requirement or whether it went beyond to enhance the patient or family experience. **RESOLVED** The Board **approved** the requests.	
TB010/18	**CARE QUALITY COMMISSION (CQC) WELL LED REVIEW REPORT**	
	Mrs Lloyd presented to CQC Well Led Review Report which details progress against the CQC Action Plan created after the April 2016 Inspection alongside updates from the unannounced visit of November 2017 and the Well Led Review of December 2017. The 'Must Do' actions from the April 2016 had been completed by the end of June 2017 and the 'Should Do' actions by January 2018. The CQC raised concerns that they had during the Well Led Review but did not issue any enforcement notices or communicate any extreme concerns. All concerns raised during the visit were appropriately dealt with at the	

	time or a plan was put in place. It was expected that the draft report would be received by mid-February with the final report available by the end of March 2018. Mrs Lloyd thanked Mrs Griffiths for her support in strengthening compliance across the Clinical Business Units and Corporate functions. She reported that NHSI had provided funding for Delivery Performance Manager; who was working to strengthen quality reporting mechanisms to support the team to be in a strong position to respond to the recommendations of the pending CQC Report as soon as it landed. Weekly CQC Action Plan meetings chaired by the incoming Interim Chief Executive, Ann Farrar had been diarised for the Executive Team. They would provide a forum at which assurance could be gained from Board to Floor sustainable and delivery was continuing to take place. The next steps would focus upon the key lines of enquiry; sustainability and the well led self-assessment review. Mrs Lloyd made reference to the 'Governance Framework' in relation to the CQC Action Plan on Page 39 of the Board Pack. A presentation had been given to the Executive Improvement Board which gave assurance of the plans, scrutiny, embedding into the Clinical Business Units and progress reports going forward. Mrs Lloyd reported that an Interim Deputy Chief Nurse had joined the team to support Gill Murphy, Deputy Chief Nurse for 12 months during the transition and departure of Mrs Lloyd in March 2018. Mr Birrell asked whether the CQC Action Plan would be incorporated into a single overarching Quality Improvement plan as discussed in the November Board. Mrs Lloyd verified that this was correct and that the Quality Improvement Plan would be brought back to the February Board. Mr Clarke queried the recruitment of a second Deputy Chief Nurse for 12 months. Mrs Lloyd explained that the post had been out in place to support Mrs Murphy while she acted up into the position of Chief Nurse during the transition period between Mrs Lloyd's departure and the recruitment of a new Director of Nursing and Midwifery. **RESOLVED:** The Board **received** the update.	DoN
TB011/18	**NATIONAL GUARDIAN'S OFFICE – FREEDOM TO SPEAK UP REPORT & ACTION PLAN**	
	Mrs Royds gave a verbal update on the National Guardian's Office (NGO), Freedom to Speak Up (FTSU) Report and Action Plan. The latter had	

	been completed by the Trust to be returned to the NGO by 15th December. The week before submission, NHSI had asked for the plan to be shared with them and had come up with a number of suggestions for incorporation. A course of action had been agreed with NHSI including the stipulation that the Board should remain sighted on the plan. The changes had meant that the submission to the NGO was delayed however they had been made aware of the reason for this. Mr Birrell asked for verification that the Board was not required to approve the plan but was simply to have visibility. Mrs Royds verified that this was the case. The Chair stated that any changes or critical items needed to be highlighted to the Board when the plan was brought for discussion. It was confirmed that Mrs Royds would distribute the plan to the Board. **RESOLVED:** The Board **received** the update.	
TB012/18	**ITEMS FOR APPROVAL / RATIFICATION**	
	The Approval of the Fit and Proper Persons Policy and Procedure For Compliance with Fit and Proper Persons Requirements (FPPR) Mr Charles reported that during the Care Quality Commission (CQC) Well Led Visit in December it had been identified that a more robust policy was required. The revised policy had been signed off by the Executive Team Meeting prior to being brought to the Board. Mr Birrell asked whether the responsibilities regarding fit and proper persons as being the responsibility of the Trust Chairman on page 12 of the policy (page 58 of the board pack) should incorporate the Non-Executive Directors as well as the Chief Executive and the Executive Directors. Mr Charles explained that the recruitment of Non-Executive Directors was undertaken by NHSI and as such that would be the responsibility of NHSI to undertake the fit and proper persons' checks. He added, however, that ongoing checks for fitness would be done by the Trust and that an amendment would be made to the policy to make it explicit. Dr Mansour made reference to page 5 of the policy (page 51 of the board pack) of the under item 5, '*Scope'* and asked whether the scope of the policy could be extended to incorporate deputies who might act up into the Trust's Executive Team for either an extended or short term period. Mr Charles responded that deputies who acted up for extended periods	

	would be expected to be subjected to the fit and proper persons' checks but those who were acting up for a short period would not. Mrs Royds advised that her title on page 7 of the policy should have 'Organisational Development' removed and that it should read instead Associate Director of Human Resources. Mrs Baxter asked whether the increasing number of overseas recruits was covered by the policy. Mr Charles confirmed that the checking of overseas personnel was covered by the policy and referring to the flow chart on page 4 of the policy (page 50 of the board pack) which included the right to work in the UK and a web search of the individual. The Board **approved** the policy subject to the agreed amendments.	
TB013/18	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	
	There were no questions from the Public.	
TB014/18	**ANY OTHER BUSINESS**	
	Formal Ratification of the Resolution to Evoke Emergency Powers for the Utilisation Loan. The Board agreed to ratify the Resolution for Emergency Powers for the Utilisation Loan which had been evoked by means of a virtual meeting on Tuesday 4th January attended by Mrs Karen Jackson, Interim Chief Officer, Mr Fraser, Mr Birrell and Mrs Gorry with Mr Charles 'present' to advise and to formally record the Action. The Board **ratified** the resolution.	
TB015/18	**ITEMS FOR THE EXTREME RISK REGISTER / CHANGES TO THE BAF**	
	There were no items to be added to the Extreme Risk Register or Board Assurance Framework.	
TB016/18	**MESSAGE FROM THE BOARD**	
	The following messages were agreed from the Board for communication to the Trust: • Recognition and thanks to staff for their outstanding efforts put into the preparation and on-going work for the CQC Inspection. • Recognition and thanks to staff who had shown their commitment over the very pressured Christmas period, ensuring that the community was well served.	
TB017/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	

	Wednesday 7th February 2018 10.00am The Seminar Room, Clinical Education Centre, Southport District General Hospital	

There being no other business, the meeting was adjourned

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Public Board Matters Arising Action List
As on 7th February 2018

BRAG Status Key

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

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
JUNE 2017	**TB116/17** **Staff Engagement Plan**	CEO July 2017	Staff Engagement Plan to be brought to the Board on the back of the final version of the Cultural Review.	To ensure that the findings of the cultural review are fed into the WRES action plan. Final Version of Review received in late August. CEO to bring details of action to October Board. **Deferred until the Cultural review process has been completed and the Cultural Review is brought to the Board.**	**AMBER**
SEPT 2017	**TB174/17** **Workforce & Organisational Development**	ADHR Dec 2017	Mrs Lloyd emphasised the requirement for the Trust to scrutinise the contractual requirements for the management of the Human Resources function and confirm whether any additional activity would be required to address this.	October update: formal Arrangements for scrutiny & reporting mechanism to the Board & its relevant committee to be put in place. December update: discussions are ongoing between STHK & S&O. Business Service Catalogues are in the process of being ratified and agreed. Once agreed can be shared more widely. **A further update will be brought to the February 2018 Board. On the Agenda.**	**GREEN**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
SEPT 2017	**TB185/17** **Items for Approval - Standard Operating Procedure for the Administration of Meetings**	ICoSec Oct 2017	The Board and Committees' Annual Business Cycles to be brought to the Board after further work has been done. Cycles for all committees are to be incorporated into a master cycle which should be published on the Trust internet site.	An update to be provided at the December Board. **The calendar has been updated to include the revised dates for the Quality and Safety Committee. Included on the February Agenda.** **A further version including the dates for the Board Development Workshops and will come to the March Board.**	**AMBER**
OCT 2017	**TB214/17** **Items for Approval:** **The Risk Strategy**	DDoN Nov 2017	Amendments to be made and returned to the Board for approval.	To be brought to the December Board for approval. **Deferred to February Board in lieu of visit by CQC in December and Christmas period. This is on the February Agenda.**	**GREEN**
OCT 2017	**TB216/17** **Any Other Business**	ICoSec Dec 2017	a) The Orientation Programme for the new Non-Executive Directors had not yet been provided and is required. b) It was agreed that Dementia Training should be provided as part of a future Board Development Session. c) A Board Evaluation Form is to be brought to all future Boards.	This has been drafted and with the Chair for review and will be circulated in December. This is being built into the Board Development Session Dementia Training to take place on 10th January 2018**.** **Orientation Programme to be circulated to the Non-Executive Directors before the February Board after sign off by the Chair.**	**GREEN**
NOV 2017	**TB226/17** **Highlight Report for The Quality & Safety Committee – Lock Down Policy**	COO Feb 2018	An emergency planning simulation exercise is to be organised. An update will be provided to the Board once completed.	**The policy is to be signed off at the January Resilience Committee and an update will be brought to the Board in February. An update on the simulation exercise will be brought to the Board once it has taken place. On the agenda.**	**GREEN**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
NOV 2017	**TB230/17 Workforce & Organisational Development Plan**	ADHR Dec 2017	It is recognised that the 'Workforce and Organisational Development Plan' must contain an Organisational Development Strategy and Plan and a Staff Engagement Strategy and Plan. Key performance indicators, targets and timeframes to be used to measure improvement and success.	**Work is being undertaken on the incorporation of recommendations made at the November Board. The revised plan to be brought back to the February Board. On the agenda.**	**GREEN**
NOV 2017	**TB232/17 Quarterly Integrated Governance Report**	DON Feb 2017	More information to be provided on lessons learned in the Quarterly Integrated Governance Report.	**To be added into the next Integrated Governance Report on Quarter 3 and in the February 2018 report. Incorporated into the IPR. To be removed from log.**	**GREEN**
NOV 2017	**TB232/17 Quarterly Integrated Governance Report**	DON Dec 2017	The findings of the Root Cause Analysis Report on the MRSA case of August 2017 to be brought to the Board.	**An update to be provided to the Board as soon as information is available.** **Mrs Lloyd to circulate the RCA Report to the Board before the February Board.**	**AMBER**
DEC 2017	**TB254/17 Patient Story**	ICEO/DoN Jan 2018	The case of the Patient from the December Board Patient Story was to be taken to the Southport and Ormskirk Senior Leaders' Forum as an illustration of patient experience but also to escalate required contact from Social Services and Community Occupational Therapy for the patient in question.	**Feedback to be brought to the Board following the System Meeting in February 2018.**	**AMBER**
DEC 2017	**Quality & Safety AAA Highlight Report**	ICEO Dec 2017	Formal commendation to be given to the team which undertook the Paediatric Mortality Review.	**ICEO to speak to Dr Chris Goddard, Chair of the review group. Update to be brought to the February Board.**	**AMBER**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
DEC 2017	**Quality & Safety AAA Highlight Report**	COO/ ICEO Jan 2018	**Overdue Follow Up Appointments.** Diabetic eye screening appointments have been impacted by the failure of a service provider arrangement with Aintree Hospital.	COO/ICEO to escalate to Hazel Richards of NHS England for intervention. Update to be given at the January 2018 Board. Discussions with NHS England (NHSE) and the network lead (to clear the backlog of 2,020 diabetic eye screening appointments) have resulted in talks with Aintree Hospital about the future of the service. **An update to be brought to the February Board.**	**AMBER**
DEC 2017	**TB256/17** **Quality Improvement Plan**	DON Jan 2018	An updated Quality Improvement Plan incorporating a timeline and milestones to be brought to the Board.	**On the February agenda.**	**GREEN**
DEC 2017	**TB258/17** **Care For You**	DoN Feb 2018	Dr Fraser to be invited to present an update on the Frailty Pathway to the February Board.	**To be added to the February agenda / Dr Fraser to be invited to give an update. On the agenda**	**GREEN**
DEC 2017	**TB259/17** **Workforce Committee AAA Highlight Report**	ADHR Spring 2018	Percentage of mandatory training moved to E-learning	**Mrs Royds' Department to investigate.**	**AMBER**
DEC 2017	**TB259/17** **Workforce Committee AAA Highlight Report**	ADHR Spring 2018	A method of measuring how effective the new E-Learning tool is to be agreed and incorporated for quarterly reports to the Workforce Committee.	**Mrs Royds' Department to investigate.**	**AMBER**
DEC 2017	**TB259/17** **Workforce Committee AAA Highlight Report**	C Fowler Jan 2018	A discussion is required to agree how to get more staff trained on E-rostering.	**Mrs Fowler to meet with new ICEO, Mrs Farrar, to discuss the way forward.**	**AMBER**
JAN 2018	**TB005/17** **ICEO's Report**	DoN Jan 2018	Feedback report from the Clinical Senate to be circulated to the Board.	**Mrs Lloyd to arrange for the report to be sent to Ms Flood-Jones for distribution.**	**GREEN**
JAN 2018	**TB007/18** **FP&I AAA Highlight Report**	DoN Jan 2018	Staff to be encouraged to have Flu Shots.	**A programme of awareness on intranet.**	**GREEN**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	COMMENTS/UPDATE	ACTION	BRAG STATUS
JAN 2018	**TB010/18** **CQC Well Led Review**	DoN Feb 2018	An overarching Improvement Plan to be brought to the Board incorporating: 2016 CQC Improvement Plan, 2017 CQC preparation plan, feedback from the CQC December 2017 Inspection and the Quality Strategy and Plan.	**To be brought to the February Board. On the agenda.**	**GREEN**
JAN 2018	**TB011/18** **National Guardian's Office – Freedom to Speak Up (FTSU)**	ADHR Feb 2018	The updated FTSU Action Plan with input from NHSI to be brought back to the Board for visibility (not approval).	**To be brought to the February Board. On the agenda.**	**GREEN**
JAN 2018	**TB012/18** **Items for Approval**	ICOSEC Jan 2018	Amendments discussed in the Board to be made to the Fit and Proper Persons' Regulation Policy.	**Amendments to be made and policy to be uploaded to the Intranet. COMPLETED and on Intranet.**	**GREEN**
JAN 2018	**TB016/18** **Message from the Board**	DoN/COO Jan 2018	The following messages were agreed: 1. Thanks to be given to all members of staff involved in the CQC Inspection for their outstanding efforts. 2. Thanks to be given to staff for who showed immense commitment over the very busy Christmas period to ensure that the community was well served.	**The Director of Nursing and Chief Operating Officer to work with Marketing to ensure the messages get through to staff.**	**AMBER**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 February 2018

Agenda Item	**TB022/18**	**Report Title**	**Interim Chief Executive's Report**
Executive Lead	**Ann Farrar,** Interim Chief Executive		
Lead Officer	**Ann Farrar,** Interim Chief Executive		
Action Required *(Definitions below)*	✓ To Receive ☐ To Approve ☐ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

Interim Leadership & Improvement Plan
Safety & Quality
Financial Position
Performance on A&E & Patient Flow
Strategic Business – Care for You
Operational Planning Process 18/19

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

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

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

☐ Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on BAF / HLRR Ref: ALL
☐ Service Change
✓ Best Practice

☐ Other List (Rationale) _____	
Impact *(is there an impact arising from the report on the following?)*	
✓ Quality ✓ Finance ✓ Workforce ✓ Equality	✓ Risk ✓ Compliance ✓ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
To lead and deliver through the Executive Team and report progress to the Southport & Ormskirk Improvement Board led by NHS Improvement.	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

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

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

1 Interim Leadership & Executive Improvement Plan

As Interim Chief Executive from mid-January to end of March 2018, I am pleased to welcome Dr.Jugnu Mahajan, Interim Medical Director, who joined the Trust in January for a period of six months.

To provide focus, stability and maintain a positive momentum for the new permanent Chief Executive to take forward, the Executive Team has produced a Single Executive Improvement Plan. This focuses on enhancing the key priorities that is, executive leadership, safety & quality, financial plan, core operational business, human resources and strategy. To continue to support the improvement journey at this Trust, NHS Improvement has established a Southport & Ormskirk Improvement Board and the first meeting is on 13th February. The Trust welcomes the continued support and will use this opportunity to describe the key developments and agree the necessary support and resource to deliver the service priorities.

2. Safety & Quality

The outcome of the CQC Well-Led review is expected in March. To support the Trust's drive forward on the transformation journey and demonstrate the improvement in delivery of care through appropriate audit measures, the first Quality Improvement Delivery Board, led by the Interim Chief Executive was held in January. The priorities are substantive progress in better outcomes and appropriate Trust-wide improvement plans to describe the continued progress required with clear measurable goals and metrics by when to go further and achieve a rating of good over a longer period. There is much to do over the next couple of months to reach the right standard of improvement; therefore, support has been put in place to ensure staff produce the right standard of evidence to demonstrate their excellent work.

There is an increase in the risk associated with the planned inspection by Health Education North West in March to ensure the right statutory education and training requirements are in place and that junior medical staff are well supported. The Interim Medical Director is the Trust's Lead and is supporting the Director of Medical Education & Training and Head of Service to ensure the right standard of evidence is provided and material gaps are identified and addressed.

3. Financial Position

The Trust continues to be off target to deliver its year-end financial position. Action plans have been developed to secure correction of this position by year end and these were discussed at the Finance Performance and Information Committee. These actions plans have been strengthened by the commencement of a financial turnaround director approved by NHS Improvement and regular monitoring of the performance continues.

The Trust has formally raised the issue of changes to activity and income levels with its primary commissioners to determine whether the issues would lead to recovery of

additional income to mitigate their impact. The commissioner response continues to be that neither commissioner is minded to accept the proposals made. Further detailed representations are being made requesting a year end settlement which will include analysis of the stranded and variable costs as a result of reductions in activity. This will be shared with NHS Improvement.

In addition the Commissioners have issued the Trust with a letter to confirm that they are required to apply the financial sanctions in full for breaches in operational and national standards for the financial year 2017/18 in line with the national contract guidance. The value of this is currently being evaluated and discussions continue with our CCG colleagues on how best to resolve this matter.

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

4. Performance on A&E & Patient Flow

A Trust-wide patient flow improvement plan is being produced to explain the primary drivers, the operational transformation required with urgency to address the challenges and a quality improvement methodology to embed these improvements across all teams. This is led by the Chief Operating Officer with the support of E&Y's improvement approach which has led to significant improvements in some local hospitals. This is a very high risk to the Trust and so a target has been set to improve Southport A&E performance by 10% no later than the end of March. This will require transformation of our processes of care, enhanced standard operating procedures, appropriate resources for 7 day services and transformation of discharge processes led by system wide partners. This approach is requiring regular weekly CEO and Chief Operating Officer system wide challenge meetings and I am grateful to all the staff for their continued hard work and professionalism in caring for patients and continually striving to provide right care, right time, and right pace.

A rapid improvement event for a better 7 day hospital site management service starts first week in February to support the recent Multi-Disciplinary Discharge Event (MADE) (created to enhanced discharge flows with "services in the community") and will be followed by a rapid improvement event to embed standard operating principles for ward rounds. This is most likely to require hospital investment similarly, the spread and roll out of faster access to more appropriate settings for patients with complex needs will need to be commissioned and led by the CCGs.

This is a national priority for the NHS and continues to be a high priority for the Secretary of State with there being a requirement for strong Board leadership and knowledge. As a result the Board and Finance, Performance and Information Committee will receive regular monthly reports on progress and plans to improve performance for challenge.

5. Strategic Business: Care for You

The first meeting of the Sefton Transformation Board was held in January and the next meeting is scheduled for 28th February. The aim is for a strategic direction of travel to be produced by the summer and this will describe the vision for the care to be provided closer to home, clinically and financially sustainable hospital acute services into the future, and how innovations in digital care and the workforce can enable these ambitions to be achieved.

This strategic planning will require the right PMO leadership and support hence the executive team has produced a summary of the skills and resource required, taking into account talents in the Trust. A request for resource support to NHSI has been made.

6. Operational Plan 18/19

During February and March the Trust needs to put arrangements in place to produce the key operational priorities and delivery plan including the financial plan and agree contracts with CCGs. National guidance has not yet been received, however, a timetable and steps are being produced and arrangements will be made for time out with Board members to develop and approve a draft Operational Plan for NHS Improvement to approve.

Ann Farrar
Interim Chief Executive
31st January 2018

HIGHLIGHT REPORT

Committee/Group Meeting date:	**QUALITY & SAFETY COMMITTEE 31st January 2018**
Lead:	**Mrs Julie Gorry, Chair**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Bearing in mind the performance indicators for the stroke service, the Committee requested that a report be prepared outlining the actions being taken and timescales for ensuring that the Trust's stroke service is in line with best practice.
- The HEENW report and actions required were discussed and the Committee stressed the importance of resolving the various issues.
- There is a need for greater clarity around the relative priority of tasks within the organisation. The strong view of the meeting was that improving quality and safety has to be explicitly adopted as the Trust's overriding priority.
- There are some side rooms in the Trust where observation is difficult. Remedial work is underway but it may be necessary to de-designate some areas.
- Staff competency in blood transfusion is low, (59%), so urgent action is being taken to improve the situation.

ADVISE

- A new Quality Improvement Delivery Group, chaired by the Chief Executive, is set up and the Executive Improvement Board will in future be overseen by NHSI. The Committee welcomed both of these developments.
- Given the relatively high number of falls recorded on ward 7A, a request was made for a report on action being taken to improve the situation.
- The existing mortality review process was described as more like a screening exercise than a detailed clinical review. The adoption of the Structured Judgement Review approach will address this problem in the medium term but as an interim measure some external case note reviews will be commissioned.

ASSURE

- Agreement has been reached with the Lancashire Care Trust on the provision of a CAMHs service, although the start date has yet to be set.
- The quarter 2 Integrated Governance Report provided a good deal of assurance around a number of areas, including the level of incident reporting, the number and management of complaints, completion of STEIS reports and acknowledgement of CAS alerts.
- Cancer waiting times have improved to the extent that the Trust has been congratulated on its performance by the Secretary of State.
- Revised arrangements and the associated terms of reference for the Quality & Safety Committee and the Mortality Operational Group were agreed.

New Risk identified at the meeting	No new risks identified.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

7th February 2018

Agenda Item	**TB025/17**	**Report Title**	**Integrated Governance Quarterly Report – Quarter 2 2017/18**
Executive Lead	**Sheila Lloyd,** Director of Nursing Midwifery Therapies and Governance		
Lead Officer	**Katharine Martin,** Senior Information Analyst for Quality & Datix Project Lead for **Mandy Power,** Assistant Director of Governance		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve ☑ To Assure	☑ To Note ☐ For Information	

Key Messages and Recommendations

To summarise exceptional issues, positive developments, achievements and priorities for further action in relation to the Quality and Safety of services delivered.

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

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

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

☑Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register:

(Please give reference no.) _____

☐ Service Change
☐ Best Practice
☐ Other List (Rationale)

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

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

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

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

1. EXECUTIVE SUMMARY: EXCEPTION REPORT – POSITIVE

The Integrated Governance report, for Quarter two has been written with the CQC key line of enquiry as the basis. The executive summary will review the positive area of the report and the areas were improvement is required going forward.

1.1. Safe

Incident Reporting

- The increase in reporting of incidents in quarter shows a positive reporting culture which is being encouraged. There was a 14% increase in the number of incidents reported from Q1 to Q2 which is encouraging given the loss of Community services. This increase was due to an increase in the number and proportion of no harm incidents.
- The proportion of no harm incidents reported is 3.5% higher than the previous period in the latest NRLS published data and there has been a subsequent 0.5% reduction in the proportion of incidents resulting in moderate or severe harm or death.
- No never events were reported in Q1 or Q2.
- There was an 8% decrease in violence and aggression incidents, which could be directly linked to the 24 hour security presence now in operation in SDGH.
- Following the intense work undertaken by the clinical areas and the Medical Devices committee, there was a 30% decrease in the number of incidents reported in Q2 relating to Medical Devices.
- The Integrated Governance achieved 100% compliance with the planned Health, Safety, Fire and Security Audits in Q2. No significant issues were identified, and any actions have been added to the local risk registers for the relevant ward/department to provide assurance around completion.

Mortality

- From the 200 number of deaths reported in quarter two, no preventable deaths were identified in the mortality reviews undertaken in Q2. The total number of reviews undertaken was 216. This also relates to deaths that occurred prior to Q2. The trust has strengthened its governance structure for mortality issues and has appointed a mortality lead with protected time. A mortality strategy and full action plan is being developed, notably the creation of a new operational group with time-limited subgroups to look at all aspects of mortality and related issues. The Trust is engaged with the national “Learning from Deaths” initiative. Required resources have been identified and a business case is being developed.

Central Alerting System

A system of alerting Trusts is in place for all alerts relating to medical devices, medicines and facilities issues. At the end of Q2 there were no overdue CAS alerts within the Trust.

1.2. Caring

Complaints

- The complaint themes within the quarter remain to be issues with Clinical Treatment, Verbal Communication and Staff Attitude/Behaviour. The Trust is seeing a continuation in the reduction of complaints received by the Trust. 73 complaints were received in Q2, three more than in Q1, but 59% fewer than the same period last year.
- For the first half of the current financial year, the Trust has received 62% fewer complaints than the same period 2016/17.
- 15% fewer concerns/information requests were received in Quarter 2, than Quarter 1.

Compliments

A reflection of patients and their families receiving a good service from the Trust has culminated in 377 compliments reported in Q2, an increase of 33 from the previous quarter. The Urgent Care CBU has seen the most increase in quarter. This will be monitored going forward as a process change has meant a reduction in recorded compliments but this is slowly increasing with staff becoming more familiar with the Datix reporting system.

Duty of Candour

The Trust was 100% compliant with the statutory Duty of Candour in Quarter 2.

1.3. Responsive

Complaints

- The Trust strives to improve the timescales for complaint responses which has continued to improve. This quarter 75% of complaints being closed within 60 working days. This demonstrates a significant improvement on the 50% reported last quarter.
- The national standard for complaint acknowledgement is 3 working days, 95% of complaints received in Q2 were acknowledged within the required 3 days. 4 complaints missed this deadline, due to communication failures between clinical areas and the Patient Experience and Complaints Team. This has been rectified.
- There was a 36% reduction in the number of complaints about appointments from Q1 to Q2.

Incident Reporting

- The Trust remains 100% compliant with the National Reporting Learning System upload timescales.
- At the end of Q2, there were no overdue StEIS reports.
- Whilst incident management remains a challenge for the Trust, the number of open incidents at the end of Q2 was 20% lower than at the end of Q1, with 1,138 open incidents in November 2017.

Claims

- 100% of records were supplied to claimants' solicitors within the required timescale.
- 100% of letters of claim were reported to NHSLA within 24 hours.

CAS Alerts

- 100% of CAS Alerts were acknowledged within 48hours.

1.4. Effective

Risk register

The quality of the risk register has been an issue for the Trust; reviews continue on a weekly basis which has resulted in a reduction in the number of open risks from Q1 to Q2, from 473 to 422. The distribution of these risks is shown in the later section of this report. All extreme risks are reported to Sub-Board Committees and have appropriate actions in place.

Clinical Audit

There has been an increase in the proportion of clinical audits running on schedule from Q1 to Q2.

2. EXECUTIVE SUMMARY: EXCEPTION REPORT – IMPROVEMENT REQUIRED

2.1. Safe

Incidents

- Patient accidents were the highest category of incident reporting in Q2, 173 of which were patient falls. 5 of these resulted in moderate or severe harm or death. Ward 7A had the highest number of falls in Q2. Urgent Care have developed a Falls Risk and Prevention Panel (FRAP) which aims to support investigation and learning from falls within their CBU. An audit of falls alarms has also been completed and staff have been reminded of their benefits. Information has also been shared across the CBU's to guide staff in accessing low beds and mats for those patients who are deemed as high risk. Planned care have demonstrated success by introducing 'falls packs' which include all relevant nursing documentation, patient information leaflets and falls risk bracelets. Due to the positive response to these packs they have now also been implemented within the Urgent Care CBU. The Falls Care bundle has been reviewed as part of a review of nursing

documentation. This renewed assessment tool will also replace the current falls risk assessment completed in the A+E department. Local results from the National Falls Audit were received late last year, these will be reviewed to inform action planning for 2018. Identified areas for improvement are around cognitive assessments, measurement of lying and standing BP, medication reviews, and patient/carer education.

- Bed Management incidents have increased by 66% from Q1 to Q2. These are dominated by the ability to transfer wardable patients from Critical Care to Wards, thus demonstrating the issues with bed pressures and patient flow. This increase has resulted in an increase in the number of mixed sex breaches reported in Q2 and nine complaints/concerns received citing bed management issues, leading to delays to be seen and cancellation of procedures. Issues around bed occupancy and patient flow are on the risk register as extreme risks to the organization. The Trust has opened 19 additional beds in Ormskirk to facilitate step down patients and help patient flow, Ernst and Young have been commissioned to support service improvement for flow and Southport System Leaders Group has been established by NHSI to enable system support and change.

- There was a 45% increase in the numbers of incidents reported relating to insufficient nurses/midwives from Q1 to Q2 (excluding Community). This increase can be directly related to Maternity areas. Issues with insufficient nurses and medical staff are one of the principle risks to the organisation and are on the risk register as an extreme risk.

- There was an increase in the number of hospital acquired grade 2 pressure ulcers from Q1 to Q2, from 14 to 18. An action plan remains in place, with Skin Bundle/Pressure Ulcer prevention training re-commencing in Q4. The Trust remains active as part of Cheshire and Mersey Pressure Ulcer Steering group reviewing issues such as risk assessment, equipment and training needs. Pressure ulcer awareness/risk assessment/skin inspection within A&E has improved dramatically. All incidents are investigated with learning points incorporated within training.

- There was a marginal increase in the number of actual claims received from 26 in Q1 to 29 in Q2. This increase can be attributed to Women & Children's services, with a rise in claims directly related to the PPH review carried out in 2016.

2.2. Caring

Complaints

- There was a 175% increase in the number of complaints relating to poor communication from Q1 to Q2, from 8 to 22. Key areas are Short Stay Unit, Ward 14B (respiratory) and Outpatients.

2.3. Responsive

Complaints

- At the end of Q2, 11 complaints remained open more than 6 months, all complainants have been kept informed of progress to date.
- 9 complaints were re-opened in Q2, the same number as Q1. Whilst there is no target for this indicator, complaints being re-opened may suggest issues with the quality of Trust complaint responses.

Incidents

- 60% of StEIS reportable incidents were reported to StEIS within 48hours. 6 incidents fell outside this timescale due to delays understanding the harm caused to the patient.
- 81% of harm reviews take place within 1 week of the incident taking place, this should be 100%.
- 42% of incidents were closed within the required timeframe in Q2.

Actions

There are issues with the completion of actions relating to incidents, complaints and risks across all Business Units, with 61 overdue complaints actions, 172 overdue incidents actions and 93 overdue risk register actions.

Following discussion at Clinical Effectiveness meeting 24 January 2018, a meeting has been arranged with the corporate and CBU teams to review roles and responsibilities, capacity and demand and to develop an action plan to address backlog of complaints and incident reporting process. Weekly status reports are shared with CBU teams on progress.

Risk Register

Reviewing risks within timescales remains an issue; 61% of risks were within their review timescales at the end of Q2. The Integrated Governance team send weekly email reminders for all overdue risks.

NICE guidelines

12.5% of new NICE guidelines had not been assessed by the responsible clinician within 8 weeks in Q2. The Audit Team have a dedicated lead for NICE, who actively liaise with clinicians. Overdue NICE guidance is also monitored through the monthly CBU reports. Following discussion at Clinical Effectiveness on 24 January 2018, a meeting is planned, led by the medical director, to determine a

clear clinical audit process from floor to board with identified roles and responsibilities, action planning and escalation.

2.4. Effective

122 policies were out of date as at 16th November 2017, an increase of 30 on the previous quarter. At the time of writing this summary (17th Jan 2018), this has reduced to 42. This is due to the drive undertaken by both the Integrated Governance Team and the relevant policy leads.

2.5. Actions for Improvement

- Weekly Incident, Complaint and Claims Reports are now being compiled and sent to the CBUs identifying both new incidents, complaints and claims, and also outstanding and overdue incidents and complaints.
- Weekly out of date policy reports are being compiled and sent to the CBUs Triumvirates, Executives and relevant authors of out of date policies.
- The Complaints Policy has been reviewed which will set out clear processes for the Business Units to report any complaints into the Complaints Team to ensure compliance with the regulations for acknowledgement within 3 working days.
- Monthly Quality & Safety CBU reports highlight overdue actions and risks and outstanding incidents, CAS alerts and complaints. They also detail non-compliant NICE guidelines and issues with clinical audits at CBU level. These papers are reviewed at Clinical Effectiveness Committee with any exceptions escalated to Quality & Safety Committee.
- The Incident Policy has been rewritten which will set out clear processes for the Business Units to report any incidents and the process to manage them.
- Risk Register workshops have taken place and further sessions have been arranged for Q3 to support the Business Units to improve their management of the risk register.
- The Risk Assessment Policy and Process is under review and the Risk Management Strategy is under review.
- The CAS Alert Policy and process has been reviewed.
- Actions required as a result of local health, safety, fire and security audits will be added to the relevant ward/departmental risk register in Datix to enable monitoring and to provide assurance that all actions have been delivered.

3. INCIDENTS

The table below shows the overall level of activity in the Trust during Q2, alongside the incidents reported.

Business Unit	Q2 Activity (Attendances/Admissions	Incidents	
		Number as a % of Activity	Numbers
Urgent Care	34,069	2.1%	705
Planned Care	44,295	1.6%	692
Specialist Services	26,029	1.9%	494
Total	**104,393**	1.9%	**2,004**

The Trust uses the Datix electronic system to manage Incident Reporting, Serious Incident and the Strategic Executive Information System (StEIS) incidents. The management of Incident Reporting, Serious Incident and the Strategic Executive System (StEIS) incidents is used as part of an overall safety and quality improvement strategy of the Trust.

The Trust uses the Datix Incident management system to capture action plans and lessons learned from Incidents, Serious Incident and the Strategic Executive Electronic System (StEIS) incidents so that patient and staff safety is at the forefront of staff minds in their day to day practice.

3.1. The National Reporting and Learning System (NRLS)

The latest NRLS data was published in October 2017. This relates to the period October 2016 – March 2017. A summary of the results for the Trust is shown below:

Time Period	No of Incidents Occurring	Median Days to Report	Rate per 1,000 bed days	% No Harm	% Low Harm	% Moderate Harm	% Severe Harm	% Death	Position based on rate per 1,000 bed days - all Acute Trusts
April - Sept 2014	1,989	67	27.16	80.2	9.8	9.5	0.5	0.1	119/140
October 2014 - Mar 2015	2,470	38	33.43	81.3	7.9	10.2	0.3	0.2	87/137
April 2015 - Sept 2015	2,748	18	37.75	79.1	14.2	5.9	0.5	0.2	73/136
Oct 2015 - Mar 2016	2,804	16	41.49	77.7	18.1	3.9	0.3	0.04	52/136
April 2016 - Sept 2016	3,001	31	44.92	79.1	18.7	1.7	0.3	0.1	33/136
Oct 2016 - Mar 2017	2,922	36	44.76	82.6	15.7	1.5	0.1	0.0	43/136

There has been a 2.6% reduction in incidents reported in the latest published six month period, with a resulting drop in the Trust's ranking against other Acute Trusts from 33/136 to 43/136.

There has been an increase in the proportion of no harm incidents, and a reduction in moderate, severe and death incidents.

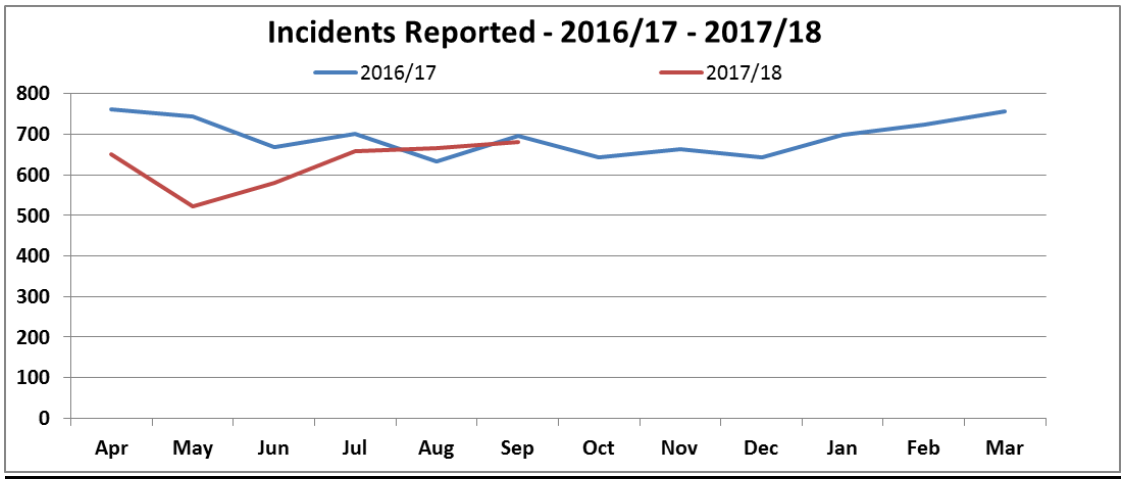
The median days to report has increased from 31 to 36. This is due to a change in process to report incidents with completed investigations, where possible, in order to demonstrate the learning from incidents within our external reporting, and assurance that our recording of harm is accurate.

The latest CQC insight report provides further assurance against our NRLS reporting, demonstrating the Trust's consistent levels in the latest six month period.

3.2. Incidents Reported

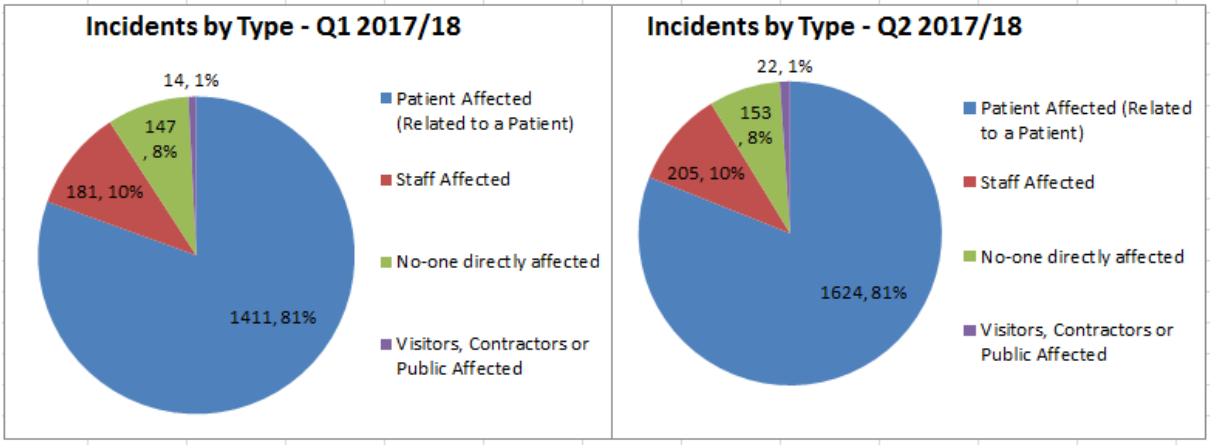
The graph below shows the incidents reported (excluding external incidents), for the first half of 2017/18, compared to the previous financial year.

Incident reporting for 2017/18 has decreased from the previous financial year, and at the end of Q2 was 10.6% lower than the same period last year, which was impacted by the loss of Community services and the cyber-attack in Q1. However figures for Q2 show a 14% increase in reported incidents (2,004 incidents) than numbers reported in Q1, and remain consistent with numbers reported in Q2 2016/17, despite the loss of Community services. This is encouraging and demonstrates a positive patient safety culture.



3.3. Incidents by Type

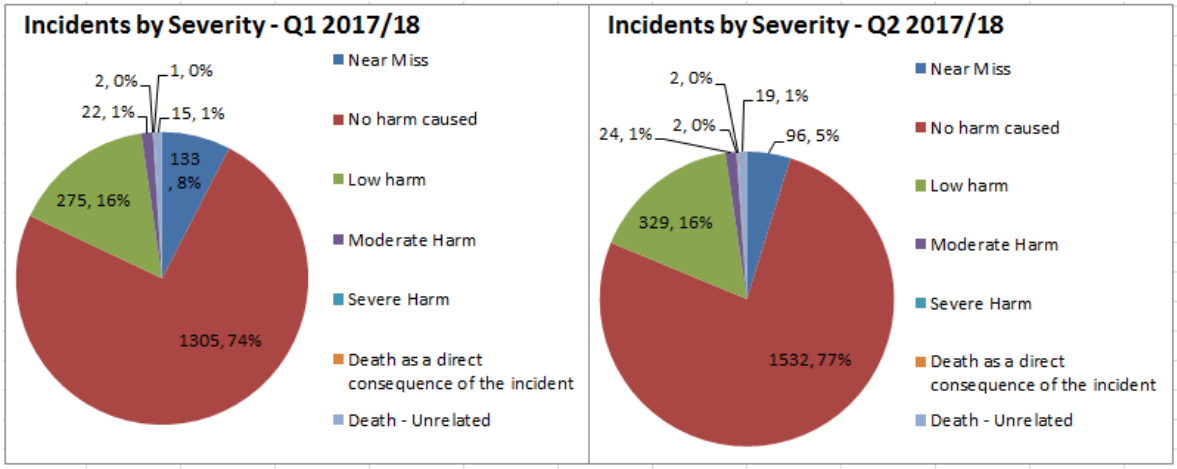
The pie chart below shows the incidents by type.



Out of the total of 2,004 reported incidents during quarter 2, 81% (1,624) were related to patients. 10% (205) reported incidents related to staff. 8% (153) did neither relate to staff nor patients. Only 22 (1%) of reported incidents related to visitor or contractors or members of the public. The comparison from Q1 to Q2 demonstrates consistency in the proportion of each type of incident reported, with the 14% increase being reflected across all incident types.

3.4. Incidents by Severity

This pie chart shows a breakdown of the incidents reported, by level of harm.



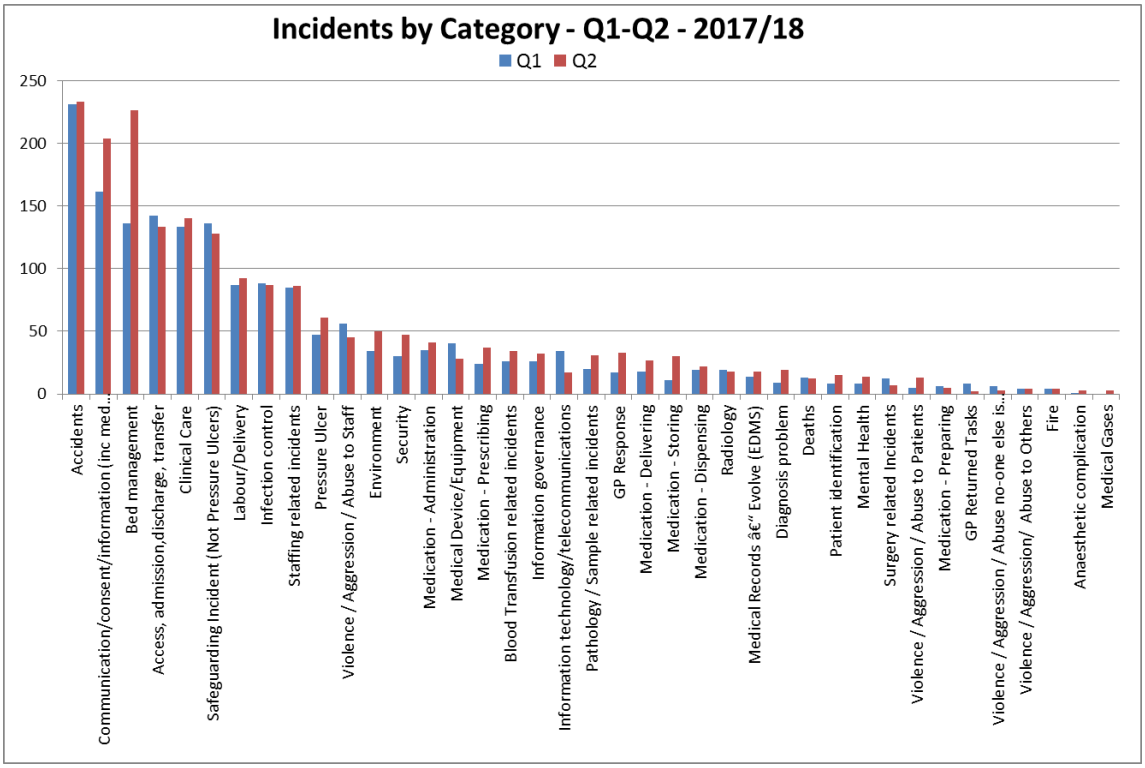
The pie chart above shows that 77% of the reported incident caused “no harm”, whilst 16 % shows as “low harm”. Hence, 93% in total of reported incidents were of low or no harm. This indicates that staff are keen to learn from incidents and are not afraid of reporting incidents in order to prevent a severe harm or catastrophic incident from occurring.

The number of reported “Near Miss” incidents (96-5%) again suggest that the Trust need to investigate the root cause of these incidents so that lessons can be learned and shared across the CBU and the organisation , if relevant, to prevent more serious incidents from occurring.

Comparison from Q1 to Q2 shows an increase in no harm incidents (17% increase) and low harm incidents (20%), with moderate, severe and death incidents remaining consistent. This is encouraging, and reflects a culture where reporters are keen to learn from the no/low harm incidents in order to reduce incidents causing significant harm. The most prevalent cause of moderate or severe harm incidents is patient falls.

3.5. Incidents by Category

The bar chart below shows a breakdown of the incidents reported in Q1 and Q2 by category:

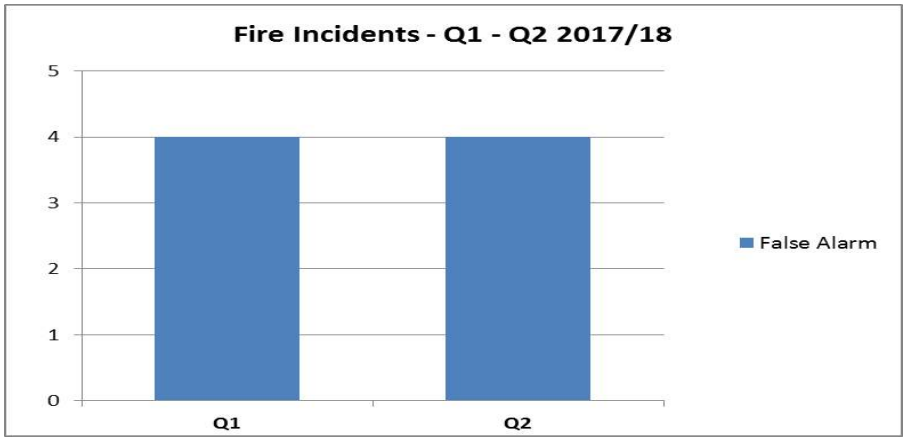


As in Q1, accidents accounted for the highest numbers of reported incidents in Q2, and numbers reported remain consistent with the previous quarter. 93% (173) of all patient accidents reported in Q2 were falls, of which five resulted in moderate, severe or death to the patient. Ward 7A (cardiology) accounted for the highest number of patient falls in Q2. The ward has added a local risk to their risk register, recognising issues with documentation, communication and use of equipment. They have devised some laminated checklists for nursing staff, and have planned audits around documentation. Comparison of the numbers of patient falls (Acute only) from 2016/17, to the current financial year, demonstrates a slight reduction in numbers, with an average of 60 falls per month in 2016/17, to 58 per month in the first half of 2017/18.

There has been a 27% increase in incidents relating to Communication/Consent and Information, of which 58% relate to issues with communication throughout the Trust, between teams, and with patients and relatives. Similarly, there has been a 66% increase in reported Bed Management incidents from Q1 to Q2, reflecting the bed pressures within the organisation and the resulting failures to transfer patients from Critical Care to ward beds. The Trust has opened 19 additional beds in Ormskirk to facilitate step down patients and help patient flow, Ernst and Young have been commissioned to support service improvement for flow and Southport System Leaders Group has been established by NHSI to enable system support and change.

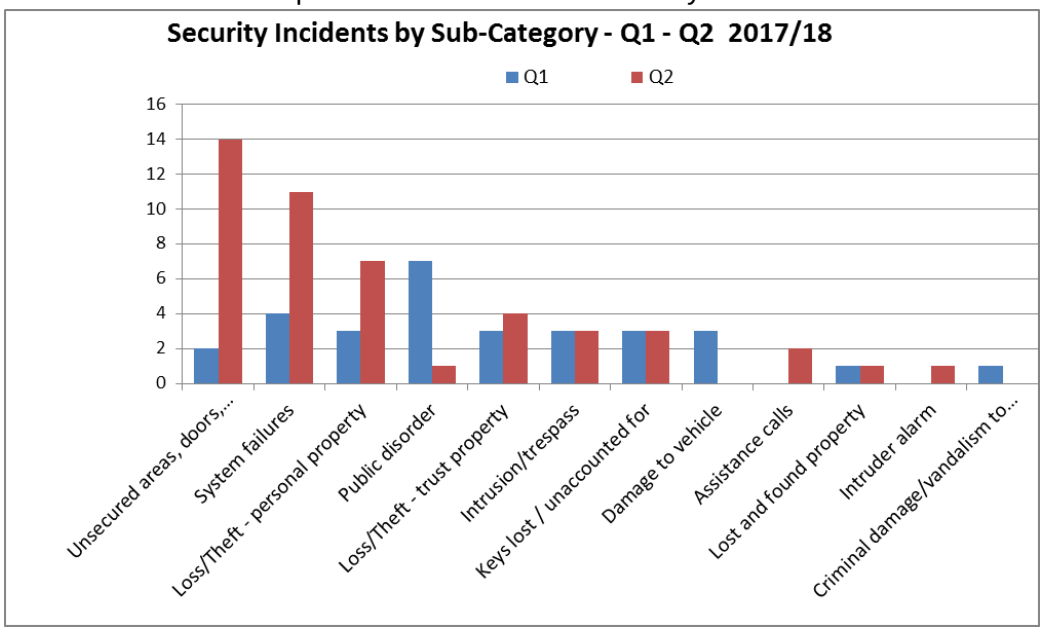
3.6. Fire Incidents

There were four fire incidents reported in Q2, the same as the previous quarter. All were false alarms.



3.7. Security Incidents

During quarter 2, there were 47 reported incidents related to Security. This represented a 57% increase from the previous quarter when 30 incidents were reported in the Trust. The table below shows a breakdown of the sub-category of the reported security incidents.

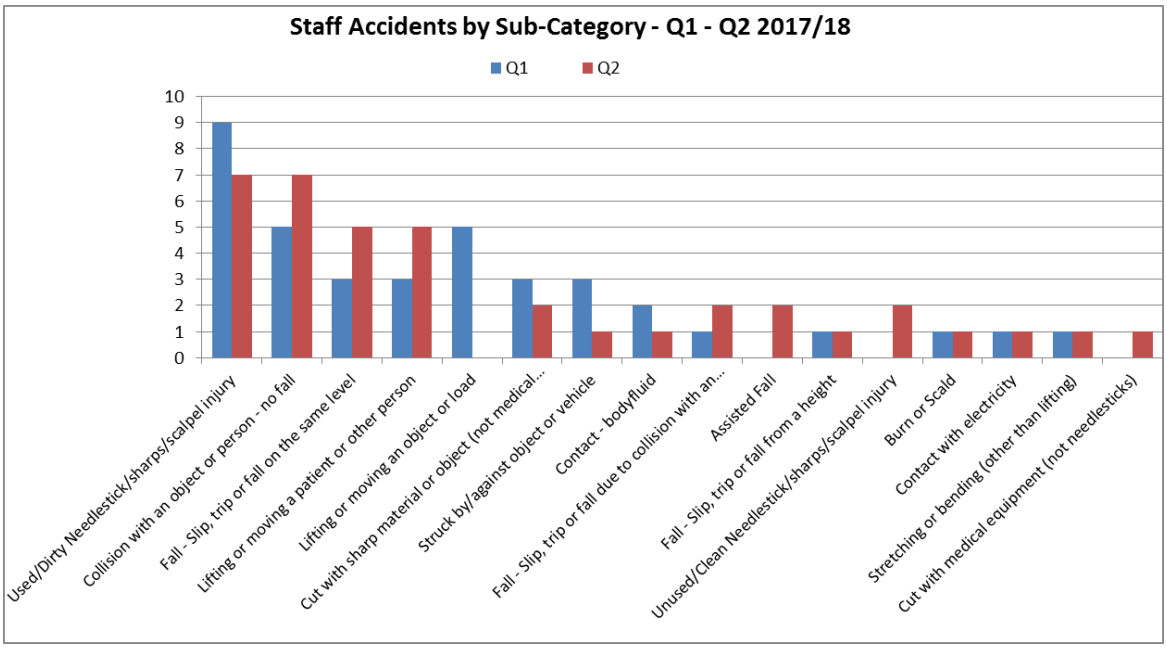


Problems securing the entrance doors of the X-Ray department in ODGH caused the significant increase in incidents around 'Unsecured areas, doors and windows'. This has subsequently been investigated by Estates & Facilities and resolved.

The increase in 'System failure' incidents was due to problems arising from failures in the baby tagging system at Ormskirk. This has since been repaired and the system is now fully operational.

3.8. Staff Accidents

During Q2 2017/18, there were 39 accidents which involved Trust staff, this remains consistent with the 38 reported in Q1. The types of accidents are shown in the graph below.



A small reduction in the number of 'Used/Dirty Needlestick injuries' was noted in Q2, compared to Q1. An action has been taken to distribute manufacturer's instructions regarding the correct use of safety covers on used sharp instruments; this consists of posters supplied by the manufacturer which have been distributed to all clinical areas in the Trust. No needlestick injuries have been Riddor reported in Q2.

While there was a slight increase in the number of incidents reporting 'Collision with an Object or Person', there was no trend / under lying factors identified.

3.9. Incident Timescales

The table below shows the adherence to timescales as set out in the policy. Failure to adhere to these timescales can impact on the Trust's ability to report to the National Reporting and Learning System (NRLS) by the required deadlines.

This risk was highlighted by the MIAA Audit Report on Incident Reporting in 2016/17.

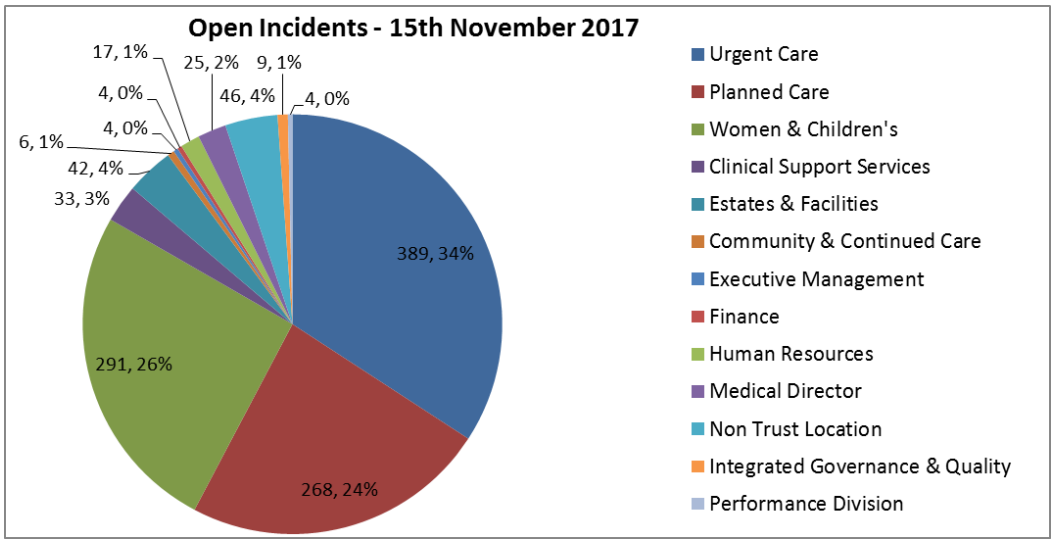
The table below shows an increase in the proportion of incidents reported within 1 day of knowledge. The CBU's are undertaking an initial review of their incident, within the target of 5 working days, in 92% of cases. This is positive and shows the focus on incident management throughout the Trust. Further work needs to be done to reduce the timescales for closing incidents. This is monitored through weekly reporting by the Integrated Governance Team, and reported through the monthly CBU Q&S papers.

Incident Timescales	Target	Q1 2017/18		Q2 2017/18	
		Actual Performance	% Incidents Achieving Target Timescales	Actual Performance	% Incidents Achieving Target Timescales
Time between Incident Knowledge and Date Reported	1 day	3.5 days	67%	2.3 days	70%
Initial review of the incident	5 days	2.5 days	94%	3.4 days	92%
Complete and close the incident	5 days from date of review	12.3 days (based on closed incidents only)	47%	16.9 days (based on closed incidents only)	42%

3.10. Open Incidents

On 15th November 2017, there were 1,138 open incidents, the oldest dating back to March 2015. The pie chart below shows the breakdown of these open incidents by Business Unit. This is highlighted within the monthly Q&S reports and is monitored by the Integrated Governance Team.

The number of open incidents reported in this report is 20% lower than in the Q1 report, which demonstrates improvements in incident management in Q2 2017/18.



3.11. Duty of Candour

Business Unit	Total Requiring DOC (Harm review QTR 2)	Compliant with Discussion		Compliant with letter/Rationale why no letter			Compliant with 10 day timeframe	
				Letter	Verbal	%		
Planned care	8	6	75%	3	5	100%	3	100%
Urgent Care	7	6	85.7%	2	5	100%	2	100%
Specialist Services	2	2	100%	2	0	100%	2	100%
Trust	**17**	**14**	**90%**	**7**	**10**	**100%**	**7**	**100%**

The integrated Governance Team, in association with the Volunteers have circulated the new NHS Resolution "Saying Sorry" Leaflets. These are aimed at encouraging staff to apologise when things go wrong; and to enlighten them that an apology is not an admission of guilt/liability. This will hopefully encourage more staff members to express remorse/regret without any misgivings.

3.12. StEIS Incidents

The table below shows the StEIS reports submitted in Q2 2017/18. Whilst there were three outstanding reports at the end of Q1, all were submitted in Q2, alongside the additional nine reports due in Q2. As a result, there were no outstanding StEIS reports at the end of Q2.

	Overdue at end of Q1	Due Q2	Submitted Q2	Overdue at end of Q2
Trust	3	9	12	0
Planned Care	2	3	5	0
Specialist Services	1	1	2	0
Urgent Care	0	5	5	0

3.13. Never Events

There were no never events reported in Q1 or Q2 2017/18. A never event has been subsequently reported in Q3, relating to a surgical procedure carried out in Q2.

Actions for Continuous Improvement

- The Policy for Reporting and Management of Incidents and the Serious Incident Including Never Events Policy are being amalgamated into one policy entitled "The Reporting and Management of Incidents and Serious Incidents".
- A Task and Finish Group is leading the work to review the policy and ensure that processes for the management of incidents are robust.

4. RISK, QUALITY AND SAFETY ISSUES

The report will now focus on the incidents which are risks featuring on the Extreme Risk register and the Quality and safety dashboard areas. These include

- Staffing
- Perinatal mortality
- Cardiac arrests
- Falls
- Pressure ulcers
- DSSA
- Medical Equipment
- Patient flow
- Mental Health and CAMHS services
- Safeguarding

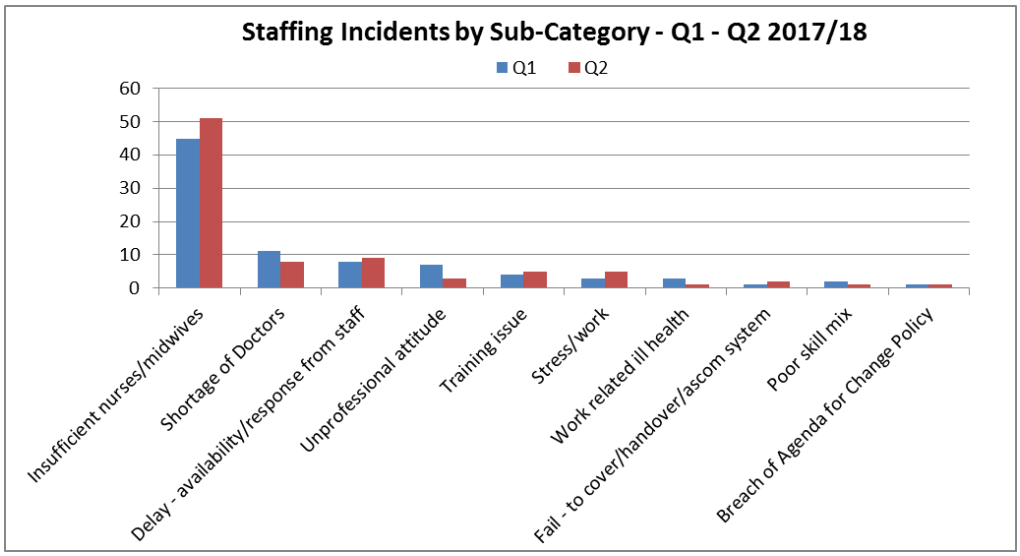
The report will triangulate any information following incidents with claims and complaints in the above areas.

4.1. Staffing

There is a high level risk on the risk register relating to safe staffing levels across the Trust. This relates to both nursing and medical staff. These risks are escalated to Trust Board monthly, and action plans are in place to mitigate the risks where possible.

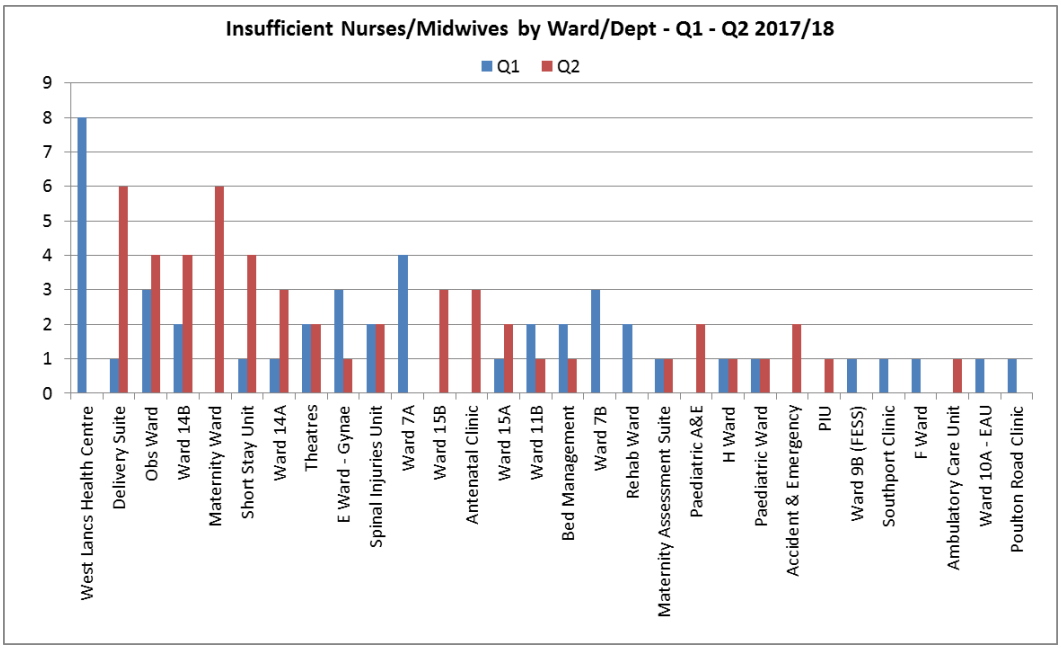
4.1.1. Staffing Incidents

86 staffing incidents were reported in Q2, one more than the previous quarter, a breakdown of these is shown below.



51 related to nursing shortages across the Trust, an increase of six on the previous quarter. The breakdown of these by ward/department is shown in the following section. Taking into account the numbers reported by Community Services in Q1 (10), the increase in those reported for Acute wards and departments only has increased by 16, which is a 45% increase from Q1 to Q2.

4.1.2. Insufficient Nurses by Ward



The incidents highlight insufficient registered and unregistered nurses on duty, often in relation to acuity of patients on the wards. There are issues of movements of nurses to address shortfalls in other areas. A significant increase in reported insufficient midwives was noted in Q2, relating to movements between the areas and resulting staffing levels which did not meet the high activity levels. Three times daily staffing reviews continue to support safe staffing in all areas. Safe staffing of 90% of greater was achieved during October and November with a dip during December of 89%. Safe staffing maintained across areas supported by temporary staffing and agency block booking to specialist areas. Staffing huddles mitigate risk areas daily and embedding of health-roster continues.

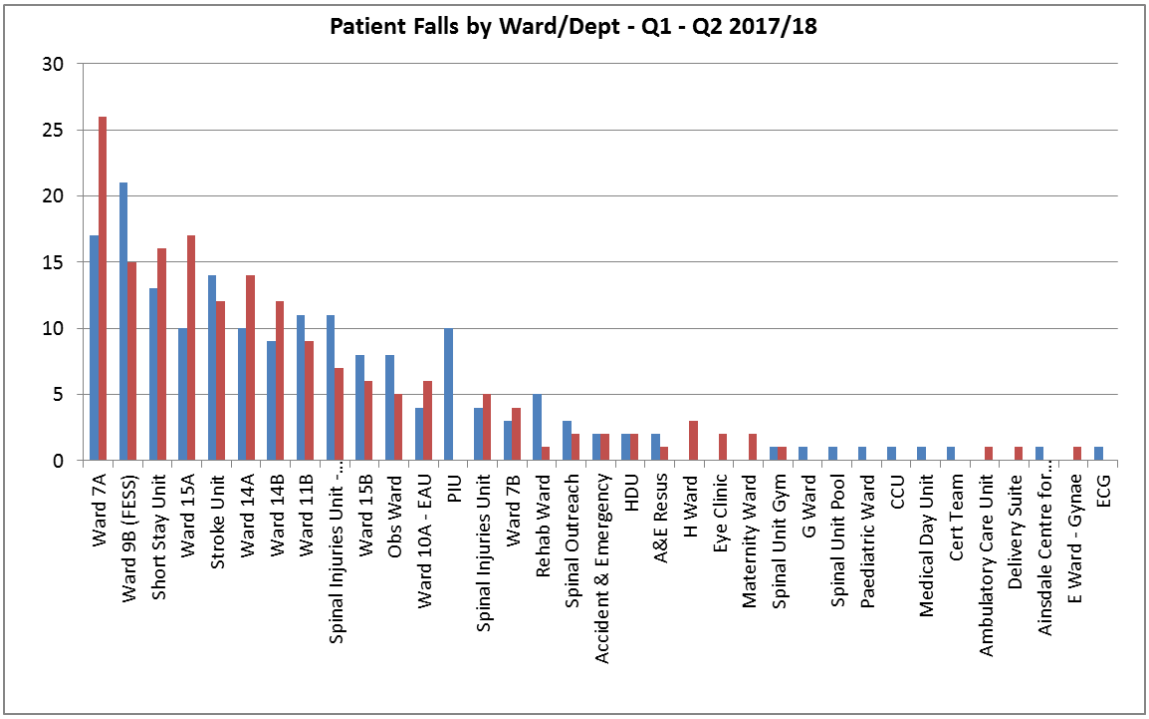
Within Q2, there was 1 complaint received which highlighted inadequate nurse staffing levels in A&E. This is one less than in Q1.

The Trust has introduced a safer staffing model using Safe Care which is captured every day based on filled shifts for both registered and unregistered nurses, on each shift; data for Q1 and Q2 is shown below:

Business Unit	Q1	Q2
Trust	96.6%	97.7%
Planned Care	98.3%	94.3%
Urgent Care	95.6%	99.3%
Women & Children's	97%	99.1%

4.2. Patient Falls

The graph below shows the location of patient falls in Q1 and Q2 2017/18.



54% of all patient falls happened overnight, this is an increase of 10% on the previous quarter.

There was a 53% increase in the number of falls on ward 7A from Q1 to Q2, from 17 to 26. All falls resulted in no or low harm. Realtime staffing averaged 95% across the quarter, and only one staffing incident was reported. Nurse sickness averaged 8.6% in quarter, with 40% of nurses temporary staff. A risk has been added to this ward's local risk register, and an action plan formulated to address issues with documentation and communication around patients at risk of falling.

Ward 15A also noted an increase in the number of patient falls, from 10 in Q1, to 17 in Q2. Sickness rates were low in Q2, but bed occupancy averaged 106%, and 44% of nursing staff were temporary/agency. All falls resulted in no or low harm.

Key themes identified from investigations into falls include issues with documentation, care plans, risk assessments and use of appropriate equipment.

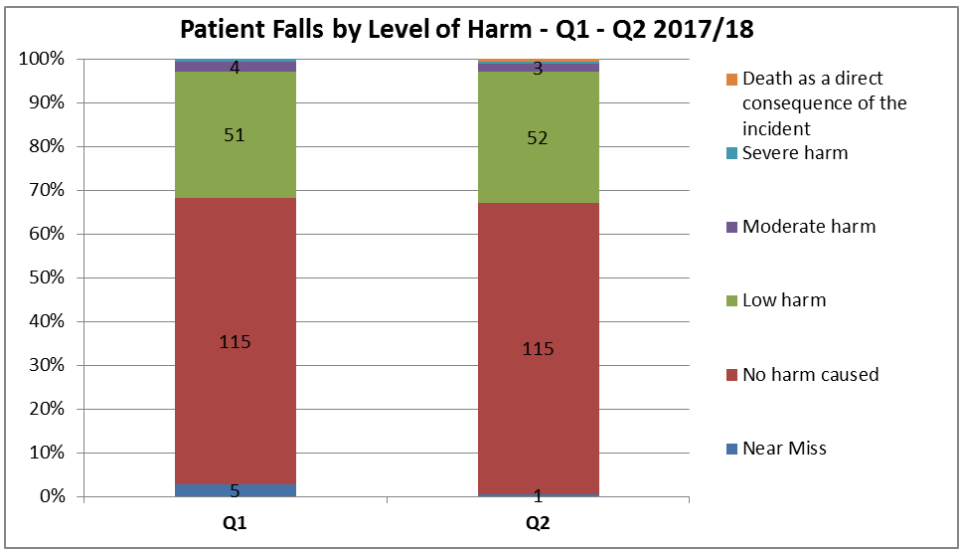
Ward 9B (FESS) noted a reduction in falls numbers from Q1 to Q2.

Two complaints were received in Q2 which highlighted falls on the Short Stay Unit. This ward has the third highest number of falls in Q1 and Q2 2017/18.

There were two new claims brought against the Trust in Q2 that related to patient falls; the anticipated legal cost of these two claims is approximately £94,000.00 due to the injuries received.

Urgent Care have developed a Falls Risk and Prevention Panel (FRAP) which aims to support investigation and learning from falls within their CBU. An audit of falls alarms has also been completed and staff have been reminded of their benefits. Information has also been shared across the CBU's to guide staff in accessing low beds and mats for those patients who are deemed as high risk. Planned care have demonstrated success by introducing 'falls packs' which include all relevant nursing documentation, patient information leaflets and falls risk bracelets. Due to the positive response to these packs they have now also been implemented within the Urgent Care CBU. The Falls Care bundle has been reviewed as part of a review of nursing documentation. This renewed assessment tool will also replace the current falls risk assessment completed in the A+E department. Local results from the National Falls Audit were received late last year, these will be reviewed to inform action planning for 2018. Identified areas for improvement are around cognitive assessments, measurement of lying and standing BP, medication reviews, and patient/carer education.

Falls by Level of Harm

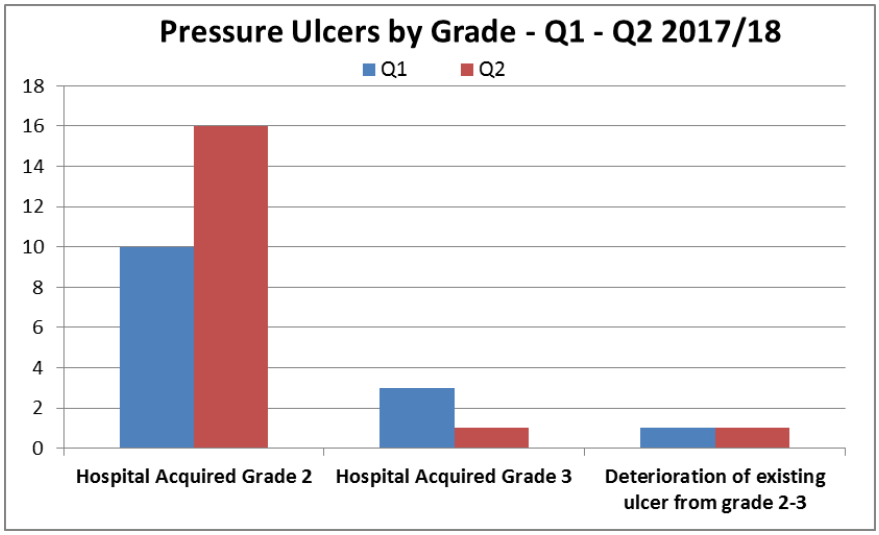


97% of patient falls resulted in no or low harm to the patient, however there were five falls which did cause significant harm. Four patients suffered fractured hips, and one patient died as a result of a head injury sustained in the fall. These are currently subject to SUI investigations.

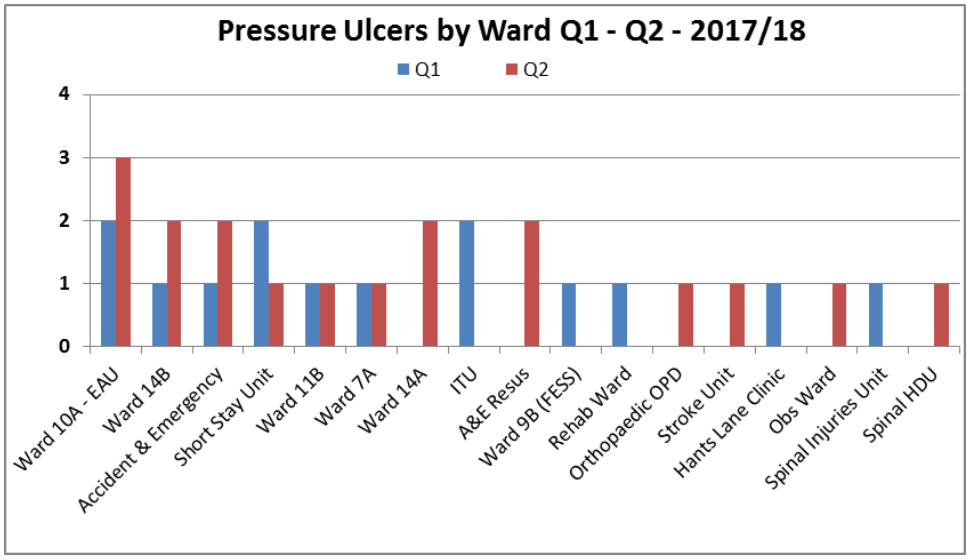
4.3. Pressure Ulcers

4.3.1. Hospital Acquired Pressure Ulcers (HAPU)

18 hospital acquired pressure ulcers/deteriorations were reported in Q2 2017/18, an increase of four on the previous quarter. This increase is in grade 2 pressure ulcers, and there has been a reduction in grade 3's reported.



The one grade three pressure ulcer reported in Q2 was on Spinal HDU. The patient had an unstable fracture and was placed in a halo jacket which resulted in the pressure ulcer. The halo jacket had been put in place by the Walton Centre, prior to transfer to the Spinal Injuries Unit. The incident has identified a lack of clinical pathway between the Walton Centre and SDGH for patients with a spinal fracture. This is being progressed by the AMD for Urgent Care.



EAU reported the highest number of pressure ulcers in Q2. Incidents highlight failure to document skin checks on handover to wards. An action plan remains in

place, with Skin Bundle/Pressure Ulcer prevention training re-commencing in Q4. The Trust remains active as part of Cheshire and Mersey Pressure Ulcer Steering group reviewing issues such as risk assessment, equipment and training needs.

Pressure ulcer awareness/risk assessment/skin inspection within A&E has improved dramatically.

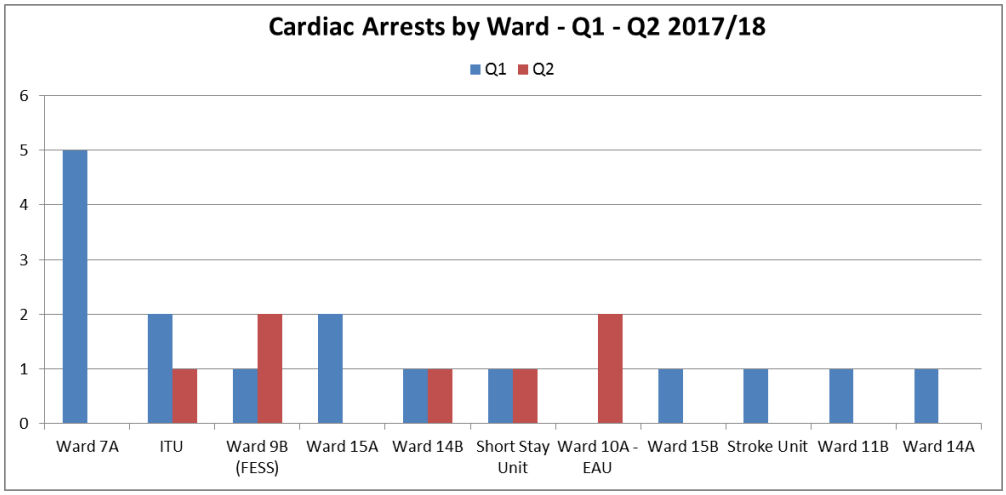
All incidents are investigated with learning points incorporated within training.

4.3.2. Claims & Inquests related to Pressure Ulcers

There were no claims or inquests opened in Q2 relating to pressure ulcers.

4.4. Cardiac arrests

The graph below shows a breakdown of the cardiac arrests by ward in Q1 and Q2 2017/18.



There has been a 56% reduction in reported cardiac arrests from Q1 to Q2. All cardiac arrests are subject to the cardiac arrest review process to identify if there were any issues with care or treatment. 7A is the cardiology ward and it would therefore be expected to have the highest number of cardiac arrests.

There were no claims or inquests opened in Q2 related to Cardiac arrests.

4.5. Perinatal mortality

Two perinatal deaths were reported in Q2, one in July and one in September. One lady attended maternity triage with reduced fetal movements and no heartbeat was found. The second was found at a routine community midwife appointment. Both deaths have been subject to a divisional review and all care was found to be appropriate.

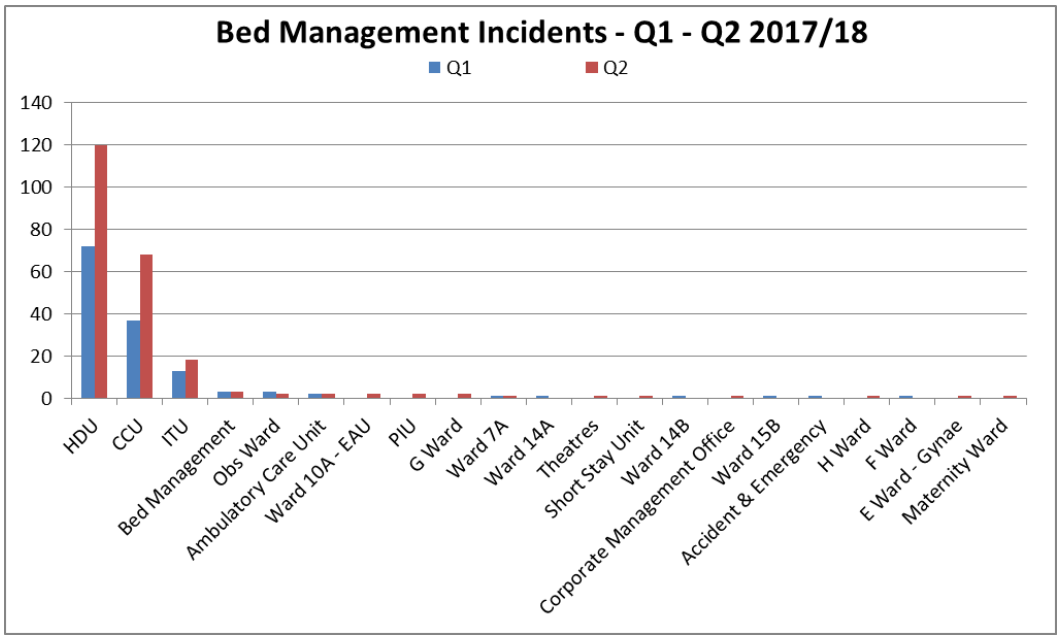
4.6. Patient Flow/bed Occupancy

An extreme risk to the organisation is that of no outflow from A&E for Admitted Patients. The impact of this is delays offloading ambulances, delays in clinical assessment and treatment, and the potential for serious incidents whilst waiting for assessment, treatment or bed.

In addition, a risk was added in Q2 relating to bed occupancy across SDGH exceeding 100%, and reaching 106% in August and September. The risk is reviewed on a monthly basis and is discussed at Sub-Board Committees.

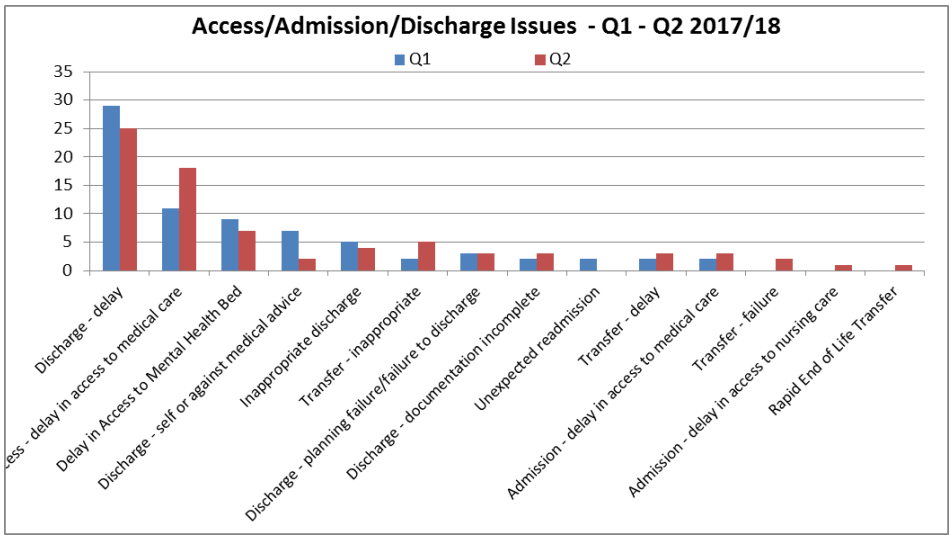
4.6.1. Bed Management/Patient Flow Incidents

Bed Management accounted for 11% of all incidents reported in Q2, with 226 incidents reported. This is an increase of 66% on the previous quarter, further highlighting the issues with patient flow across the Trust.



91% of bed management incidents were reported by Critical Care, and relate to the inability to transfer wardable patients from HDU/ITU care due to a lack of available beds. This has resulted in breaches in the Trust's ability to deliver same sex accommodation, resulting in 48 breaches in Q2, an increase of 30 on the previous quarter.

The graph below shows an increase in incidents relating to delays in access to medical care, this increase relates to issues with missed follow-ups for patients in some specialties. This issue has been StEIS reported, and added to the Trust risk register. All affected patients have been risk stratified, and clinic appointments made as appropriate.



Issues with patient flow across the Trust have resulted in the above incidents being reported in Q1 and Q2.

4.6.2. Complaints relating to Bed Management Issues

Nine complaints or concerns were received in Q2 which cited issues with admission or discharge due to issues with bed management. These included:

- No bed for an elective surgical patient, resulting in cancellation of their surgery.
- A patient waiting ten hours in A&E due to lack of available ward beds.
- An elderly patient being discharged in the middle of the night.
- An inappropriate discharge of a poorly patient.

4.7. Mental Health Patients/Out of Hours cover for CAMHS patients

There is an extreme risk to the Trust around the treatment of psychiatric patients within A&E. Potential delays in psychiatric assessment and access to mental health beds pose issues for the safety of both patients and staff and can impact on the Trust's ability to meet performance targets. The Trust now has an onsite mental health support team Monday – Friday 9-5, with plans in place for 24 hour support.

In addition, the limited out of hours cover for West Lancashire CAMHS patients poses a risk of self-harm of patients or harm to staff, other patients and damage to facilities.

4.7.1. Incidents and Complaints

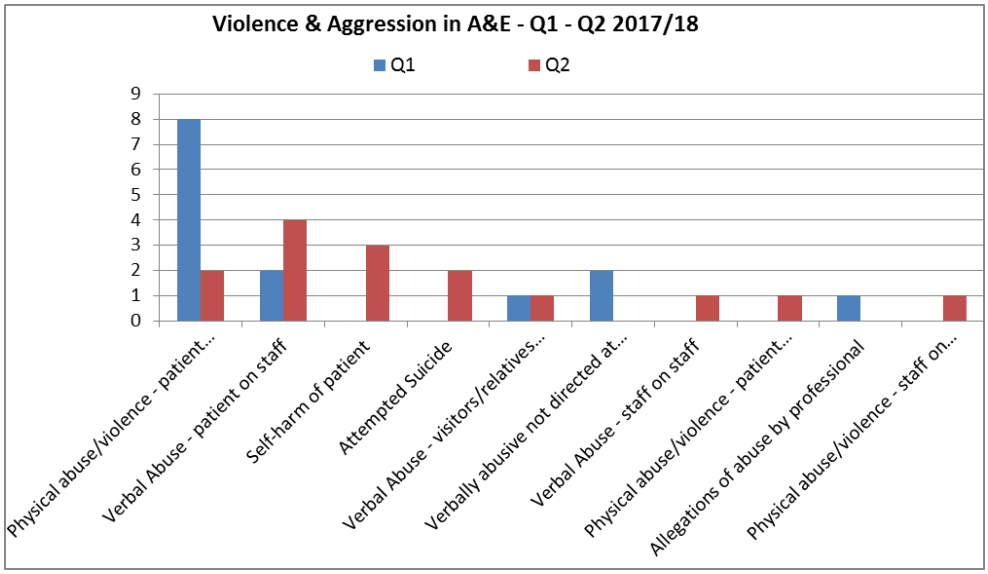
There were seven incidents reporting delays in access to adult mental health beds reported in Q2 2017/18, which is a reduction of two on the previous quarter.

One incident relating to an aggressive CAMHS patient was reported in Q2.

One complaint was received in Q2 which alleged a lack of liaison with mental health services observed on several attendances.

4.7.2. Violence & Aggression in A&E

The graph below shows the nature of violence and aggression incidents in A&E and Observation Ward, in Q1 and Q2, some of which are related to the Mental Health issue.



No new claims were received or settled in Q2 2017/18 relating to violence and aggression.

Actions for continuous improvement

- Work continues on a dedicated safe room in Paediatric A&E in ODGH, which is expected to open in early Q4.

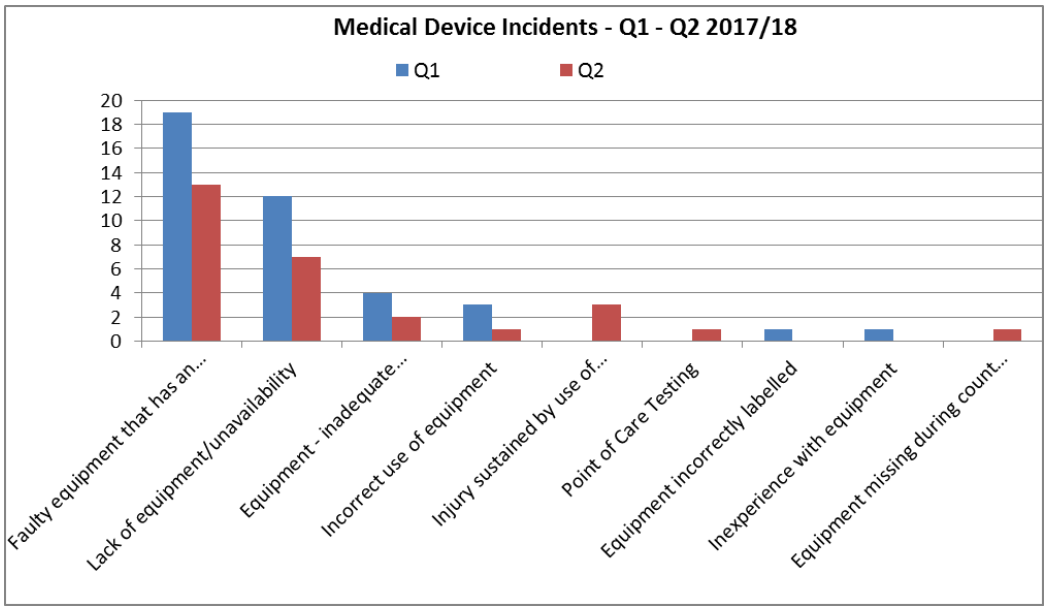
4.8. Medical Equipment

There is an extreme risk on the risk register relating to replacement of medical equipment, with the potential consequence of compromise to patient care.

The asset register for medical devices is incomplete and further actions are required to improve the quality of the asset register.

4.8.1. Incidents

28 incidents were reported in Q2 related to medical devices/equipment, a reduction on the 40 reported in the previous quarter and a continuation of the downward trend. The Medical Devices Policy has been reviewed, and the Medical Devices Committee reinstated. 71% of all incidents reported in Q2 (20 incidents) reported faulty equipment impacting patient care, or a lack of equipment. Theatres accounted for 39% of all medical device incidents reported in Q2.



4.9. Safeguarding Incidents

During Q2 there were three Section 42 enquiries raised against the Trust by Local Authority/CQC. We have not received outcomes for any of those enquiries to date. We have completed four provider responses to support Local Authority enquires during Q2. From the other three notifications we had, one was escalated to the risk department for investigation, one was StEIS reported and the other was a request for information only. All were in relation to neglect and poor care.

Receiving outcomes remains something that the Trust team have to request from both Sefton and West Lancs Local Authorities.

5. COMPLAINTS

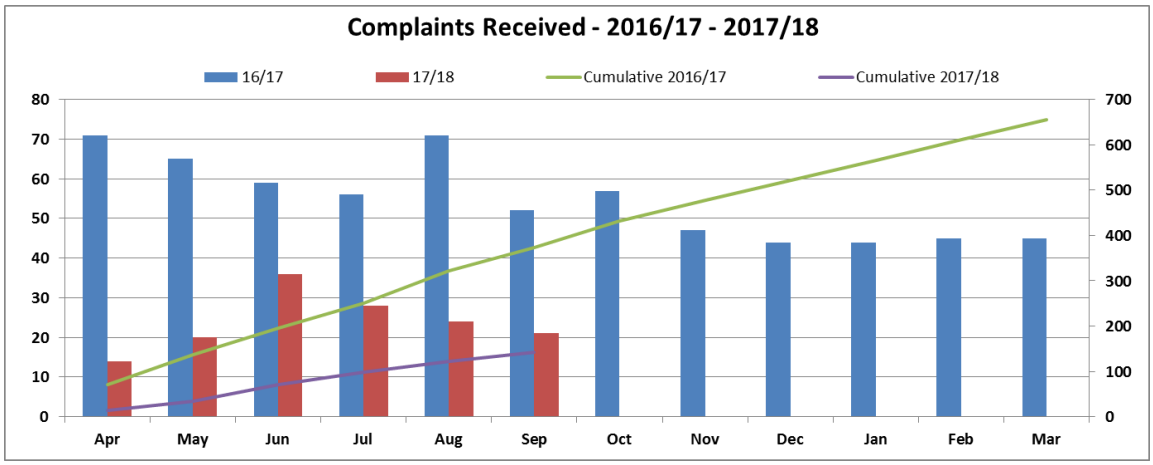
The table below shows the overall level of activity in the Trust during Q2, alongside the complaints received.

Business Unit	Q2 Activity (Attendances/Admissions	Complaints/Concerns/Information Requests	
		Number as a % of Activity	Numbers
Urgent Care	34,069	0.17%	58
Planned Care	44,295	0.14%	61
Specialist Services	26,029	0.13%	34
Total	**104,393**	0.17%	**174**

The Trust uses people's concerns and complaints to improve the quality of its care.

Quarter 2 has seen a continuation in the reduction of complaints received by the Trust. 73 complaints were received in Q2, three more than in Q1, but 59% fewer than the same period last year.

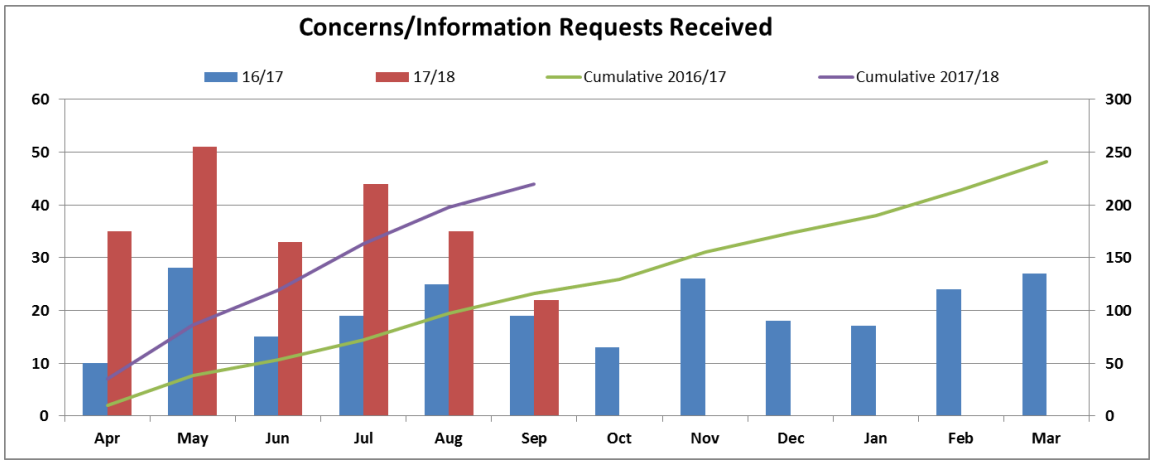
For the first half of the current financial year, the Trust has received 62% fewer complaints than the same period 2016/17.



	Q1	Q2
No of Complaints	70	73

Due to changes to the way some informal complaints were re-classified as 'concerns/information requests' there has been an increase in the numbers received in 2017/18, compared to the previous financial year (90% higher in 2017/18).

101 concerns/information requests were received in Q2. This is 15% fewer than in Q1.



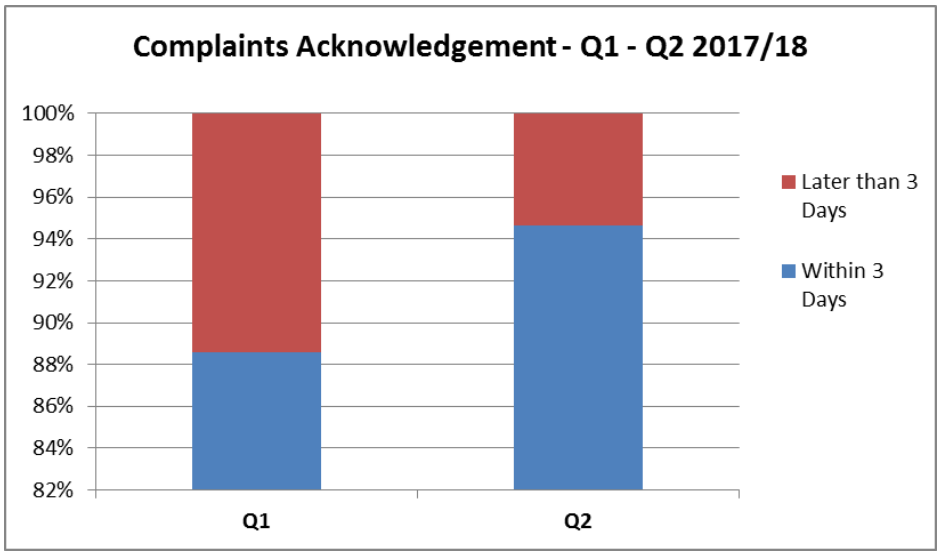
	Q1	Q2
No of Concerns/Information Requests	119	101

Taking into account both complaints and concerns/information requests, the Trust has received 28% fewer in Q2 2017/18 than Q2 2016/17, and 8% fewer than the previous quarter, maintaining the downward trend evident throughout the previous financial year and Q1 2017/18.

5.1.1. Complaint Acknowledgement

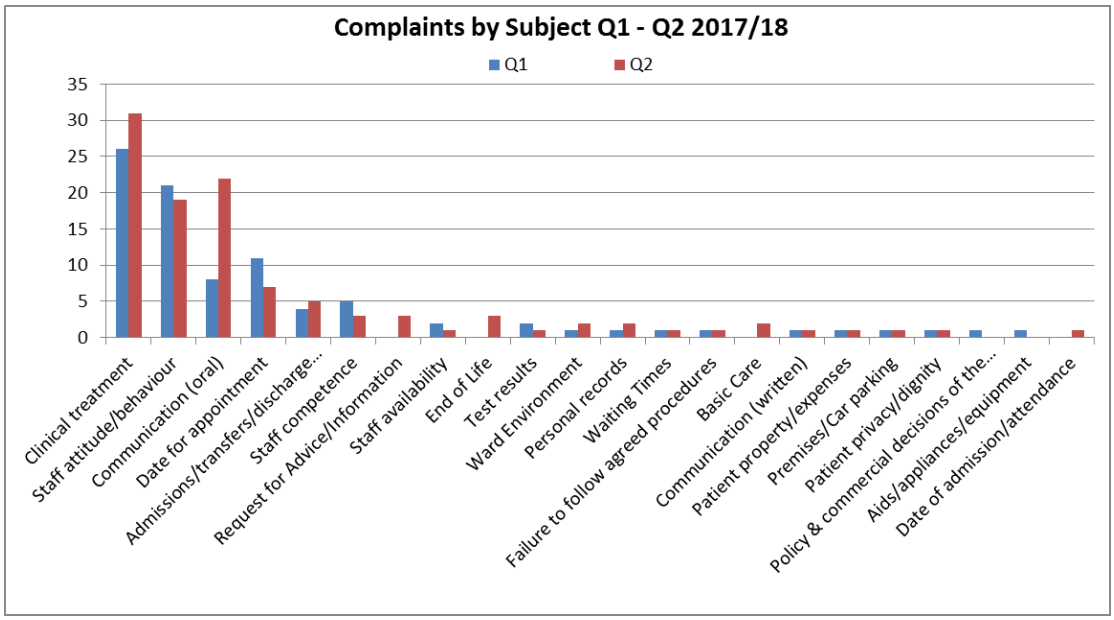
The NHS Complaints Regulations 2009 state that all complaints must be acknowledged with 3 working days of receipt. The Trust acknowledged 95% of formal complaints within the required 3 day timescale, with four complaints which were non-compliant, this was an increase on the previous quarter.

Failure to achieve 100% compliance on this indicator was due to communication failures between the CBU's and the Patient Experience & Complaints Team. These have been rectified.



5.1.2. Reasons for Complaint

All complaints are categorised by the subjects and sub-subjects contained within them. This means that any one complaint can contain multiple subjects. The graph below shows the complaints by subject for Q1 and Q2 2017/18.



The top three reasons for complaint in Quarter 2 were **Clinical Treatment** (29%), **Oral Communication** (20%) and **Staff Attitude/Behaviour** (18%). Combined, these three subjects account for 67% of all complaints received in Q2. Areas with a notable increase in these areas in Q2 include Paediatrics, Short Stay Unit and Outpatients.

There has been a 175% increase in the number of complaints citing poor communication from Q1 to Q2. This could directly correlate to the significant increase in reported incidents of this nature in Q2.

Encouragingly, there has been a 36% reduction in the number of complaints about appointment dates from Q1 to Q2.

5.1.3. Closed Complaints by Outcome

The business units have been actively working on closing down historic complaints, assisted by the Integrated Governance Team. The Trust has closed 87 complaints in Q2, which is higher than the number of new complaints received, so the Trust continues to make inroads into complaint backlogs.

The table below shows the outcome of all complaints, which have been investigated and closed in Q1 and Q2 16/17. The highest number of upheld complaints in Q2 related to Clinical Treatment, including diagnosis issues. This was followed by delays/cancellations of appointments or procedures. There are no themes relating to specific areas.

Closed Qu	Upheld	Partly Upheld	Not Upheld
Q1	24.5%	45.9%	29.6%

Q2	34.5%	42.5%	23.0%

5.1.4. Re-Opened Complaints

Numbers of re-opened complaints in Q2 2017/18 remain consistent with the previous quarter.

Quarter	Complaints Received	Complaints Re-Opened	% of Re-Opened Complaints
Q1	70	9	12.9%
Q2	73	9	12.3%

5.1.5. Parliamentary Health Service Ombudsman (PHSO)

In Q2 2017 the PHSO accepted two cases for investigation. The Trust was also advised of the outcomes of four complaints, two of which were not upheld, and two of which were partly upheld. An action plan was developed as a result of a PHSO report received in Q2 which has resulted in a new process being implemented within ACU for reviewing patients with abnormal bloods. A further action plan will be completed in Q3.

5.1.6. Complaint Timescales

The Trust aims to close all formal complaints within 60 working days. The table below shows the average number of working days between complaint receipt (or re-opened date for re-opened complaints) and closure, for all complaints closed during the first two quarters of 2017/18. Whilst the table shows the Trust is often not meeting this 60 day timescale, the more complex complaints remain open in agreement with the Complainant and they are updated regularly.

	Average of No of Working Days to Close	
Complaint Level	**Q1**	**Q2**
Level 1 (lowest level)	2	4
Level 2	68	51
Level 3	74	90
Level 4 (most serious)	105	158
Grand Total	**75**	**79**

5.1.7. Current Open Complaints

All complaints are aimed to be completed within 60 working days (this is a local target the trust is working towards as the national target is 6 months) . The table below shows

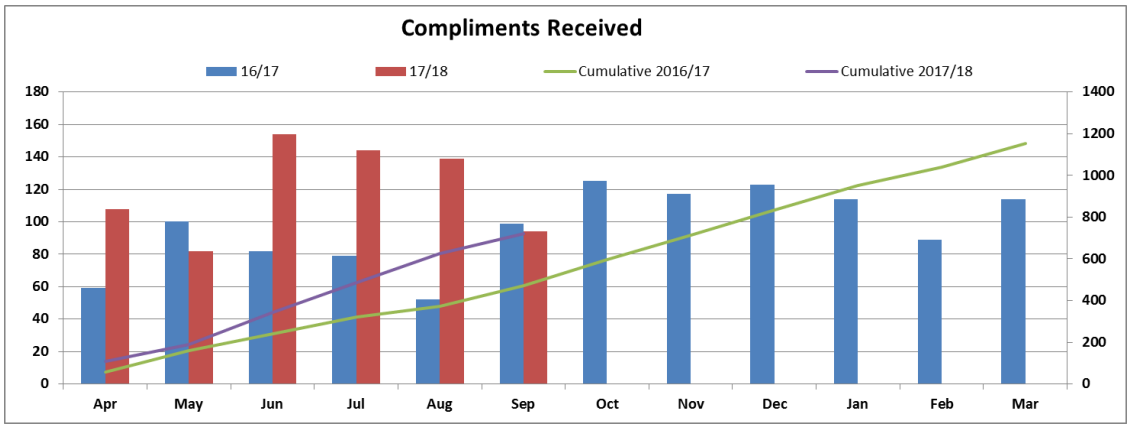
the current open complaints as at 16th November 2017. This shows a total of 111 open complaints, with 50 complaints open two months after they were received, with 11 complaints remaining open six months or longer.

Whilst the number of open complaints remains the same as in the previous report, the number of complaints open for longer than six months has reduced from 12 to 11. These complaints are the most complex and remain open in agreement with the complainant, who is regularly updated. Similarly, the number of complaints open for longer than two months has reduced from 59 in August 2017, to 50, demonstrating the improving turnaround times for complaints.

	Month Complaint First received (Or Re-Opened if relevant)												Grand Total
	2016		2017										
	Jun	Nov	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	
No of Outstanding Complaints	1	1	3	5	1	7	5	15	12	12	36	13	111

5.2. Compliments

The graph below shows compliment numbers this year compared to last. There has been a 10% increase in reported numbers from Q1 to Q2. Numbers reported by the end of Q2 2017/18 are 53% higher than the same time period last year.



5.3. Friends & Family Test – Patient Comments

Development work has taken place to enable Friends and Family feedback to be captured within Datix, with effect from Q3.This will be reported on in future reports.

6. RISK REGISTER

The table below shows all the current open risks (as at 17th November 2017) on the Trust's Risk Register, by Business Unit and Risk Level.

	Extreme Risk	**High Risk**	**Moderate Risk**	**Low Risk**	**Ungraded**	**Total**
Estates & Facilities	0	34	27	21	1	83
Planned Care	4	29	24	18	0	75
Urgent Care	4	38	9	0	0	51
Women & Children's	2	34	5	1	2	44
Clinical Support Services	1	18	19	4	0	42
Medical Director	2	12	12	12	0	38
Finance	3	5	4	11	0	23
Human Resources	4	13	5	0	0	22
Integrated Governance & Quality	1	9	4	1	0	15
Performance Division	0	3	11	1	0	15
Executive Management	6	4	4	0	0	14
Total	**27**	**199**	**124**	**69**	**3**	**422**

All Extreme level risks have been reviewed across the Trust in order to ensure the Quality & Safety Committee are cited of all the current extreme level risks (above 15), as described in the Risk escalation processes reflected in the Trust Risk Management Strategy.

A series of Risk Register workshops were run in October 2017 to improve the quality of risks on the risk register, and work continues to ensure that risks of all levels have comprehensive levels of controls, assurances and actions in order to mitigate the risks identified and actively reduce the level of risk to the organisation.

7. CLAIMS

The table below shows the overall level of activity in the Trust during Q2, alongside the incidents, complaints and claims received.

Business Unit	Q2 Activity (Attendances/Admissions	Claims	
		Number as a % of Activity	Numbers
Urgent Care	34,069	0.01%	5
Planned Care	44,295	0.02%	9
Specialist Services	26,029	0.05%	13
Total	**104,393**	0.03%	**29***

*includes 2 claims where the CBU has not been identified

As at 17th November 2017 there were 398 open claims, both potential and confirmed. These were split as follows:

Claim Type	Number of Open Claims
Clinical Negligence (CN)	374
Employer's Liability (EL)	18
Public Liability (PL)	6

Clinical Negligence – is a breach of a clinical duty of care and the effects or causes of that breach.

Employer's Liability – is the liability that a company owes to its employees for their health, safety and welfare at work.

Public Liability – is the duty of care owed by a company to anyone other than employees, who can access its premises for legitimate business/purposes.

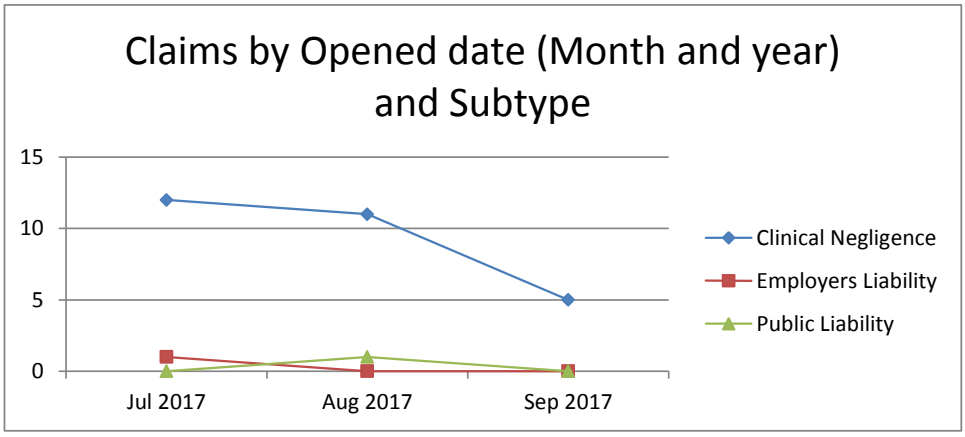
Potential Claims - are those matters where the claimant has requested disclosure of their records and/or intimated that they seek to bring forth a claim against the Trust

Confirmed Claims – are those matters where the claimant has formalized their allegations against the Trust.

7.1.1. New Claims by Business Unit

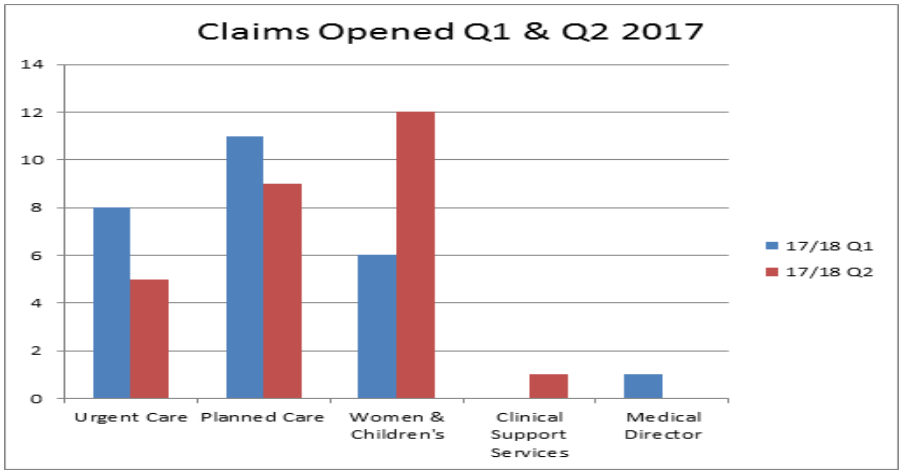
There has been a minimal increase in number of new claims intimated against the Trust between Q1 (26 new claims) and Q2 (29 new claims).The following line graph highlights the numbers of claims received over Quarter 2 of financial year 2017/2018. The variation in number of claims received cannot be correlated to any particular event or trend. The claims received relate to incidents that have

occurred over a number of years and the date a claim is received does not correlate in any meaningful way to the date of the incident.



The following graph and table indicate how claims opened in Q1 and Q2 of financial year 2017/2018 were spread across the business units. It is not possible to show this information as a "trend" over recent quarters due to the way the claims are closed on the database. It is however fair to say that the distribution across business units for clinical claims remains fairly constant and our figures are representative of the national picture for claims.

Number of new Clinical Negligence claims by Business Unit:



There has been a significant increase in number of new claims intimated against the Trust between Q1 and Q2. That increase has been predominantly attributed to the rise in the number of Women & Children claims; which has doubled from the previous financial quarter. This can be attributed to PPH claims as a result of the investigation into 22 PPH's; of these 11 patients have brought a civil claim against the Trust. Claims in Urgent and Planned Care have reduced.

Of the claims opened in Q2, 2 were incidents reported on Datix:

One was a StEIS reportable incident relating to an unexpected admission to the neonatal unit, following the birth of a baby in poor condition.

The second was reported by the pharmacy team as a medication error which was managed locally. The claimant nonetheless avers that as a result of these errors they suffered Deep Vein Thombosis.

Details of any claims that are settled are circulated to the business units in order that they can consider them and incorporate them in their risk process where lessons can be learned.

Claims in financial terms

The following information equates directly to the financial reserves held by the NHS Resolution (*formerly Litigation Authority (NHSLA)*) in relation to claims we have reported to them. The current financial reserves for claims (in £) are as follows:

Claim Type	Number of Open Claims	Total Financial Reserve held by the NHSLA £k	Total potential financial cost to this Trust £k
CN	137	£32,192,732.00	Paid under the Trust's Annual CNST Contributions = Last Year's £3,099,592.00
EL/PL	61	£985,237.00	Annual LTPS Contribution = £137,717.00 Excess payable under LTPS Scheme £121,000
Total	**126**	**£33,177,969**	**£3,358,309.00**

In addition there are 321 claims that have not as yet fallen into the category of being reportable to the NHS Resolution and a reserve value is therefore not yet attached to them.

For CN claims the NHS Resolution pay out the full amount of any claim settled.

For EL & PL claims this Trust must pay the first £10,000 and £3,000, respectively, of any claim paid out. The NHS Resolution pay anything over and above these amounts. The potential financial cost to this Trust therefore includes actual amounts paid out on claims in addition to potential excess payments that may have to be paid out by this Trust. Until costs are settled a claim is not removed from the NHS Resolution's figures.

Risk issues

It can be difficult to highlight specific risk issues from claims as a claim rarely involves one specific incident. However details of any claim that is settled are circulated to the business units in order that they can consider them and incorporate them in their risk process where lessons can be learned.

7.2. Inquests

As at 17th November 2017 there were 20 open inquests. These were split as follows:

Business Unit	Grand Total
Urgent Care	13
Planned Care	5
Community & Continued Care	1
Grand Total	20

Inquest – a fact-finding exercise to enable the Coroner to certify the death. In order to do so, the Coroner must establish who the deceased was, where and when they died and how they came by their death.

Analysis of the data pertaining to inquests indicates that these matters are spread across the directorates. It is not possible to identify any "trend".

Risk issues

As at 17th November 2017, the Trust had referred 2 inquisitorial matters to the NHS Resolution, under the inquest funding scheme. These matters were referred to the NHS Resolution as there was a significant litigation risk. These were matters where the Trust Incident and complaints process had identified sub-optimal care and/or treatment. Details of these matters have been circulated to the respective directorates in order that they can consider them and incorporate them in their risk process where lessons can be learned.

8. CLINICAL AUDIT

The table below shows the performance against Trustwide audits in the forward plan, in October 2017.

Green	Progressing on schedule	**Amber**	Delays, behind schedule	**Red**	Cause for concern, no progress made	**Blue**	Completed; action plan and changes to practice being monitored

CBU	Speciality	Db ID	Auditor	Audit Sponsor	Audit Title	Oct-17
Trustwide	Nursing	17-022	Michelle Kitson	Sheila Lloyd	Learning Disability Mortality Review	Progressing on schedule

CBU	Speciality	Db ID	Auditor	Audit Sponsor	Audit Title	Oct-17
					Programme (LeDeR)	
Trustwide	Trustwide	17-026	Trust Clincians	Dr Gillies	NCEPOD	Progressing on schedule
Trustwide	EOL Care	17-053	Dr. Groves (was William Thompson)	Dr. Groves	The Family Situation and the Needs of Patients Likely To Be Dying	Progressing on schedule
Trustwide	EOL Care	17-054	Dr. Groves (was Osman Mirza)	Dr. Groves	The Documentation of the Multi-Progress and agreement that the patient is likely to be dying and the senior clinicians responsible for the treatment/care	Progressing on schedule
Trustwide	EOL Care	17-056	Dr. Groves (was Diandra Daley)	Dr. Groves	Audit the assessment and planning of food & drink needs for patients who are recognised as likely to be dying	Progressing on schedule
Trustwide	EOL Care	17-057	Dr. Groves (was Alice Neilson)	Dr. Groves	Documentation, assessment & planning of spiritual & cultural needs of a patient & there family once recognised as likely to be dying	Progressing on schedule
Trustwide	EOL Care	17-065	Ella Williams (was Dr. Gabriella Timmins)	Dr. Karen Groves	Audit of GSF registered patients admitted from A&E	Completed; action plan and changes to practice being monitored
Trustwide	Integrated Governance	17-072	Dominic Williams	Dominic Williams	Audit of QS89 - Pressure Ulcers	Progressing on schedule

CBU	Speciality	Db ID	Auditor	Audit Sponsor	Audit Title	Oct-17
Trustwide	Integrated Governance	17-119	Janette Mills	Sue Johnson / Heather Nunn	Audit of Nutrition Policy	Progressing on schedule
Trustwide	Integrated Governance	17-124	Janette Mills	Mandy Power	Audit of VTE Process	Progressing on schedule
Trustwide	EOL Care	17-137	Dr. Groves (was Dr S El Sheikha)	Dr Groves/Dr Wallbank	Needs of dying patients in critical care	Progressing on schedule
Trustwide	EOL Care	17-210	Louise Charnock (was Med Students Joe & Akash)	Dr Groves	Syringe Drivers - completion of checklist & incidents re-audit	Progressing on schedule
Trustwide	EOL Care	17-211	Max Knipe	Dr Groves	Re-audit of Admin of regularly prescribed analgesia in palliative care patients in the general wards of the hospital (carried over)	Completed; action plan and changes to practice being monitored
Trustwide	EOL Care	17-212	Luke Taylor / Alexandra Shaw	Dr. Karen Groves	Effectiveness of handover information for those approaching end of life	Progressing on schedule
Trustwide	EOL Care	17-213	Jo Hutchinson	Dr Groves	Re-audit of Mouthcare assessment in patients who are NBM/recognised likely to be dying.	Completed; action plan and changes to practice being monitored
Trustwide	EOL Care	17-214	Heather Woodcock	Dr Groves	Eating & Drinking at the end of life re-audit	Progressing on schedule
Trustwide	All services	17-221	Dr Mansour / Dr Gillies /	Dr Mansour / Dr Gillies /	Audit of 7 day 24 hour service	Delays, behind schedule
Trustwide	Nursing	17-332	Michelle Kitson	Gill Murphy	Audit of Learning Disabiliy Case	Progressing on schedule

CBU	Speciality	Db ID	Auditor	Audit Sponsor	Audit Title	Oct-17
					Notes	
Trustwide	Trustwide	17-349	Janette Mills	Mandy Power	Health Records Content Audit	Progressing on schedule
Trustwide	Integrated Governance	17-351	Simon Bunting / Dale Ankers	Simon Bunting	Electronic Discharge Trust Audit	Completed; action plan and changes to practice being monitored
Trustwide	Integrated Governance	17-368	Sue Johnson	Sue Johnson	Referrals to the Continence Service	Completed; action plan and changes to practice being monitored
Trustwide	Integrated Governance	17-401	Janette Mills	Mandy Power	Consent Documentation Audit	Progressing on schedule
Trustwide	Nursing	17-405	Lisa Bull / Gemma Lloyd	Sue Norbury	Benchmarking Professional Curiosity / Routine Enquiry	Progressing on schedule
Trustwide	Safeguarding	17-419	Janette Mills	Susan Norbury	Audit of dependent recording on nursing notes	Progressing on schedule
Trustwide	Integrated Governance	17-422	Michelle Kitson	Michelle Kitson	LD patient experience questionnaire	Progressing on schedule
Trustwide	Safeguarding	17-427	Janette Mills	Susan Norbury	Audit of DNA policy	Progressing on schedule
Trustwide	EOL Care	17-430	Clare Lee	Dr. Karen Groves	Conversations about recognition of dying and preferred place of care	Progressing on schedule
Trustwide	Safeguarding	17-435	Julie Allistone	Specialist Nurse Safeguarding	MCA / DOLs benchmark	Progressing on schedule
Trustwide	Therapies	17-447	Heather Woodcock	Nicola Ivanovic	Speech and Language Therapy Service Awareness Project	Progressing on schedule

Any areas of non-compliance are added onto the relevant CBU risk register. It is the responsibility of the CBU to develop an action plan to address the non-compliance.

9. POLICIES

The Integrated Governance Team maintains a central database of all Policies. The Policy Co-ordinator informs policy authors when their policies are due for renewal 6 months ahead of time. Second reminders are sent at two months and a final reminder is also sent at one month and every month thereafter.

Individual Executive Directors and the Business Unit Triangles are also informed on a monthly basis of the status of the policies for which they are responsible and are out of date or past their review date.

As at 16th November 2017, there were 122 out of date policies (216 policies in the organisation), this is an increase of 30 on the previous reporting period. The breakdown is shown below:

Responsible Business Unit	**Number of out of Date Policies – September 2017**	**Number of out of Date Policies – November 2017**
Capital & Facilities	8	8
Contracts & Performance	8	9
Exec Team	1	1
Finance & Procurement	3	5
HR & Comms	24	36
Medical Director	10	9
Medical Education	0	3
Nursing & Quality	10	11
Planned Care	5	7
Quality & IG	6	13
Urgent Care	2	5
Specialist Services	15	18

As at 17th January 2018, this figure had reduced to 42 out of date policies.

Monthly reporting will take place at the Clinical Effectiveness meeting and a report is escalated to the Executive Team on a weekly basis.

10. MORTALITY

Within Southport and Ormskirk NHS Trust a new mortality process was introduced in Dec 2015. The aim is to review the notes by a member of medical staff within 10 days of the death. A number of questions are completed for each set of notes.

In the period 1st July – 30th September, 216 deaths went through the mortality review process. There were 200 deaths in Q2.

Outcome of Mortality Review	Number of reviews
1) Not preventable death due to terminal illness or condition upon arrival at hospital	64
2) Not preventable death and occurred despite the health team taking preventative measures	152
3) Not preventable death BUT medical error of system issue was present	0
4) Possibly preventable death resulting from medical error or system issue	0
5) Likely preventable death resulting from medical error or system issue	0

Any mortality review classified as 3, 4 or 5 in the table above is reported on Datix and investigated accordingly. In the previous quarter, four 'Not preventable death BUT medical error of system issue was present' were identified, so the outcome from mortality reviews within Q2 shows an improvement.

The Trust has strengthened its governance structure for mortality issues and has appointed a mortality lead with protected time. A mortality strategy and full action plan our being developed, notably the creation of a new operational group with time-limited subgroups to look at all aspects of mortality and related issues. The Trust is engaged with the national "Learning from Deaths" initiative. Required resources have been identified and a business case is being developed.

11. HEALTH AND SAFETY

The Health and Safety Committee met twice in Q2 in July & September 2017.

These were the areas covered during the meetings:

- **Reporting Framework** – An amended reporting framework covering key areas of health and safety was introduced which provides the committee with improved assurances.
- **Annual Work Plans for Health and Safety, Fire Safety and Security Management** – These plans were presented to the committee at the meeting in July 2017 and identified compliance with the Health & Safety at Work Act.
- **Security Service** – The Trust Security Service has been increased to provide 24 hour a day, 7 days per week coverage at SDGH, this was introduced in August 2017 and has led to a reduction in security incidents.
- **Skyguard Lone Worker Devices** – These have been introduced to the following areas: -
  - Community Midwives
  - Community Paediatrics
  - Sexual Health
  - Rehabilitation

- **Terms of Reference** – The Terms of Reference for the Committee have been reviewed following discussions at the Committee's meetings. The terms of reference have been expanded to reflect the committee's role in oversight of health & safety, fire safety and security management.
- **Health & Safety & Fire Risk Assessment** – The programme for health and safety audits was noted.
- **Security Surveys – all areas of the Trust are to be reviewed before the end of March 2018.**

11.1. Health and Safety Audits

The table below shows the number of audits completed.

KPI Standard	Target for Q1	Compliance for Q1	Target for Q2	Compliance for Q2	RAG
Health and Safety Audits	7	7	14	14	**GREEN**
Fire Audits	7	7	14	14	**GREEN**
Security Audits	N/A	N/A	N/A	N/A	

The Risk Department are continuing to carry out Health & Safety Audits, Fire Risk Assessments and Security Surveys. The Health and Safety Audits and fire risk

assessments are being carried out together, while the Security surveys will be reviewed before the end of March 2018.

The audits are designed to be a joint exercise with staff side safety rep's, however it is not always possible for staff side rep's to participate due to pressure in services. The Risk Department have reminded the managers, of the staff side safety rep's, that they are entitled to be released to take part in audits.

The completion of actions arising from audits is an operational management responsibility, which is monitored by the risk management team. The status of individual action plans is reported to the Trust Health & Safety Committee and Quality & Safety Committee. The completion of actions from audits is included in the CBU reports to the Quality and Safety Committee.

In order to strengthen the arrangements for the management of action plans, these plans will be managed using the Datix web risk register. This will allow improved management and tracking of completion of actions, which will improve the assurance that actions have been completed.

The Risk Management Department will be providing support to CBU's to ensure that actions are completed correctly and in a way that provides sustainable management of health & Safety.

RIDDOR Reportable Incidents

There were 3 RIDDOR reportable incidents during Q2. The breakdown is as follows:

- 2 incidents related to patient falls
- 1 incident related to a staff fall

Health & Safety Related Claims

In Q2, the Trust received one notification of a claim whereby a member of staff had suffered an accident in the course of discharging their contractual duties. The claim has been repudiated and the claimant asked to provide proof of injury.

12. WALKABOUTS

Quality Visits were established to provide evidence and assurance against CQC fundamental standards and to give Executive and Non-Executive Directors an opportunity to visit staff and patients in clinical areas. Quality Visits use 15 Steps Challenge toolkit providing a series of questions and prompts to guide the Directors through their first impressions of a ward or clinical area. Once the visit has taken place a feedback proforma is completed and shared with the ward Matron or Team Manager. A quarterly summary report of all visits, issues identified, actions arising and the feedback from staff in the areas visited will be reported through future versions of this report.

The visits commenced in October 2017, however were paused in December due to the CQC visit. The following areas have been visited, and key themes arising from the visits are included in the table below:

- 15b
- 9a
- 10b
- CCU
- H Ward
- Spinal Unit
- Pharmacy
- 14a
- Theatres on both sites
- Treatment Centre
- Maternity Ward & Delivery Suite
- 7b
- Antenatal Clinic/Ward
- A&E
- 15a
- 9b (FESS)
- 7a

Positives	Recommendations
Welcoming Staff	Environment (tired looking)
Well Organised	Limited Storage Space
Proud and Productive Staff	Lack of general space

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7th February 2018

Agenda Item	TB026/18	Report Title	Draft Quality Improvement Strategy
Executive Lead	**Sheila Lloyd,** Director of Nursing Midwifery Therapies and Governance		
Lead Officer	**Jo Simpson,** Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Receive ✓ To Approve ☐ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

The Quality & Safety Committee have recommended that the Board is asked to approve the Trust's Draft Quality Improvement Strategy 2018-21 and to note that the strategy will be further updated with additional metrics and will be monitored through the Quality Improvement Dashboard

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

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

Governance

✓Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register:
(Please give reference no.) _____
☐ Service Change
☐ Best Practice
☐ Other List (Rationale) _____

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

✓Quality	☐ Risk

☐ Finance ☐ Workforce ☐ Equality	✓Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ✓ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

NHS
Southport and Ormskirk Hospital
NHS Trust

Quality Improvement Strategy
2018 - 2021

Version 8

Forward

Our vision for quality improvement is to deliver high quality services, safe at all times.

At Southport and Ormskirk Hospitals NHS Trust our Quality Improvement Strategy sets out our plan over the next four years to fully implement and embed or vision.

The strategy aims to improve standards of care for our patients and focus on addressing the recommendations resulting from the Care Quality Commission (CQC) Inspections, National Guardians Office Report and Action Plan, Health Education North West Action Plan and the Clinical Senate Report; it also sets the baseline from which to develop our longer-term objectives and priorities.

Our ambition is to have no ‘Inadequate’ CQC ratings for our core services by 2019 and reduce our ‘Requires Improvements’ by 2020.

Version 8

Introduction and Context

Patient safety and quality of care are at the heart of the NHS agenda. Treating and caring for people in a safe environment and protecting them from avoidable harm is one of the five 'outcome' domains outlined in the NHS Outcomes Framework.

There have been a variety of reports and consequently an increasing framework of regulation and performance metrics which has shaped the way we structure, set and monitor our quality outcomes.

The Strategy is focused on the Scope for Change values of the organisation**: supportive, caring, open, professional and efficient** and supports the Trust strategic objectives. We expect and support staff to work to these values as they strive to deliver safe, consistent and high quality care.

Leading Change Adding Value

Jane Cummings, Chief Nursing Officer for England, launched Leading Change Adding Value Framework in May 2016. This is a framework every nursing, midwifery and care professional, in all settings, can use to ensure that they achieve the best quality of experience for patients and people, the best health and well-being outcomes for our populations, and use finite resources wisely to get best value for every pound spent. The impact and leadership ability of our workforce is phenomenal and together we need to recognise the potential to manage the challenges of today and shape the future. The Trust encourages the use of this framework to reach further both individually and collectively, to focus on what is important and connect with each other to achieve more for our patients.

The key leadership contribution of nursing, midwifery and care staff is crucial to maintaining high standards and delivering change in the Trust. Leading Change, Adding Value sets out shared ambitions and commitments that work with the Trust's leadership development programmes.

Definition of Quality

Quality means different things to different people and the NHS is the only healthcare system in the world with a single definition of quality.

At its simplest, Quality is defined as care that is **safe**, **effective** and provides as positive an **experience** as possible. The definition of quality sets out three dimensions to quality:

- **Patient Safety:** providing high quality care which is safe, prevents all avoidable harm and risks to the individual's safety; and having systems in place to protect patients;
- **Clinical Effectiveness:** providing high quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes. Making sure care and treatments achieve their intended outcome;
- **Patient Experience:** providing high quality care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what the individual wants or needs, and with compassion, dignity and respect. It's about listening to the patient's own perception of their care.

This simple, yet powerful definition was first set out in *High Quality Care for All* in 2008, following the NHS Next Stage Review led by Lord Darzi. This definition now enshrined in legislation has the patient and the NHS Outcomes Framework at the heart.

The Care Quality Commission (CQC)'s inspection approach goes further to build on the three dimensions of Quality by adding two additional dimensions:

- **Organisational Culture & Leadership:** commissioning high quality care which is well-led;
- **Responsiveness:** commissioning high quality care which is responsive to the needs of patients.

Quality care is not achieved by focusing on one or two aspects of this definition; rather, high quality care encompasses and balances all three aspects.

The Care Quality Commission's Intelligent Monitoring System and new insight model focuses on key areas of quality and safety. Their assessment of services is based on the following five questions which are based on the things that matter most to people:

Trust Strategic Aims

The Trust agreed its Strategic Objectives at its Board meeting in September 2017. The Board has overall responsibility for ensuring systems and processes are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

Strategic Objectives 1 - Agree with partners a long term acute services strategy
Strategic Objectives 2 - Improve clinical outcomes and patient safety
Strategic Objectives 3 - Provide care within agreed financial limit
Strategic Objectives 4 - Deliver high quality, well-performing services
Strategic Objectives 5 - Ensure staff feel values in a culture of open and honest communication
Strategic Objectives 6 - Establish a stable, compassionate leadership team

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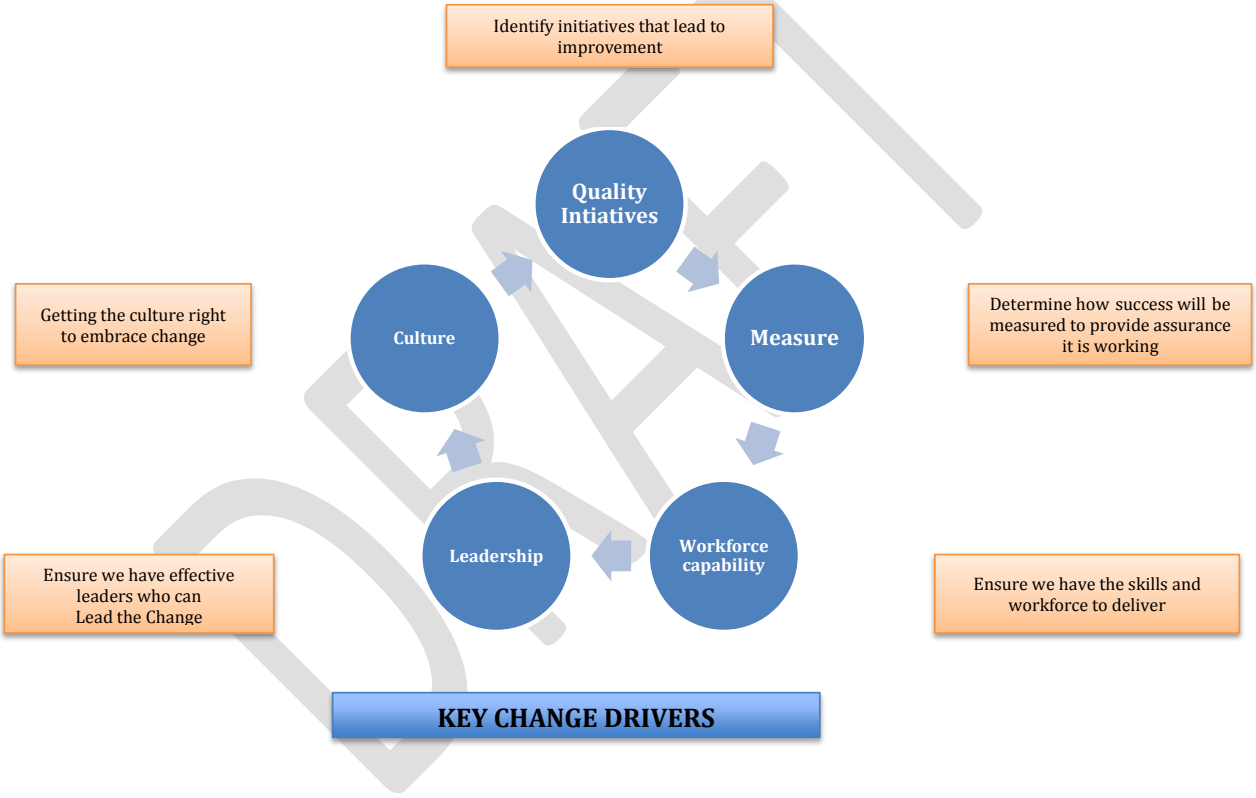
What are we trying to deliver?

Our strategy will help us deliver improvements in the quality of our clinical services, we will focus work on projects that will have an impact on delivery of our goals, these themes are outlined in the strategy as are the measurements we will use to determine our success.

The improvements we seek will not happen by themselves. The key aims of the Strategy will be facilitated through the four key, inter-dependent drivers, as demonstrated below.



Our vision is to deliver high quality services, safe at all times. In order to do this we will build on the foundations from the previous Quality Improvement Strategy and work in collaboration with our patients, our staff and our partners. We will create a culture of continuous quality improvement where every member of staff understands their role in delivering the Quality Improvement Strategy.

The quality improvement strategy outlines four key quality improvement goals and under each goal

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will be a portfolio of work streams and projects that will lead to demonstrable improvements in outcomes, safety and patient experience.

The five key quality improvement goals are:

- Enhancing Patient & Carer Experience
- Delivering Care for You
- Safer Staffing
- Reducing Mortality
- Preventing Harm

Goal 1 - Enhancing Patient and Carer Experience - 2017-19

We want to ensure that all patients, carers and families are engaged with, involved in their care and have a positive experience when they utilise our services. We want to ensure that their care is delivered by staff that are equipped with the skills to provide knowledgeable, compassionate, caring and safe care. We believe that every member of staff is responsible for delivering the best care to all our patients, carers and their families in every setting.

Providing a good quality patient experience requires actively seeking, responding to and learning from patient feedback. The Trust has a dedicated Eexperience of Care Strategy which describes eight agreed pledges which will be implemented uses the always event methodology from Institute for Healthcare Improvement (IHI).

What we will deliver

Developing the Experience of Care Strategy 2017 -2019

The Trust's Strategy has been developed in conjunction with key stakeholders, staff, patients, carers and their families. A number of listening events were held between 2014 – 2017, that enabled patients, carers and families to share their experiences with Trust staff. This information was utilised in conjunction with National Patient Surveys, Friends and Family Test results and the main themes that are highlighted in patient complaints.

A common thread identified across all work streams was that patients, carers and their families wanted us to get the basics right and to enable them to have trust and confidence in the staff caring for them. We have listened to what they have said and have highlighted issues that were raised as being of paramount importance such as pain relief and nutrition within the Strategy. Trust and confidence will be built when patients, carers and their families see that their issues are being addressed in a timely manner and care and safety of patients across the organisation is our first priority.

All staff at the Trust are committed to delivering safe, effective care that result in a positive patient experience. We also wish to increase the way we engage with patients, carers and their families across the local health economy.

The aim is that Patient, Carers and families will be at the heart of all decisions from Trust Board to ward and departments. Matrons will be accessible and visible across the organisation to receive real time feedback and to address concerns as soon as they are raised.

THE EIGHT KEY PLEDGES
PLEDGE ONE Develop and implement systems and processes to involve Carers & Families in decision making
PLEDGE TWO Access to information is easy and relevant for patients, carers families and professionals
PLEDGE THREE We will 'get the basics right' in caring for all
PLEDGE FOUR Improve staff involvement and awareness of their impact on Patient, Carer & Family experience
PLEDGE FIVE Improve & enhance discharge processes and facilitate better links into Community support Networks
PLEDGE SIX Respond to complaints & concerns in a timely manner and follow up on lessons learned
PLEDGE SEVEN Increase the profile of Patient, Carer & Family Experience, collecting and acting upon feedback & opinion in a more robust manner
PLEDGE EIGHT Develop systems and processes to capture patient's and family's memories to share and cherish for the future

Each of the eight pledges has a proposed plan of action. Each Pledge will have a specific group in place to review and implement the pledge utilising the Always Event toolkit.

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How we measure patient and carer experience:

Some examples of how we measure patient and carer experience include

- Monitoring Complaints and Compliments
- Improve National Patients Survey responses
- Improve Friends and Family Test (FFT) response rates and results
- Improve response rates Ward/departmental specific patient surveys
- Share Patient and Carer Stories

Improvement metrics:

- Delivering compassionate care
- Implement Friends and Family Test in all areas, increase proportion of FFT responses, achieve improved % satisfaction and apply lessons learned into practice.
- Agree strategy for improved metrics in national and local patient surveys
- Improve patient and family experience by applying learning from complaints & patient stories and the annual bereavement survey
- Reduce number of complaints related to key themes

'I Want Great Care' initiative

The use of "I Want Great Care" will drive quality improvement through a cycle of continuous improvement at ward level, with local actions taken by Matrons and Ward Leaders to address concerns and issues raised through patient feedback in a timely way. The "I Want Great Care" data is systematically monitored and displayed on all wards and departments involved. To achieve our aim we will deliver a programme of actions that ensure that our patients and families describe our Trust as their provider of choice based on the quality of their experience. The work we focus on will be based on the guiding principle that all care will be viewed through the eyes of patients and their families.

Goal 2 - Delivering Care for You

With the support of NHSI, AQuA and the Northern Clinical Senate are working together to review the needs of the population and to redesign how all care will be delivered. This review will focus on "place based" population needs for access to appropriate Health and Care services and not organisational needs. All possible options will be considered and evaluated, using a robust methodology which can provide sufficient assurance to stakeholders and the public.

What we will deliver

- Support from Northern Clinical Senate - independent clinical advice and support as part of the development of the 'Care For You Programme'
- Safe At All Times, Completion of Phase 1 Southport by November 2017 and Phase 2 Ormskirk March 2018
- Participation in Get it right first time (GIRFT) programme to help to improve the quality of care by reducing unwarranted variations.
- Model Hospital – Improve the use of the Model Hospital digital information service to identify and realise productivity opportunities and explore comparative productivity, quality and responsiveness, to provide a clearer view of improvement opportunities.
- AQuA Advancing Quality Pathway – using AQuA service improvement methodology to support quality improvement and Service Reviews
- Complete Service Reviews in
  Frailty Pathway
  Emergency Surgery
  Women's & Children's
  Patient Flow

How we measure delivering care for you:

Some examples of how we measure delivering care for you include

- Completing Service Reviews
- Utilising AQuA Advancing Quality Pathways
- Monitoring and Reporting NICE guidelines
- Participation in Get it right first time (GIRFT) programme
- Developing Workforce Strategy

Improvement metrics:

- Improving patient flow
- Ensure patients are cared for in an environment which is fit for the purpose to which it is being put to support right care being delivered in the right place.
- Developing a Frail Elderly Pathway
- Transforming Surgical Services

Goal 3 – Safer Staffing

We aim to ensure there is a staffing resource that reflects a multi-professional team approach based on delivering safe, sustainable, high quality care seven days per week. Safer means not just

numbers but correct skill mix matched to our bed base and activity, using new staffing roles (such as clinical nurse specialists and Physician Associates), and less reliance on a temporary workforce. Safer also means staff being trained to have the necessary competencies to look after patients in their care

What we will deliver

- Safe Sustainable and Productive Staff ie investing in new roles and skill mix
- Improved Patient Outcomes
- Increase Staff Satisfaction
- Financial Sustainability
- Reduce Variation

How we measure Safer Staffing

Some examples of how we measure Safer Staffing include

- Reducing Variances
- Evidence Base Workforce Planning and activity monitoring tools
- Delivering against Health Education England (NW) Action Plan
- Full utilization of Health Roster/SafeCare (Allocate)
- Continued Professional Development
- Care Hours Per Patient Day

Improvement metrics:

- Reduce vacancies and use of temporary staffing
- Further develop staff recognition and staff engagement strategies
- Improve all staff survey metrics to national average
- Develop an engagement and transformation development programme
- Improving mandatory training and staff appraisals
- Achieving improvement in relation to seven day working priorities

Goal 4 - Reducing Mortality

We aim is to reduce the number of avoidable deaths and support the deteriorating patient. Reducing the number of avoidable deaths, by reducing the number of patients who die as a result of avoidable harm at the Trust will be measured by consistently remaining in the ‘statistically as

expected' range for our Standardised Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR).

What we will deliver

- Implement the learning from deaths agenda using the Royal College of Physicians (The structured judgement review (RCP SJR) methodology.
- Make incident review a structured process in every CBU to identify and ameliorate risk.
- Involve clinical staff in these processes to maximise engagement
- Create a 'projects room' or 'communications hub' to co-ordinate, communicate and engage staff in the continuous iterative process of improvement.
- Incorporate human factors training in all critical incidents training and system design.
- Implement seven day working

How we measure reducing mortality:

Some examples of how we measure reducing mortality include

- Learning from Deaths (including % mortality reviews completed)
- Develop Mortality Dashboard
- Standardised Hospital Mortality Index (SHMI) below 100
- Reduce SIs that result in patient death

Improvement metrics:

- HSMR / SHMI
- Implement NHSE Mortality Governance Framework with surveillance group to identify and learn from all potentially avoidable deaths
- Implement Learning from Deaths methodology
- Dr Foster Mortality Alerts
- Reduction in Never Events
- Reductions in repeated themes for Serious Incidents.

Goal 5 - Preventing Harm

Harm can be defined as 'unintended physical or emotional injury resulting from, or contributed to by clinical care (including the absence of indicated treatment) that requires additional monitoring or treatment.' We wish to look at all potential sources of harm such as medication errors, pressure ulcers and falls; whilst strengthening our reporting and learning system to enable our staff to recognise and prevent potential harms occurring

What we will deliver

- Implementing Quality Walkabouts by Executives, Non-Executives and Stakeholders
- Sign up to Safety
- Reducing Infection Prevention & Control
- Promote Falls Prevention
- Reduction in Medication Errors
- Reduction in Pressure Ulcers

How we measure preventing harm:

Some examples of how we measure preventing harm include

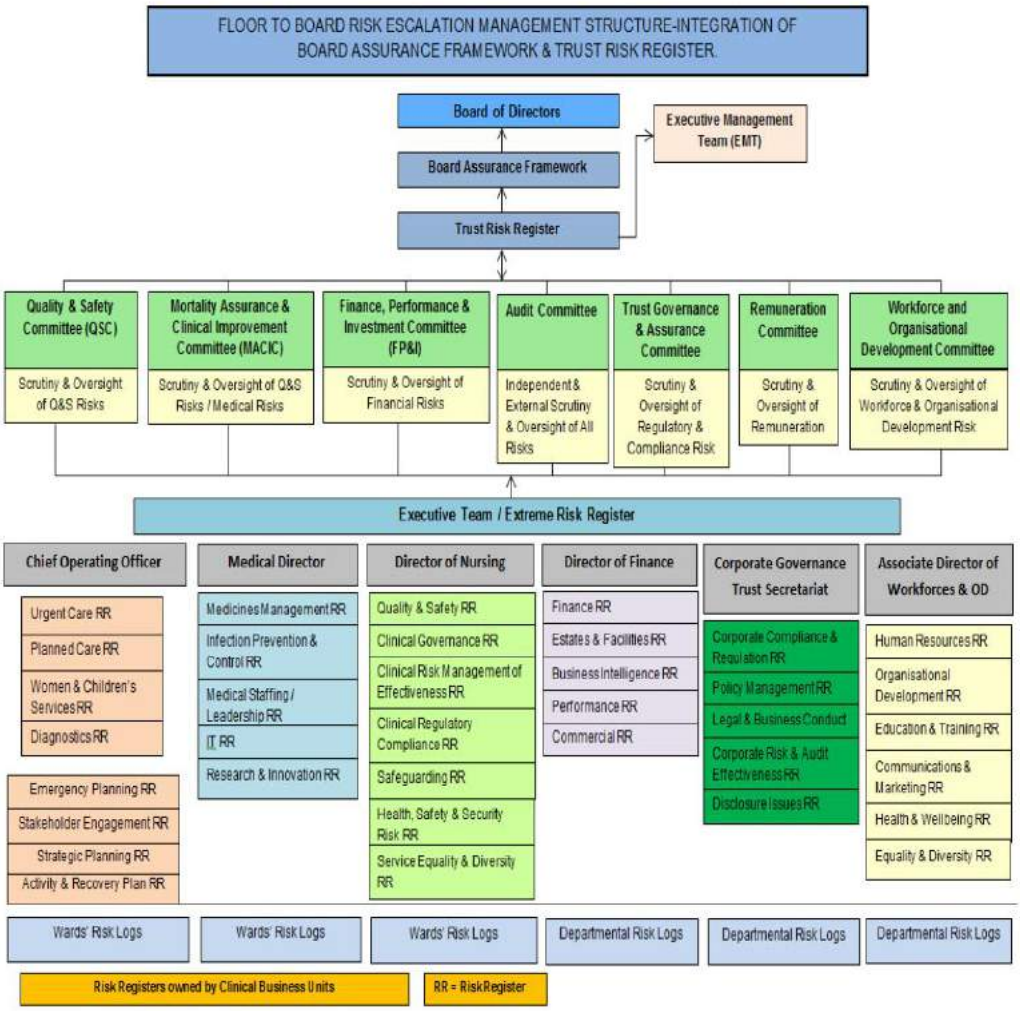
- Improving Safety Thermometer performance
- Recuing Healthcare Associated Infections
- Reducing Never Events
- Reduce Serious Untoward Incidents that results in patient harm

Improvement metrics:

- Achieve HCAI objectives
- Ensure safety huddles are embedded in practice across all wards and in the A&E department
- Reduce the number of hospital acquired pressure ulcers through improved education and appropriate utilisation of specialist equipment
- Reduce the number of inpatient falls via an improved prevention and management of inpatient falls action plan
- Improve medication safety to ensure incident reporting is above national average and that lessons learnt are shared
- Improve RCA investigation training for clinicians and managers

Quality Improvement Governance

The Trust Board receive monthly performance information against key quality and safety performance indicators, and any quality concerns are highlighted by the Director of Nursing and the Medical Director.



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The Quality and Safety Committee is a sub-committee of The Board. It provides the Trust Board with assurance that quality and safety within the organisation is being delivered to the highest standards and that there are appropriate processes in place to identify gaps and manage them accordingly. CBUs review their quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis at their Quality and Safety / Governance meetings; monthly Quality and Safety Reports are received by the Clinical Effectiveness Committee and any concerns on quality are escalated via this committee to the Quality and Safety Committee is a sub-committee.

Leadership for Safety

In order for the Trust to achieve high quality care we need to ensure that we have the right structures and processes in place allied to an appropriate culture with supporting values and behaviours and staff who are appropriately trained. The Trust will ensure that there is strong clinical leadership by involving clinicians and staff in transforming the way we deliver services and listening to their views on the improvement of clinical quality and being clear about what high quality care looks like in all specialties and reflecting this in a coherent approach to the setting of standards.

Improving quality and healthcare outcomes is the responsibility of everyone working in the NHS, no matter what their position or level of authority in the organisation; this is the culture that all of our staff must adopt to ensure patients are kept safe and are well-looked after. Individual health care professionals, their ethos, behaviours and actions, are the first line of defence in maintaining quality and therefore it is expected that all employees will:

- Participate in the delivery of the quality and safety agenda thus ensuring that the clinical quality assurance process is delivered from 'Board to Ward'
- Work professionally in accordance with the Trust and where appropriate, professional Code(s) of Conduct
- Provide safe clinical practice in the treatment and care of patients in accordance with Trust policies and protocols
- Report concerns regarding the treatment of patients and the quality and safety of care.

<u>Enabling resources</u>

Delivering the Strategy

Our quality improvement methodology

We are committed to ensuring all our staff are empowered to make improvements for the benefits of our patients and their families. We will use the Model for Improvement as our framework for quality improvement; but will also use other appropriate quality improvement methodology as required on a project by project basis.

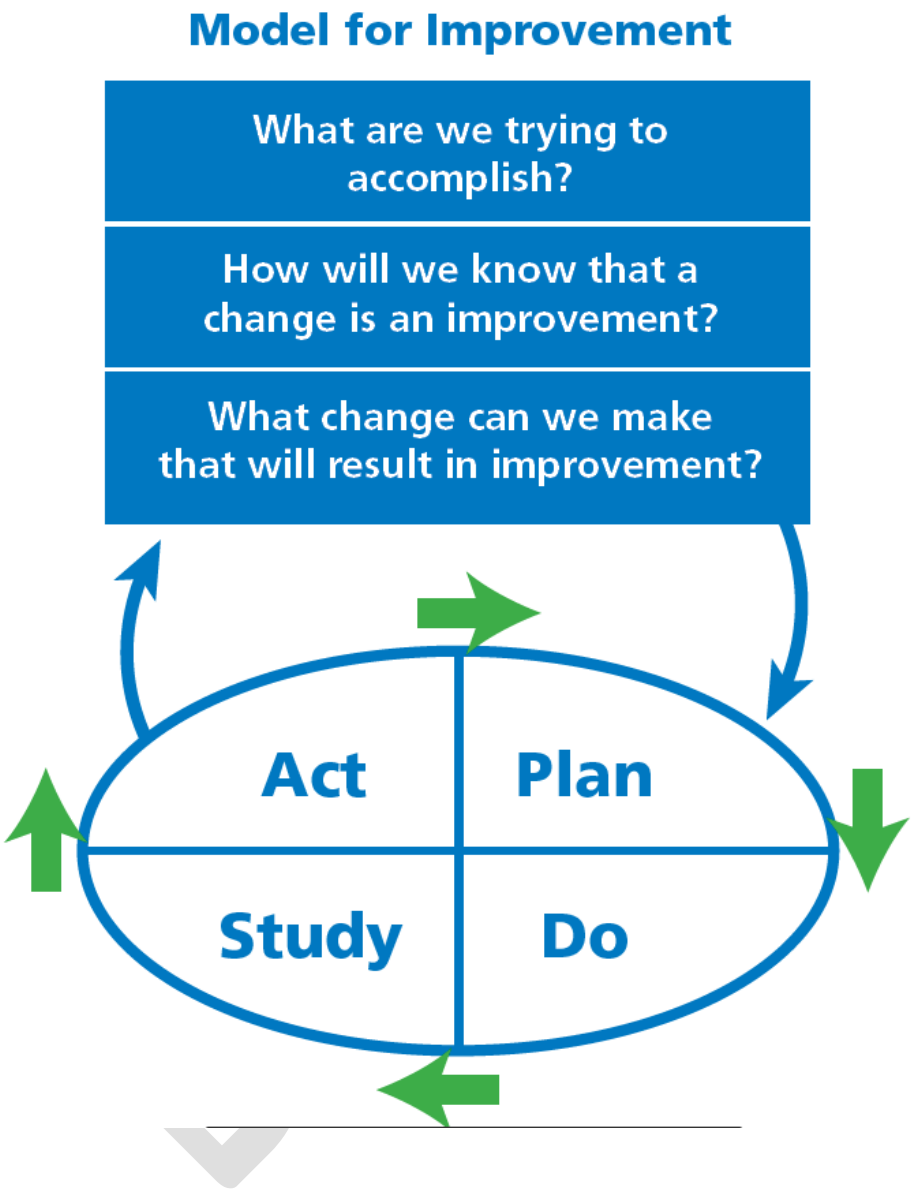
Model For Improvement:

The Model for Improvement is a framework for improvement widely used in NHS organisations. The framework has three fundamental questions:

1. What are we trying to accomplish - Setting an aim for improvement
2. How will we know that change is an improvement - Measurement for improvement
3. What change can we make that will result in improvements - Ideas for improvement

Ideas for improvement are then tested and refined prior to implementation through the use of PDSA cycles:

- **Plan:** Planning the test, predicting what will happen
- **Do:** Running the test
- **Study:** Learning from the test
- **Act:** Based on learning adapt, adopt, abandon the test



Quality improvement capability building

We recognise improvement is more likely to succeed and be sustained if it is designed and led by the staff doing the job. In order to enable staff to make change happen they will be supported by improvement experts and quality improvement from AQuA to ensure staff are trained to ensure Quality Improvement Methodology is embedded throughout the Trust.

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Business intelligence / Evaluation Measurements:

It is crucial we measure performance for improvement purposes, and with the support of our Business Intelligence Department we will use specialist measurement for improvement techniques and methodologies to develop a Quality Improvement Dashboard to allow us to track progress against our aims.

Robust outcome metrics will be set for each Goal to identify progress and success in achieving this improvement plan. There will be a portfolio of projects for which key performance indicators will be agreed in consultation with clinical leaders. These will be linked to our quality goals. A dashboard will be developed to enable monitoring and provide assurance to the Trust Board through the Quality & Safety Committee

Communication & Engagement:

Linking back to our Trust values, we expect all our staff to put quality and safety at the heart of all we do and to strive for continuous improvement in the standards of healthcare we provide. However, we do recognise the need for key individuals to lead the quality improvement programme at the Trust. We will have a Service Improvement Resource whose role is to engage clinical staff in patient safety and quality improvement. In addition, the Assistant Director of Quality will oversee the delivery of the quality improvement work streams we have in place.

Leadership Capacity and Culture:

Building capacity and culture - we recognise that this quality improvement strategy will only be successful if we develop improvement capacity throughout our workforce and recognise, reward and celebrate those that are actively engaged in quality improvement activity. We will develop skills, build capacity and create opportunities for shared learning across the wider multi-disciplinary team.

Good Governance / Clinical Effectiveness:

Our Clinical Audit Team is crucial to the delivery of this strategy, the Clinical Audit Plan will support and prioritise audits related to the four aims of this Strategy. The audit template for support will ask which aim the audit relates to this will link Quality Improvement Strategy and Clinical Audit.

A number of key work streams have been highlighted that clearly link to each aim of the Quality Improvement Strategy, these will sit under the remit of the Quality and Safety Committee and will use a robust quality improvement project framework comprising of a project initiation document, driver diagram, clear aims and measurement strategies to drive improvement forward.

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CQC Improvement Plan:

Recommendations including Must and Should Dos from the recent CQC Inspection will be monitored through the Quality Improvement Strategy, the Strategy will also ensure the Trust is prepared for external review / accreditation by maintaining an overview of the quality standards set by external agencies and co-ordinating assessment and inspection visits.

Quality Improvement Strategy Plan on a Page 2018 - 2021

Enablers

- Communication & Engagement
- Improvement Methodology
- CQC Improvement Plan
- Leadership Capacity & Culture
- Good Governance
- Evaluation Measurements

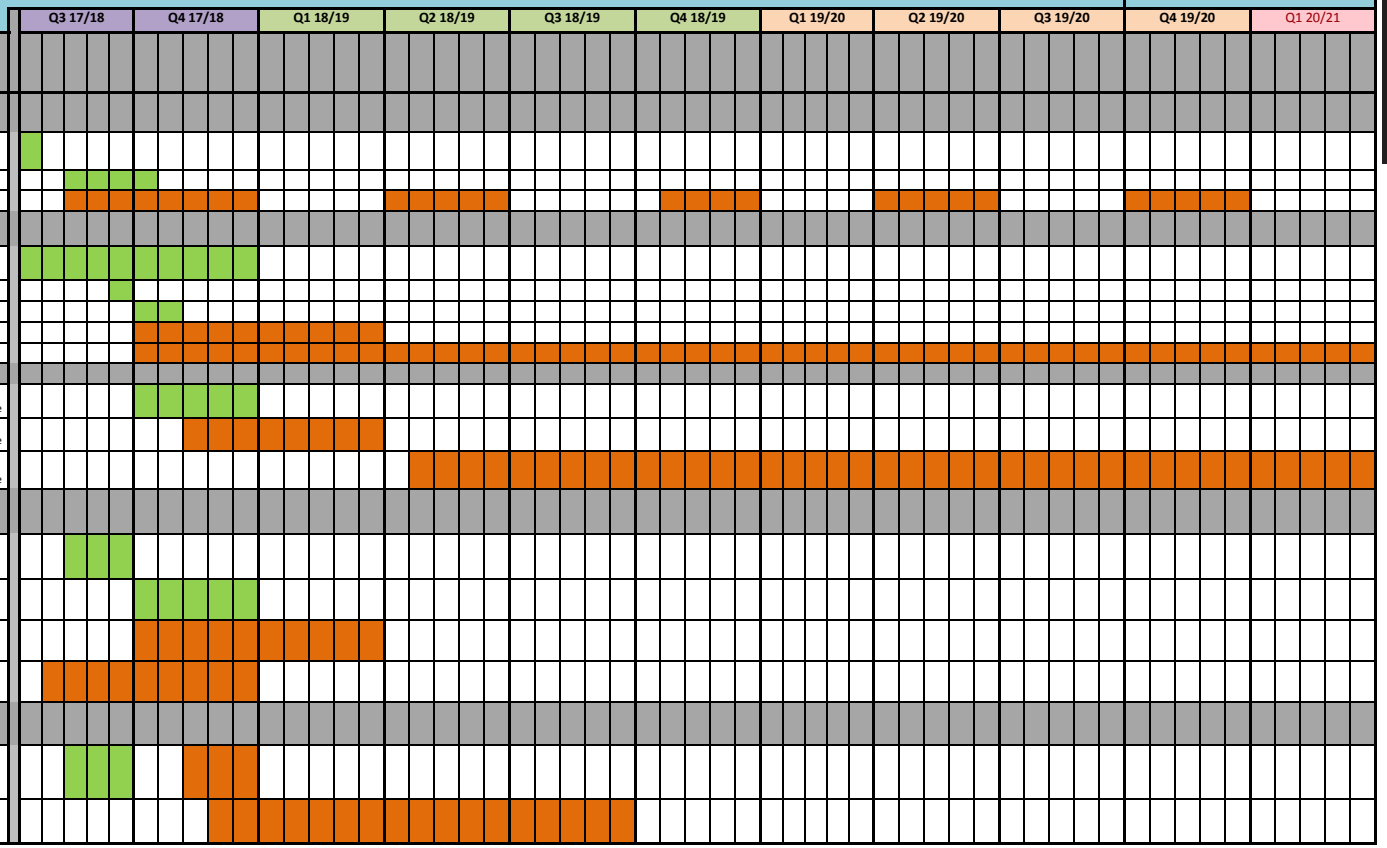
Our Vision

Delivering high quality services, safe at all times

Goal	Aim	How we measure
Enhancing Patient & Carer Experience	Identify lesson learn Improve quality, safety and efficiency Reduce harm	➢ Complaints and Compliments ➢ National patients survey ➢ Friends and family test (FFT) ➢ Ward/departmental specific patient surveys ➢ Patient and carer stories
Delivering Care for You	Increase clinical engagement in improvement Improve quality, safety and efficiency Improve use of existing capacity	➢ Service Reviews ➢ AQuA Advancing Quality Pathway ➢ NICE guidelines ➢ Get It Right First Time (GIRFT) ➢ Model Hospital ➢ Staffing levels
Safer Staffing	Safe Sustainable and Productive Staff Improved Patient Outcomes Increase Staff Satisfaction Financial Sustainability Reduce Variation	➢ Workforce / Staffing KPIs ➢ Evidence Base Workforce Planning ➢ Health Education England (NW) ➢ Health Roster/SafeCare (Allocate) ➢ Continued Professional Development
Reducing Mortality	Reduce harm Rapid senior assessment Improve length of stay / flow Implement rapid improvements Identify lessons learnt	➢ Learning from Deaths (including mortality reviews) ➢ Mortality Dashboard ➢ Standardised Hospital Mortality Index (SHMI) ➢ SIs that result in patient death
Preventing Harm	Reduce harm Identify lessons learnt Improve length of stay / flow Increase clinical engagement in improvement	➢ Safety Thermometer ➢ Healthcare associated infections ➢ Never Events ➢ Serious untoward incidents that results in patient harm

Southport & Ormskirk Hospital NHS Trust
Quality Improvement Plan 2018-2021

	TASK	STATUS	ASSIGNED TO
1.0	**Enhancing Patient & Carer Experience**		
1.1	Sign off of the Developing the Experience of Care Strategy 2017 -2019	Completed	Deputy DON
1.2	Pledge Groups Established and in place	Completed	Deputy DON
1.3	Report to Quality & Safety Committee	Awaiting	Deputy DON
2.0	**Delivering Care for You**		
2.1	Development of PIDs for Pathways	Completed	DON
2.2	Visit from Clinical Senate	Completed	DON
2.3	Clinical Senate Report Received and Circulated	Completed	DON
2.4	Establishment of Quality Improvement Team	On Track	Asst Dir Quality
2.5	Developing Reports	On Track	DON
3.0	**Safer Staffing**		
3.1	NHSI Commence Workforce Piece of Work	Completed	Asst Dir Workforce
3.2	Development of KPIs	On Track	Asst Dir Workforce
3.3	Update on Workforce Piece of Work	On Track	Asst Dir Workforce
4.0	**Reducing Mortality**		
4.1	Sign off Mortality Policy	Completed	Med Director
4.2	Embed 'Learning from Deaths'	Completed	Med Director
4.3	SJR Training	On Track	Med Director
4.4	Develop Dashboard	On Track	Head of BI
5.0	**Preventing Harm**		
5.1	RCA Training in Place	Completed	Asst Dir Gov
5.2	Develop Integrated Governance Repot	On Track	Asst Dir Gov



Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7th February 2018

Agenda Item	**TB027/18**	**Report Title**	**CQC Improvement Plan Update**
Executive Lead	Sheila Lloyd, Director of Nursing Midwifery Therapies and Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve ✓ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

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

The Board is asked to receive this report as assurance that the CQC improvement plan is in place with appropriate systems and processes to implement identified actions and escalate any additional concerns as required.

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

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

Governance

✓Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register:
(Please give reference no.)
_____

☐ Service Change ☐ Best Practice ☐ Other List (Rationale) _____	
Impact *(is there an impact arising from the report on the following?)*	
✓Quality ☐ Finance ☐ Workforce ☐ Equality	☐ Risk ✓Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ✓ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

CQC Improvement Plan Update on Must and Should Do's

February 2018

1 Executive Summary

The CQC conducted a focused follow up inspection of the organisation between the 12th and 15th April 2016. This was to review the progress of the Trust following a previous inspection in November 2014 when concerns were raised. The CQC reviewed all the services across the Trust including all the areas of concern which were raised at the previous inspection in order to assess any changes.

Overall, the Trust was rated as **Requires Improvement**.

With specific **Inadequate** ratings in:

- A&E - rated inadequate for Safe
- Surgery – rated inadequate for Safe, Well Led and overall.

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

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

2 Trust Approach to Must Do and Should Do actions

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

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

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

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

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

3 Current Position and Progress

As reported to the last Trust Board and Quality and Safety Committee, the table identifies the actions completed either MUST or SHOULD. Although these actions have been completed, many are new developments and will require embedding across the organisation. A review has been undertaken to strengthen actions and ensure the outcomes are sustainable, metrics have also been reviewed to allow for more robust monitoring. This has resulted in a number of actions being re-RAG rated however the CBUs are currently assessing compliance, action plans are in place for each area and additional evidence is being reviewed, the MUST and SHOULD Dos will be reported to Quality and Safety Committee and Board in future meetings. This work is ongoing and executive oversight and support will continue until evidence of sustainability is available.

In addition, issues logged during the unannounced core services and well led visits have been incorporated into the revised CQC Action Plan. Progress will continue to be monitored and reported prior to the publication of the CQC Report in March 2018.

Current status of MUST and SHOULD do actions.

Action Plan	Speciality	Must Do	Off track- Review	Completed	Should Do	Off track- Review	Completed
Trust Board	Board	8	2	6	1	-	1
All CBUs	Outpatients / Imaging	-	-	-	11	3	8
Urgent Care	Accident and Emergency	13	1	12	3	2	1
	Medicine	8	-	8	10	1	9
Planned Care	Surgery	16	2	14	4	2	2
	Spinal Injuries	-	-	-	7	-	7
	Critical Care	-	-	-	3	-	3
Women and Children	Paediatric A&E	-	-	-	6	-	6
	Children's Services	1	-	1	6	-	6
	Maternity and Gynaecology	3	-	3	13	3	10
	Sexual Health	5	-	5	4	1	3
All CBUs	*End of Life*	*1*	*1*	-	*6*	*1*	*5*

End of Life (EoL) transferred to Community, however some actions support the care of our patients and are being managed through the EoL Strategy Steering Group

Must do actions currently off track, have been escalated through Executive Team and Quality Improvement Delivery Group.

Scheme	Area	Action off track	Progress to Date
Documentation	End of Life	The service must improve the consistent use and completion of formal pain assessment; assessment of nutritional and hydration status in the community; mental capacity assessments when indicator on the DNACPR	• DNACPR Audits have been in place and are Included on forward plan as 6 monthly ongoing audits reported at EoL Strategy Steering Group .
	Surgery	Surgical services must take action to ensure that all risk assessments are appropriately completed for patients	• Reviewing documentation for recording of patient risk assessments and agree whether appropriate • Developing a project plan for implementation of new patient documentation taking into account the review and audit outcomes • Audit of documentation (patient record)
Oxygen	Surgery	The service must take action to ensure that Oxygen is prescribed to patients, in line with recommended guidelines prior to administration	• Ensure that the policy for prescribing oxygen is in place and staff are aware of the policy • Regular audits undertaken by Medicines Management • Prescribing Oxygen Stickers designed (same as Trust screen saver) displayed in all ward and clinical areas.
Mortality	Trust Wide	Improve the consistency and learning from mortality review processes	• MACIC group established and now incorporated into Quality & Safety Committee • Learning from deaths project plan developed / implemented • All deaths to be reviewed in line with Learning from Deaths • Training for staff required to undertake reviews of deaths
4 Hr A&E Target	Urgent & Emergency Care	The service must improve performance particularly in relation to the department of health four hour target, wait times following a decision to admit, ambulance handovers	• Escalation process in place • Flow improvement manager in post • Increase Consultant Physician presence until 21:30 • Additional ANPs to support

Scheme	Area	Action off track	Progress to Date
			ambulatory care • A&E Delivery Board ongoing monitoring and assurance provided to Trust Board
General	Trust Wide	Ensuring that they address all the actions detailed within the location reports	• Quality Improvement Delivery Group in place. • Review of CQC Action Plan and revalidation of the evidence.

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

Scheme	Area	Action off track	Progress to Date
Clinical	Critical Care	Take appropriate actions to improved availability of support services (such as speech and language therapy and social worker support) over seven days including outside of normal working hours	• Business case developed by Head of Therapies for additional therapy support • Job descriptions going through Agenda for Change • Has been flagged with Trust 7 Day Services Group
Estates & Environment	Maternity & Gynecology	The service should ensure community midwives have timely access to patient information including safeguarding information	• Undertaking review to identify accessibility requirements of community midwives • Undertake a risk assessment of the outcome of the risk implement recommendations of review
	Medicine	The service should consider more appropriate areas for storage of equipment on the ward and review the equipment needs of the service	• Identify any equipment within ward / service areas which has not been recorded on list or is out of date / requires maintenance etc and alert Medical Devices lead • Reviewed all equipment on the ward / service area to ensure that it is required and if not required arrange with Medical Devices for it to be returned • Identify appropriate storage area within the ward for medical devices and other equipment
Workforce	Maternity & Gynecology	The service should ensure all midwives should be up to date with their annual appraisals	• Compliance monitored monthly at Governance, unfortunately compliance has fallen again in

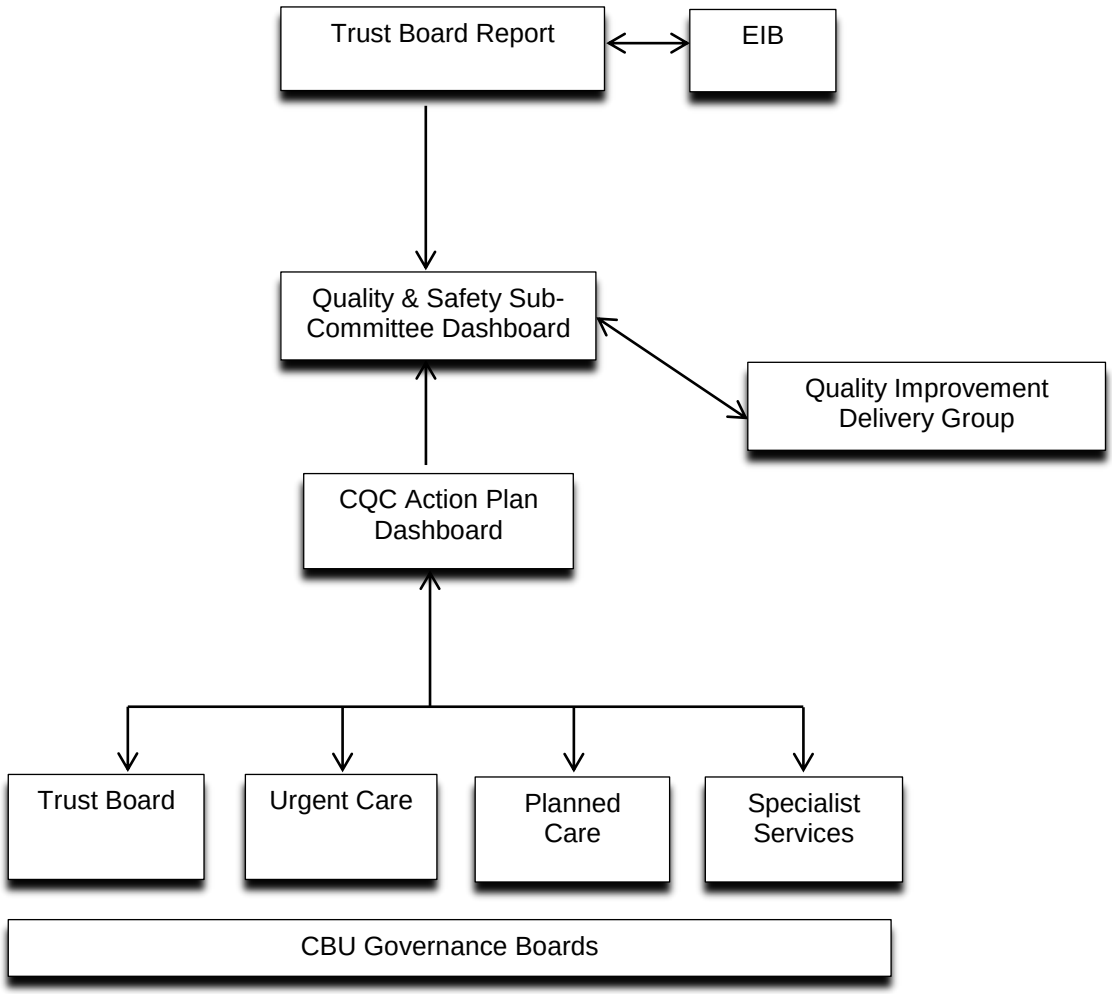
Scheme	Area	Action off track	Progress to Date
			November to 74.29% against 90% target. All staff have now got dates in diaries for appraisals.
	Maternity & Gynecology	The service should ensure specialist midwives are available to provide support to patients with specific needs	• Specialist midwives in place, reviewing patients using the services
	Outpatients & Diagnostics Imaging	The Trust should ensure that staffing levels are sufficient and recruit medical consultants, radiologists and ultra-sonographers in line with substantive numbers	• Substantive appointment for Sonographer made. 12 month Fixed term contract for Radiologist issued and substantive advert for appointment re-advertised. Joint working with Whiston under discussion, 2 trainee sonographers in post. Ongoing monitoring of recruitment and staffing levels via Q&S reporting
Documentation	Outpatients & Diagnostics Imaging	Procedure documentation should be accurate and reviewed in a timely manner, and ensure all appropriate staff are aware of procedural changes	• Ensure that Development and Management of Procedural Documents • Ensure that any procedure documentation relating to Outpatient and Diagnostics Imaging is produced in line with the above policy
	Sexual Health Services	Consider introducing a regular record keeping audit	Service to implement CLIN CORP 06 Clinical Record Keeping Policy Audit to be undertaken on compliance
		The service should ensure that all risk assessments are completed and kept up to date	• Reviewing documentation for recording of patient risk assessments and agree whether appropriate • Developing a project plan for implementation of new patient documentation taking into account the review and audit outcomes • Audit of documentation (patient record)

4 **Quality Improvement Delivery Group**

From January 2018 a new forum ‘Quality Improvement Delivery Group’ (QID) has been established as a sub-group of the Quality and Safety Committee to monitor delivery against the revised CQC Action Plan, draft Terms of Reference include:

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

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



Executive Improvement Board meetings continue to monitor progress and compliance, with regular relationship meetings with CQC in place. At the Executive Improvement Board, 18th January 2018, the Trust provided assurance on progress to date and plans to deliver and embed recommendations going forward (presentation Appendix A).

5 Draft Reports

The Trust are preparing for the receipt of the draft reports following the Core Services and Well Led reviews in November and December 2017. A process is in place for the CQC Factual Accuracy process to ensure appropriate response and challenge

6 Conclusion

The Trust is currently reviewing the CQC Action Plan and focusing on embedding the changes and moving from an ‘action plan’ to a ‘sustainable improvement plan’ to be

monitored through the Trust's new Quality Improvement Strategy. Some early feedback from our recent CQC Well-Led review indicated there is still variation across the CBUs and clinical services in terms of compliance.

Therefore, the following actions are in progress:

- Reviewed evidence provided to date and revalidated the current position
- CBUs to undertaking self-assessments of compliance against the 'Must and Should Do's' utilising the Trust's governance and committee structure.
- Review of the reporting process as part of the new (in draft) Quality Improvement Plan.
- Refresh and update the reporting documentation to Trust Board, EIB and other stakeholders.
- The development of the Quality Improvement Strategy that will incorporate any outstanding actions from the 2016 CQC Report, 2017 Well Led and Core Services Inspections and the National Guardians Office Report, Health Education North West (HENW) visit and the Self-Assessment Well Led Gap Analysis.

Jo Simpson, Assistant Director of Quality
February 2018

Southport and Ormskirk Hospital
NHS Trust

Executive Improvement Board

CQC Well Led Review Update

12 January 2018

Sheila Lloyd
Director of Nursing Midwifery Therapies and Governance

NHS
Southport and Ormskirk Hospital
NHS Trust

- Introduction to the Well led Review
- Issues Identified During the Inspection
- CQC Initial Verbal Feedback
- Immediate Actions to Enable Assurance and Compliance
- Risks
- Next Steps – Preparing Post Inspection Plan
- Future Ways of Working with the CQC

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NHS Trust

Introduction to the Well Led Review

Action	Process
Planning & Preparation for CQC Unannounced and Well Led Review	CBU Action plan review meetings, staff engagement, 'quality bus', mock inspections, peer review of 2016 action plan and evidence, staff booklet, executive walkabouts, 'you said, we listened, we did'
Submission of Annual Provider Information Return (PIR)	Centrally managed through BI, floor to board review and evidence submission, CBU – BOD self assessment of rating (RI)
Self Assessment / Review of Leadership and Governance using the Well Led Framework	CBU / Corporate / Board approach - Workshop to pull together, Gap Analysis completed from floor to board
Development of Well Led Action Plan	Output from workshop, executive sign off
Unannounced Core Services Visits – A&E, Medicine, Surgery, W&C, Spinal	Central facilitating hub, 3 times daily conference calls, responsive to issues raised on daily basis by CQC – submitting action plan and evidence to CQC
Planned Well Led Review Visit	
Final Report Expected March	Continuing to actively respond to CQC information requests, taking immediate actions to enable assurance and compliance

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Issues Identified during Inspection

Actioned / Closed	Short Term Action	Longer Term Action
Medicines Management • CD Disposal • Insulin Storage • Pain Control (A&E)	Medicines Management • CD Storage Theatres • CD Records	Medicines Management • Review and update all pharmacy policies
Medical Equipment • Resus Trolleys	Medical Equipment • Piped Oxygen & Suction in critical areas	Medical Equipment • Piped Oxygen & Suction across all areas
Environment • Sub Wait in A&E • Oasis Room • General Cleanliness	Environment • General Cleanliness	Environment • Refurbishment of Southport Site • Expansion of A&E
Safeguarding • MCA / DOLs Documentation Training		

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Issues Identified during Inspection

Actioned / Closed	Short Term Action	Longer Term Action
A&E • Sepsis Pathway • Mental Health Liaison Staff on site		
Surgery • Pre-Op Fasting		
Spinal Unit • Security / Lockdown		
	Community Midwives • Location • IT Connectivity	
Documentation • Therapy Records		

Embed – Sustain – Assure Compliance across all areas

Southport and Ormskirk Hospital
NHS Trust

CQC Initial Verbal Feedback, led by Nick Smith, Regional Lead

- Thanked Staff for welcome, openness, honesty
- Culture – bring staff with you, hearts and minds
- Lack of strategic plan
- 2016 inspection – concerns re actions being sustained
- Inconsistent use of Informatics / Data Quality
- Continuity and Sustainability of Executive Team
- Continue to request information as part of inspection

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Immediate Actions to Enable Assurance and Compliance

• Refresh CQC metrics – Must Do's, Should Do's and escalated issues during visit	16/01/18
• Review roles, responsibilities and accountabilities, from floor to board	16/01/18
• Weekly Quality Improvement Delivery Group – chaired by CEO for assurance	18/01/18
• Review existing evidence of compliance	23/01/18
• Quality Improvement Plan to QSC, incorporating CQC – Business as usual	31/01/18
• Quality Improvement Plan to Board	07/02/18

Southport and Ormskirk Hospital
NHS Trust

Risks

- Culture and Behaviours
- Experience, Capability and Capacity
- Systems and Tools (Datix and VitalPac)
- Engagement & Ownership

Southport and Ormskirk Hospital
NHS Trust

Next Steps - Preparing the Post Inspection Plan

- Continue to action issues raised during visits
- Deliver Quality Improvement Plan through the Quality Improvement Delivery Group
- Peer Review of Compliance

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Future Way of Working with CQC

- Relationship Meetings
  - CQC Engagement with Staff
  - Focused Service Reviews
- Monthly Insight Report – review and action
- Delivering Actions from pending 2018 Report
- Submission of annual PIR (July 2018)

Southport and Ormskirk Hospital NHS Trust

EXCEPTION REPORT	
Committee/Group:	**Workforce Committee**
Meeting date:	25 January 2018
Lead:	Jim Birrell

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Issue	**Action**
Induction for Jnr Doctors	• Following problems with the last intake, there is a need to ensure that effective induction arrangements are in place for the Junior Doctors joining the Trust shortly
Medical Education – Leadership	• The visit by Health Education North West and the subsequent action plan have highlighted the need for a strengthening of medical education leadership within the Trust. The Committee feel that this exercise should incorporate a greater role in the process for the Guardian of Safeworking

ADVISE

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

Issue	**Action**
Sickness levels – increase in December 2017	• This is partly as a consequence of the Trust's comparatively unchallenging sickness absence policy. The Committee asked that as a matter of urgency the Trust adopts a policy similar to those applying in other local NHS organisations.
Paediatric rota issues	• Discussions are taking place regarding Paediatric rota problems and the solution may be to appoint an extra consultant.

Apprenticeships National Workforce Strategy	• Good progress is being made on appointing apprentices but to obtain optimum benefit from the Apprenticeship Levy the Trust needs to develop a comprehensive plan • A draft National Workforce Strategy has recently been published. The Trust intends to comment on the National Strategy by the deadline of 28/03 and ensure that its own strategy, which will hopefully be available in March, takes into account the themes and direction of travel set out in the national paper.
ASSURE	
(Detail here any areas of assurance that the committee has received)	
Issue HR Policies	**Action** • A report was considered on the current state of HR policies and it was noted that the HR Team plan to update and agree all documents by the end of May.
New Risk identified at the meeting? (If identified please add to risk register)	• GDPR (IG Risk) • Gender Pay Gap Reporting
Review of the Risk Register (Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions) • It was noted that the Apprenticeship Levy risk will be reduced • The lack of E&D Lead can be reduced once the post has been recruited to	

Southport and Ormskirk Hospital NHS Trust

Public Trust Board

7th January 2018

Agenda Item	TB030/18	Report Title	Trust Monthly Safe Staffing Report
Executive Lead	**Sheila Lloyd** Director of Nursing Midwifery Therapies and Governance		
Lead Officer	**Carol Fowler** Assistant Director of Nursing – Workforce		
Action Required *(Definitions below)*	✓ To Receive ☐ To Approve ☐ To Assure		✓ For Note ☐ For Information

Key Messages and Recommendations

In line with National Quality Board (NQB) guidance in November 2013, 'How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability'. This monthly Safe staffing report details the progress and emerging risks in meeting these requirements.

- The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices presented the following overall % fill rates of planned inpatient staffing levels against actual staffing levels for the month of December 2017 against the accepted level of 90%:
  - 83.35% Registered Nurses (RN) on days
  - 84.88% Registered Nurses on nights
  - 96.70% Care staff on days
  - 101.14% Care staff on nights

- **Trust vacancies:**
  - 12.16% (116.14 wte) Registered Nurse vacancies at band 5 and above
  - 13.48% (44.30 wte) Healthcare assistant vacancies band 2 and above.

Nurse Bank spend v total Nurse spend	11.10%
Nurse Agency spend v total Nurse spend	3.29%
Nurse Bank spend v Trust Bank spend	72.71%
Nurse Agency spend v Trust Agency spend	20.38%

- **Trust whole time equivalent (wte) funded establishment versus contracted:**
  - 873.02 wte funded establishment Registered Nurse
  - 766.88 wte contracted Registered Nurse
  - 380.08 wte funded non registered nurse
  - 335.78 wte contracted non registered nurse

There are no new emerging risks to note, the board are advised of the current risks via the risk register (ID1368) and monthly Safe Staffing reports.

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

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

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

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

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

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

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

To note this report

Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

Trust Monthly Safe Staffing Report

1. Aim of the Report

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

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

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

2. Background

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

Southport and Ormskirk Hospital NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and non-registered staff, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', the percentage skill mix ratio of registered nurses to non- registered, and the number of staff per shift required to provide safe and effective patient care.

2.1 Overall Fill Rates

The December 2017 submission indicates a trust fill rate for registered nurses on days 83.35 %, non –registered nurses days 96.70%. Fill rate of registered nurses nights 84.88% and 101.14% for Non-registered nurses nights. Where the overall fill rates for care staff is higher than 100% the figures are raised by both the employment of additional 'specials' (i.e. 1 patient to 1 care staff member) to protect vulnerable patients and the wards compensating for a shortfall in the registered nurse headcount on a shift by employing a non –registered nurse when efforts to backfill with a bank and/or agency registered nurse or the permanent registered nurses being offered extra time or overtime have proved unsuccessful.

3. Recruitment and Retention

The recruitment and retention of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge. Trust workforce data shows there were 12.16% Registered nurse Vacancies (116.14WTE) and 13.48% non-registered nurse vacancies (44.30WTE) at the end of December 2017 across the Clinical Business Units.

As with all NHS employers Southport and Ormskirk Hospital NHS Trust requires a healthy level of staff turnover to bring the benefits of enabling staff to move to new opportunities, different skills and ideas being brought in by new starters alongside existing staff being able to share their existing knowledge. Incorporating all clinical business unit leads, collaboration with NHSI and focused support in our future ACP and Trainee Assistant Practitioner (TAP- band 4 development roles) opportunities have now commenced. Q4 will see agreed timelines against commencement of the collaborative work with NHSI workforce teams both nationally and regionally inclusive of recruitment and retention methodologies.

Nurse staffing reports as a high risk on the Trust Risk Register and is reviewed monthly. Recruiting and retaining the nursing and midwifery workforce continues to be an area of increased focus.

Apprenticeship Levy: A particular emphasis on utilising the levy within nursing has been actioned through the implementation of the TAPs – December saw recruitment to 13 substantive Healthcare assistants onto the apprenticeship pathway for development opportunities into Assistant Practioner roles within nursing establishments. Q4 will see continued focus in developing a trust Enhanced Care team.

Community Engagement manager: The Trust welcomes this new role appointed to manage the widening participation agendas and commences in post in January 2018.

The post holder will have specific lead responsibility for the creation of a sustainable model to support entry level vocational learning developments with a specific focus on pre-employment, traineeships and work experience programmes.

Through liaison with local community resources, the post holder will lead on development programmes that impact on the future employment of hard to reach areas of the community. Working with local schools, colleges and training providers, the Clinical Education and Development Manager and internal lead for apprenticeship programmes, the post holder will support the promotion of pathways in to the NHS as a career choice for the future.

3.1 The Recruitment of Bank staff via NHSP

Recruitment of bank Registered and non-registered staff is on-going, advertising every two months to recruit to the nurse bank and is delivering continued improvements.

Monthly operational meetings with NHSP continue with key leads from clinical business units attending to assure business unit staffing requirements are actioned.

4. Student Nurse Recruitment Update

The Trust's Student Nurse Practice Education Facilitators have confirmed optimum Recruitment Open Day dates for 2017-2018:

- Local recruitment on site event Feb 2018
- RCN recruitment event Feb 2018
- LJMU careers fair 20th Feb 2018
- Edge Hill careers event 9th March/11th July 2018

The trust has increased its student cohort by 8 (UCLAN) students with a further 7 students planned in early 2018.

On-going Recruitment of Registered Nursing Staff

The Trust has representation on the Cheshire and Merseyside Director of Nursing workforce recruitment and retention collaborative program. The programme awaits appointment of a Director of Nursing to lead on delivery deliver going forward – advert out to recruitment currently.

The Trusts Assistant Director of Nursing (Workforce) represented the Trust on 13th December 2017 at the North Region Workforce Think Tank/Summit - "Care in the North: Our Future Our Workforce" – Chaired by Margaret Kitching, Chief Nurse North, NHS England/NHS Improvement. A workforce group to take the work forward is being chaired by Mike Wright Chief Nurse at Hull and East Yorkshire NHS trust with a request from Southport and Ormskirk Hospital NHS trust for membership. The Chief Nursing Officer Conference in March 2018 will be an opportunity to showcase the work being done/planned.

5. Staffing Related Reported Incidents

A total of 36 staffing related incidents reported in December 2017. 20 out of the 36 incidents highlighted 'insufficient nurses/midwives'.
Of the 20 incidents reported, 14 related to night duty. In relation to the 6 incidents reported related to day duty, 2 were on ward 14b, where the incidents highlight

movements of staff to accommodate shortfalls on other wards. 2 incidents were reported by Maternity, with issues highlighting insufficient midwife numbers to accommodate the levels of activity on two separate occasions. 2 incidents were reported from the merged E/G wards on ODGH site, with issues highlighting the inability to merge the wards overnight due to patient numbers, leaving potential of inadequate nursing staff to cover both wards. The second incident highlighted the movement of a nurse from G ward to SDGH site, leaving a Gynaecology nurse to look after both Gynaecology and Orthopaedic/Urology patients. A total of 4 incidents were reported from A&E/Observation ward in December 2017, on different occasions. All incidents highlight nurse sickness leaving areas insufficiently staffed to accommodate the acuity and volume of patients. 2 incidents reported on ward 14A report registered nurses being moved to accommodate shortages in other areas.
Non ward based senior nurses covered across the Trust with particular additional support offered over public holidays in December 2017 to assure safe staffing.
Matrons clinical input is considerable at times and continues to support the safe staffing of each ward and across the Trust sites. These clinical hours are not routinely captured on either HealthRoster or the Unify data. This will be captured going forward.

Where wards are not able to cover the third registered nurse on a shift with either a permanent member of staff or a temporary member of staff who is familiar with the ward they have used an experienced Healthcare Assistant.

6. Inpatients experiencing moderate harm or above in December 2017

No moderate harm or above experienced/reported in December 2017.

7. NHS Improvement (NHSI) Safer Staffing Guidance

Within the delivery plan NHSI are commencing the governance and workforce planning elements with an onsite meeting confirmed for 30th January 2018. A timeline will support the collaborative engagement going forward and will be shared amongst executive and clinical teams.

Summary

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

Carol Fowler
Assistant Director of Nursing and Midwifery (Workforce Lead)

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7th February 2018

Agenda Item	**TB031/17**	**Report Title**	**Update on National G Freedom to Speak up (FTSU) REPORT AND Action plan**
Executive Lead	**Sheila Lloyd,** Director of Nursing, Midwifery and Governance		
Lead Officer	**Jan Ross,** Deputy Director of Nursing Midwifery and Governance		
Action Required *(Definitions below)*	☐ To Receive ✓ To Approve ☐ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

As the Trust board is aware, the National Guardians Office conducted a review of the speaking up processes, policy and culture at Southport and Ormskirk NHS Trust in September 2017.

This paper gives an overview of the report and the 23 recommendations. The board is asked to note the report and approve the final version of the action plan.

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

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

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

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

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

☐ Quality	☐ Risk
☐ Finance	✓ Compliance

☐ Workforce ☐ Equality	☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
The Trust board is asked to note the report and approve the final version of the action plan	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

Introduction

As the Trust board is aware, the National Guardians Office conducted a review of the speaking up processes, policy and culture at Southport and Ormskirk NHS Trust in September 2017. The full report has previuosly been to Trust Board.

The reason for the review was due to the office receiving information alerting them to the Trusts resposnse to its workers were the management of speaking up was not in line with good practice.

The review was the first of its kind and the methedology used was a case review into processes, policy and overall culture. Case reviews assessed the handling of NHS workers concerns where they did not meet the standard of accepted good practice in supporting speaking up.

Purpose

The purpose of the review was to find evidence of where speaking up was not meeting good practice and make recommedations to remedy this. The Trust fully supported the review and provided all required information.

Summary of Findings

The review found evidence that the culture, policies and procedures of the Trust did not always support workers to speak up, including evidence of a bullying culture. Many workers who spoke to the team during the review expressed a belief that the Trust did not take their views or concerns seriously.

The review also found that the Trust did not appropriatley support the needs of its black and ethnic minority workers, including a failure to respond to multiple and serious concerns raised by many of those workers.

The reports hightlights that there was evidence that new Trust leadership team were taking steps to improve the Trusts speaking up processes, policy and culture.

Recommendations

The final report stated that the National Guardians Office found evidence that the Trusts support for speaking up was not in accordance with good practice and made 23 recommendations to support improvement.

22 of the recomedations were for the Trust and 1 recommendation for the Care Quality Commission.

The report has now been published.

Work to date

The Freedom to speak up Guardian provides a detailed Quarterly report that is submitted to the Freedom to Speak up Guardians office. Q3's report demonstrates, 4 concerns raised within that period and the detail of the concerns are in the report, there are no common themes to report. The report has not been shared as it has confidential information within it.

Next Steps

The Trust has a freedom to speak up Guardian in post however this is a temporary post to ensure continutity of the service. The recruitment process is taking place this month to secure a permenent post holder.

The 22 recommendations have been put into an action plan this has been agreed by NHSI who will include in the Trusts monthly improvement board meeting and tract the required actions. Within the Trust the action plan will be measured through a monthly Freedom to speak up operational meeting and then escalated and reported through Quality Improvement Deilvery Group – chaired by the Chief Executive.

The trust Board is therefore asked to note the work to date and approve the final action plan which will then be submitted to the National Guardians office for publication.

Jan Ross, Deputy Director of Nursing Midwifery and Governance

January 2018

Action Plan Following National Guardian Case review (15/11/17)

Southport and Ormskirk Hospital NHS Trust

No	Source Document	Area for improvement	Action or improvement required	Target Date	Current Status	Executive Lead	Action Owner	Monitoring Forum	Assurance Forum	Frequency of Reporting	Metric / process for assurance	Update
	Culture of raising concerns - policies and procedures											
1.1	National Guardian Office	The trust should publish its new speaking up policy	Communication plan developed for the roll out of the policy in conjunction with stakeholders	31-Mar-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Gill Murphy)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	All staff familiar with policy Number of concerns raised through this forum Audit of implementation of policy Communications plan	
1.2	National Guardian Office	The trust should publish its new speaking up policy	Policy to be published on website and intranet	31-Mar-18		Chief Nurse (Sheila Lloyd)	Communication lead (Tony Ellis)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	All staff familiar with policy	
2.1	National Guardian Office	The trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.	Develop comms plan to ensure that all relevant stakeholders are aware of the revisited policy i.e. all staff briefings or emails, attend team meetings, newsletter and video updates, screen savers, posters Include Trust Policy and Guardian in Staff Induction programme	01-May-18		Chief Nurse (Sheila Lloyd)	Communication lead (Tony Ellis)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Number of concerns raised through this forum Evauation of Induction Programme Communications plan	
2.2	National Guardian Office	The trust should take steps to ensure all existing and new workers are aware of the contents of the new freedom to speak up policy.	Cover in induction programme for new starters and doctors programme	01-May-18		Chief Nurse (Sheila Lloyd)	Communication lead (Tony Ellis)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Number of concerns raised through this forum Evaluation of Induction Programme	
	Culture of raising concerns - senior leadership and culture											
3.1	National Guardian Office	The trust should implement all aspects of its draft Freedom to Speak Up action plan, by the plan's stated completion dates	Develop governance structure to ensure that the relevant board committee is monitoring the delivery of the action plan and receiving regular assurance that progress is in line with the action plan and that risks are being mitigated. Delivery through Quality Improvement Delivery Group.	01-Feb-19		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Governance structure Agenda and minutes from Quality Improvement Delivery Group and monitoring/assurance through sub committee (workforce) Copies of reports	Update being presented to Board February 2018
3.2	National Guardian Office	The trust should implement all aspects of its draft Freedom to Speak Up action plan, by the plan's stated completion dates	Regular updates provided by the Executive sponsors to the senior management team and issues escalated to the executive	01-Feb-19		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Agenda and minutes from Quality Improvement Delivery Group and monitoring/assurance throough sub committee (workforce) Copies of reports Update to Board & Executives Action plan	Update being presented to Board February 2018
3.3	National Guardian Office	The trust should implement all aspects of its draft Freedom to Speak Up action plan, by the plan's stated completion dates	Develop a clear comms plan to help communicate the vision and achieve staff buy in	01-Mar-18		Director of HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Communication Plan Freedom to speak up report	Update being presented to Board February 2018
	Culture of raising concerns - culture of valuing workers											
4.1	National Guardian Office	The trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all those managers and leaders responsible for handling concerns provide feedback to every individual who speaks up, including any actions they intend to take in response.	In line with the policy develop a process to deliver feedback within timescales as appropriate	31-Mar-18		Chief Nurse (Sheila Lloyd)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Number of concerns rasied vs feedback given (if appropriate) covered in Freedom to speak up report	
4.2	National Guardian Office	The trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all those managers and leaders responsible for handling concerns provide feedback to every individual who speaks up, including any actions they intend to take in response.	Train all relevant managers and leaders	Dec-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Number of staff trained Evaluation of training	

No	Source Document	Area for improvement	Action or improvement required	Target Date	Current Status	Executive Lead	Action Owner	Monitoring Forum	Assurance Forum	Frequency of Reporting	Metric / process for assurance	Update
4.4	National Guardian Office	The trust should ensure that, in accordance with its own policies and procedures and in accordance with good practice, all those managers and leaders responsible for handling concerns provide feedback to every individual who speaks up, including any actions they intend to take in response.	Review process for feedback including training of relevant staff and make appropirate changes to the process	Mar-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Evaluation and review of process Change to process implemented	
	Culture of Raising Concerns - measuring the effectiveness of speaking up processes											
5.1	National Guardian Office	The trust should put in place effective systems to monitor the development of a positive speaking up culture	Develop a process to gather feedback from staff that have raised concerns	01-Jul-18		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Feedback shows that staff awareness and confidence is growing	
5.2	National Guardian Office	The trust should put in place effective systems to monitor the development of a positive speaking up culture	Conduct a pulse survey to measure staff awareness/confidence at the time the revised speaking up policy is launched	01-Jul-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Survey results	
5.3	National Guardian Office	The trust should put in place effective systems to monitor the development of a positive speaking up culture	Plan focus groups at 3 and 6 months to gather feedback and improvement suggestions	Jul 2018 and september 2018		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Focus groups held Feedback received and suggestions incorporated as appropriate	
5.4	National Guardian Office	The trust should put in place effective systems to monitor the development of a positive speaking up culture	Feedback from staff reps i.e. union or employee forum reps	01-Jul-18		Chief Nurse (Sheila Lloyd)	DeputyChief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Feedback received	
5.5	National Guardian Office	The trust should put in place effective systems to monitor the development of a positive speaking up culture	Analyse exit interviews and feedback from grievances	May-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Feedback received Exit interview	
5.6	National Guardian Office	The trust should put in place effective systems to monitor the development of a positive speaking up culture	Establish discussion forum's on the intranet or create a anonymous 'post box'	Jul-18		Chief Nurse (Sheila Lloyd)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Weekly	Feedback received	
	Culture free from bullying											
6.1	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	identify good practice from other trusts	01-Apr-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Review undertaken and areas of possible good practice shared and incorporated into Trust values and behaviours	
6.2	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	Review bullying and harassment policy to ensure that expectations and consequences are clear.	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Policy reviewed	
6.3	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	review performance management policy to ensure that expectations and consequences are clear.	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Policy reviewed	
6.4	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	review training around values, behaviours etc. and consequences of inappropriate behaviour	Apr-18		Director HR/OD (Jane Royds)	OD Lead	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Training programme in place Values and behaviours incoroporated into training programme	
6.5	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	communicate any changes to policies with a clear statement that bullying and harassment will not be tolerated.	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Communication plan	
6.5	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	Train managers to identify/recognise, prevent and address bullying and harassment	Dec-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Training programme in place Values and behaviours incoroporated into training programme	
6.7	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	Retrain HR staff to deal with bullying and harassment cases fairly and promptly and inline with policy and procedure	Dec-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Training programme in place Values and behaviours incoroporated into training programme	
6.8	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	develop an approach to monitor the impact of the changes	Apr-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Staff survey (culture indicators) improvement Pulse surveys undertaken and improvements identified	

No	Source Document	Area for improvement	Action or improvement required	Target Date	Current Status	Executive Lead	Action Owner	Monitoring Forum	Assurance Forum	Frequency of Reporting	Metric / process for assurance	Update
6.9	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	provide regular updates to the board on progress and issues.	Apr-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Updates to Board Agenda and minutes	
6.1	National Guardian Office	The trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	Develop comms/training/performance management approach that will maintain the momentum of a culture free from bullying and harassment.	Sep-18		Director HR/OD (Jane Royds)	OD lead	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Communication plan	
	Culture of visible leadership											
7.1	National Guardian Office	Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	Develop a monthly exec/NED/CoG walk about 15 steps approach	01-Mar-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Pulse survey (routinely undertaken) to assess impact of walkabouts	
7.2	National Guardian Office	Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	monthly breakfast/lunches/coffee mornings with Execs/NEDs	01-Mar-18		Director HR/OD (Jayne Royds)	OD lead	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Attendance by Executives Attendance by staff	
7.3	National Guardian Office	Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	Improvement focus groups	01-Apr-18		Director HR/OD (Jayne Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Dates of focus groups Topics of focus groups Feedback mechanisms from focus groups Attendance levels	
7.4	National Guardian Office	Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	Exec email updates - must do Director of Nursing; CEO, MD & COO as essential	Feb-18		Director HR/OD (Jayne Royds)	OD lead	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Audit of exec emails undertaken to assertain frequency Read receipt to be added to audit staff response	
7.5	National Guardian Office	Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	Videos on the intranet	Feb-18		Chief Nurse (Sheila Lloyd)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Audit of website	
7.6	National Guardian Office	Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	All staff briefings	01-Mar-18		FTSU Guardian (Martin Abrams)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Audit of number of staff briefings	
7.7	National Guardian Office	Trust leaders should take appropriate steps to ensure that they are visible and accessible to all workers to promote a culture of visible leadership.	CEO weekly or monthly all staff comms	01-Apr-18		CEO	Communication lead (Tony Ellis)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Audit of number of staff comms	
	Handling concerns											
8.1	National Guardian Office	The trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.	identify good practice from other trusts	Apr-18		FTSU Guardian (Martin Abrams)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Q1	Review undertaken and areas of possible good practice shared and incorporated into Trust values and behaviours	
8.2	National Guardian Office	The trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.	develop a quality assurance process to audit case files to identify gaps in compliance with aspects of policy and good practice (lessons learned)	Apr-18		Director HR/OD (Jayne Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Audit of policy	
8.3	National Guardian Office	The trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.	review a sample of case files and make recommendations for improvements	Apr-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Audit of policy	

No	Source Document	Area for improvement	Action or improvement required	Target Date	Current Status	Executive Lead	Action Owner	Monitoring Forum	Assurance Forum	Frequency of Reporting	Metric / process for assurance	Update
8.4	National Guardian Office	The trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.	implement the changes and monitor to assess the impact	Apr-18		Director HR/OD (Jane Royds)	OD lead	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Audit of policy Pulse survey of staff Report to Board Board agenda and minute	
8.5	National Guardian Office	The trust should ensure that it responds to the concerns raised by its workers strictly in accordance with its policies and procedures and in accordance with good practice and report to the board evidence of this.	report to board details of complaince with the policy and the learning identified.	May-18		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Report to Board Board agenda and minute	
9.1	National Guardian Office	The trust should ensure that its responds to all concerns raised by its workers in relation to the recruitment of staff strictly in accordance with its policies and procedures and in accordance with good practice.	Recruitment process audits	Mar-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Audit of policy (recruitment)	
	Supporting good practice- speaking up training											
10.1	National Guardian Office	The trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.	identify good practice from other trusts	Dec-18		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Review undertaken and areas of possible good practice shared and incorporated into Trust values and behaviours	
10.2	National Guardian Office	The trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.	source an external training company or develop in house training and guidance materials to include how to investigate concerns, conflict resolution, how to reduce stress, how to give feedback in an un-defensive way, how to respond to concerns raised about yourself, sign posting	Septmber 2018		Director HR/OD (Jane Royds)	Deputy Chief Nurse (Gill Murphy)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Training programme in place Review of effectiveness of training Numbers trained	
10.3	National Guardian Office	The trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.	include references to speaking up in other existing training programmes - i.e. manager/supervisor training	Dec-18		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Review of staff material Updated staff material with freedom to speak out details	
10.5	National Guardian Office	The trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.	rollout training programme.	Septmber 2018		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Training programme in place Review of effectiveness of training Numbers trained	
10.6	National Guardian Office	The trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.	Obtain feedback/evaluation from training delegates and improve course as necessary	Dec-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Training programme in place Review of effectiveness of training Numbers trained	

No	Source Document	Area for improvement	Action or improvement required	Target Date	Current Status	Executive Lead	Action Owner	Monitoring Forum	Assurance Forum	Frequency of Reporting	Metric / process for assurance	Update
10.7	National Guardian Office	The trust should provide all workers, including all managers, with regular, updated and mandatory training on speaking up and supporting and responding to people who speak up. The trust should monitor the effectiveness of this training.	FTSUG to obtain feedback from workers about how supported they have felt by the person they raised their concerns with	Septmber 2018		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Survey of those who have spoke up	
11	National Guardian Office	The trust should ensure that appropriate steps are taken to publicise the role of the guardian and any staff supporting that role, using methods that reach all workers.	Communication plan developed identifying role and appropriate publicity material and intranet page developed	Apr-18		Director HR/OD (Jane Royds)	Communication lead (Tony Ellis)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quartely	Intranet Publicity material Comms plan	
12.1	National Guardian Office	the trust should ensure that it provides appropriate resources for the role of FTSUG, in line with guidance provided by the NGO, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome and possible conflicts.	identify what FTSUG/Champion model similar sized trusts use and benchmark	Apr-18		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	One off	Review undertaken and areas of possible good practice shared and incorporated into Trust values and behaviours	
12.2	National Guardian Office	the trust should ensure that it provides appropriate resources for the role of FTSUG, in line with guidance provided by the NGO, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome and possible conflicts.	review FTSUG role and develop champion roles as necessary	Apr-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quartely	Job Description FTSUG Job Description Champion roles Recruitment of both Regular meetings in place	
12.3	National Guardian Office	the trust should ensure that it provides appropriate resources for the role of FTSUG, in line with guidance provided by the NGO, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome and possible conflicts.	assess the impact of the extra resources by analysing staff feedback	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)		NHSI Improvement Board Workforce Committee	Quartely	Number of concerns raised through this forum	
13.1	National Guardian Office	The trust should take appropriate steps to ensure that minority and vulnerable workers, including BME workers are free to speak up	meet with BME support groups to publicise the revised policy and to understand what barriers BME staff face	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quartely	Programme of support to BAME Number of BAME reporting concerns	
13.2	National Guardian Office	The trust should take appropriate steps to ensure that minority and vulnerable workers, including BME workers are free to speak up	develop solutions or provide the support needed to enable BME to feel confident to speak up	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quartely	Programme of support to BAME Number of BAME reporting concerns	
13.3	National Guardian Office	The trust should take appropriate steps to ensure that minority and vulnerable workers, including BME workers are free to speak up	Monitor the effectiveness of the changes made.	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quartely	Review undertaken	
14.1	National Guardian Office	The trust should look again at its appointment process for the role of FTSUG and ensure a Guardian is appointed using a process that is open and fair.	Identify good practise from other trusts and recruit in line with policy	May-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Review undertaken and areas of possible good practice shared Successful recruitment	
	Supporting good practice - transparency											

No	Source Document	Area for improvement	Action or improvement required	Target Date	Current Status	Executive Lead	Action Owner	Monitoring Forum	Assurance Forum	Frequency of Reporting	Metric / process for assurance	Update
15.1	National Guardian Office	The trust should seek to share the learning of its cultural review with its workers, taking all necessary steps to protect the confidentiality of individuals	Take legal advice about what can be shared with workers	Mar-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	All learning is shared and embedded across the trust	
15.2	National Guardian Office	The trust should seek to share the learning of its cultural review with its workers, taking all necessary steps to protect the confidentiality of individuals	analysis of concerns (key themes) and share learning and accompanying action plan with staff	May-18		Chief Nurse (Sheila Lloyd)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	one off	All learning is shared and embedded across the trust	
	Supporting good practice-fit and proper persons											
16.1	National Guardian Office	the trust should take appropriate steps to ensure that all aspects of its work are consistent with the Francis Freedom to Speak Up principles, including where it undertakes a Fit and Proper Person review.	Ensure Policy for for carrying out FPP investigations is in place	Apr-18		Director HR/OD (Jane Royds)	Company Sec (Audley Charles)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	FPP Policy Audit	
16.2	National Guardian Office	the trust should take appropriate steps to ensure that all aspects of its work are consistent with the Francis Freedom to Speak Up principles, including where it undertakes a Fit and Proper Person review.	develop a quality assurance process to audit a sample of FPP investigations to identify areas where the investigation has not followed the investigation procedure and good practice	Apr-18		Chief Nurse (Sheila Lloyd)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Audit of policy	
17	**Recommendation was directed at CQC and not the trust.**											
	Supporting good practice - support for staff during the speaking up process											
18.1	National Guardian Office	the trust should take steps to ensure that its policies and procedures are supportive of all workers affected by the speaking up process, including those who are the subject of concerns raised.	identify good practice from other trusts i.e. multiple channels to raise concerns, counselling, facilitated open and reflective discussions to generate solutions, team building, mediation etc.	Dec-19		Director HR/OD (Jane Royds)	Director HR/OD (Jane Royds)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Review undertaken and areas of possible good practice shared	
18.2	National Guardian Office	the trust should take steps to ensure that its policies and procedures are supportive of all workers affected by the speaking up process, including those who are the subject of concerns raised.	Review all relevant policies and procedures and amend accordingly.	Jul-18		Director HR/OD (Jane Royds)	Director HR/OD (Jane Royds)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Identification of relevant policies Evidence of review of relevant policies	
19.1	National Guardian Office	the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up	Develop guidance for staff so that they know how to support staff including when to offer mediation	Jun-18		Director HR/OD (Jane Royds)	Director HR/OD (Jane Royds)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Mediation usage	
19.2	National Guardian Office	the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up	Awareness and training for staff	Dec-18		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Staff trained	
19.3	National Guardian Office	the trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up	Request feedback from staff who have raised concerns and received mediation to further refine the process	Ongoing		Director HR/OD (Jane Royds)	FTSU Guardian (Martin Abrams)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Feedback from staff who have used mediation process	
	Vulnerable and minority workers - meeting the needs of black and minority ethnic workers											
20.1	National Guardian Office	The trust should take all appropriate steps to address the concerns raised by BME workers in the trust 2016 survey.	Understand the issues raised and identify key actions	Jul-18		Director HR/OD (Jane Royds)	Director HR/OD (Jane Royds)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Monthly	Staff survey key actions relating to BME	
20.2	National Guardian Office	The trust should take all appropriate steps to address the concerns raised by BME workers in the trust 2016 survey.	Seek advice from WRES team at NHS England about how to address issues and to improve trust and confidence in BME staff	Jul-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Good practice identified and shared	

No	Source Document	Area for improvement	Action or improvement required	Target Date	Current Status	Executive Lead	Action Owner	Monitoring Forum	Assurance Forum	Frequency of Reporting	Metric / process for assurance	Update
20.4	National Guardian Office	The trust should take all appropriate steps to address the concerns raised by BME workers in the trust 2016 survey.	Once actions have been agreed and implemented - train all managers to be aware of and support BME needs	Jul-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Annual	Training of staff in place	
21.1	National Guardian Office	The trust should appoint an equality and diversity lead and ensure that position is appropriately resourced.	Develop JD	Mar-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	one off	JD	
21.2	National Guardian Office	The trust should appoint an equality and diversity lead and ensure that position is appropriately resourced.	Role advertised	Mar-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	One off	Advert	
21.3	National Guardian Office	The trust should appoint an equality and diversity lead and ensure that position is appropriately resourced.	Open and fair recruitment process	Mar-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	One off	Process in line with policy	
22.1	National Guardian Office	The trust should take action to implement all the recommendations of its cultural review.	Develop governance structure to ensure that the relevant board committee is monitoring the delivery of the cultural review action plan and receiving regular assurance that progress is in line with the action plan and that risks are being mitigated.	Apr-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Governance structure Agenda and minutes from monitoring forum and assurance forum Copies of reports	
22.2	National Guardian Office	The trust should take action to implement all the recommendations of its cultural review.	Regular updates provided by the Executive sponsors to the senior management team and issues escalated to the executive management team.	Quarterly		Director HR/OD (Jane Royds)	Deputy Chief Nurse (Jan Ross)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	Quarterly	Updates on delivery of review	
23.1	National Guardian Office	The trust should consider requesting support from the NHS England WRES Implementation Team to help meet the needs of its BME workers	See Recommendation 20.	Feb-18		Director HR/OD (Jane Royds)	Deputy HR Lead (Audrey Cushion)	Monthly FTSU meeting	NHSI Improvement Board Workforce Committee	One off	Good practice identified and shared	

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

7th February 2018

Agenda Item	**TB032/18**	**Report Title**	**Learning from Deaths - Quarter 3 Report**
Executive Lead	Dr Jugnu Mahajan, Interim Medical Director		
Lead Officer	Dr Paul Mansour, Deputy Medical Director		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve ✓ To Assure		✓ To Note ☐ For Information

Key Messages and Recommendations

This paper presents data from quarter 2 showing that 186/200 (93%) of in-hospital deaths were subject to a mortality review, and that none of these reviews showed either 'possible' or 'likely' avoidable deaths. However, the current review system has significant limitations, which will be corrected when the improved review system, based on the Royal College of Physicians' structured judgement review methodology is fully implemented.

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

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

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

✓ Statutory requirement
☐ Annual Business Plan Priority
✓ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register: (Please give reference no.)

_____

☐ Service Change
✓ Best Practice
☐ Other List (Rationale)

Impact *(is there an impact arising from the report on the following?)*	
✓ Quality ☐ Finance ☐ Workforce ☐ Equality	✓ Risk ☐ Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
1. Roll out the structured judgement review methodology to all departments; 2. In the meantime, remind clinical teams of the purpose of the initial screening mortality review; 3. Ensure that a random selection of deaths is subject to full mortality review.	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ✓ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

QUARTER 3 LEARNING FROM DEATHS PAPER

1 EXECUTIVE SUMMARY

1.1 In March 2017, the National Quality Board issued national guidance about "Learning from Deaths", requiring trusts to publish mortality data from quarter 3 of 2017/18 as an agenda item to the public Trust Board, including estimates of "avoidable" deaths.

1.2 This paper, the first such report to the Board Of Directors, presents data from quarter 2 showing that 186/200 (93%) of in-hospital deaths were subject to a mortality review, and that none of these reviews showed either ‘possible’ or ‘likely’ avoidable deaths.

1.3 However, the current review system has significant limitations, which will be corrected when the improved review system, based on the Royal College of Physicians’ structured judgement review methodology, is fully implemented.

2 BACKGROUND

2.1 In March 2017, The National Quality Board issued "National Guidance on Learning from Deaths: a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care”. This guidance included the requirements that by Q2, Trusts must publish a Learning from Deaths policy, and that from Q3 onwards Trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting. These data should include the total number of the Trust’s in-patient deaths and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, Trusts must estimate how many deaths were judged more likely than not to have been due to problems in care. A dashboard accompanying this guidance showed what information needs to be collected and provided a suggested format for publishing the information.

2.2 The Learning from Deaths policy was approved by the Board in September 2017. This is the first quarterly paper to be brought to the Board, and presents data from Q2.

3 QUARTER 2 DATA

TABLE 3.1: TOTAL DEATHS AND NUMBER REVIEWED

MONTH	TOTAL DEATHS	LEARNING DISABILITY DEATHS	MORTALITY REVIEWS
July '17	68	0	65 (96%)
Aug '17	68	1	68 (100%)
Sept '17	64	0	53 (83%)
TOTAL	200	1	186 (93%)

TABLE 3.2: MORTALITY REVIEW OUTCOMES

Outcome of Mortality Review	July '17	August '17	Sept '17
1) Not preventable death due to terminal illness or condition upon arrival at hospital	14	22	19
2) Not preventable death and occurred despite the health team taking preventative measures	51	46	34
3) Not preventable death BUT medical error of system issue was present	0	0	0
4) Possibly preventable death resulting from medical error or system issue	0	0	0
5) Likely preventable death resulting from medical error or system issue	0	0	0
TOTAL REVIEWS:	65	68	53

4 LIMITATIONS OF CURRENT MORTALITY REVIEW PROCESS

4.1 During quarter 2, the recommended Structured Judgement Review (SJR) methodology was not in use, as training was only made available to the Trust in

November 2017; this methodology is currently being rolled out through Trust departments using the methodology by April 2018. Therefore, the categories used to classify deaths are not directly comparable to those recommended by the Learning from Deaths document, and the suggested dashboard template cannot therefore yet be used.

4.2 During this time period, the "mortality reviews" carried out would more accurately be termed "screening reviews", as they were relatively superficial in nature and carried out by the team responsible for the patient's care. True in-depth mortality reviews should be carried out for deaths classified by the initial screening review as falling into categories 3, 4 5, as well as for a random selection of death as quality assurance. However, it appears that the random in-depth reviews have not been carried out on a regular basis.

4.3 Nationally, it is estimated that between 0.5% and 4% of in-hospital deaths are "avoidable" on the balance of probabilities, and therefore at Southport and Ormskirk it would be expected that at least one, and possibly as many as eight, deaths during quarter 2 might have been identified as potentially avoidable (categories 4 or 5). It is even less feasible that no category 3 errors were identified during the quarter, suggesting that the screening reviews are not as robust as previously considered. (The new screening system will be more objective, based on a simple tick box screen which will automatically identify those deaths requiring a full structured judgement review under the national guidance.)

5 NEXT STEPS

5.1 The SJR methodology will be rolled out across the trust, department by department, with a view to all departments using the methodology by April 2018. This work will be coordinated and overseen by the Mortality Operational Committee (MOC), reporting to the Quality & Safety Committee.

5.2 In the meantime, clinical teams will be reminded that the initial screening review must be credible and robust and must pick up more deaths to go forward to a full review. In addition, a random selection of deaths each month must also go forward to a full mortality review.

Dr. Paul Mansour, Acting Medical Director
January 2018

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Trust Board

7th February 2018

Agenda Item	**TB033/18**	**Report Title**	**Merger of the Quality and Safety Committee and Mortality Assurance and Clinical Improvement Committee (MACIC)**
Executive Lead	**Ann Farrar,** Interim Chief Executive		
Lead Officer	**Audley Charles,** Interim Company Secretary		
Action Required *(Definitions below)*	☐ To Receive ✓ To Approve ☐ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

The Mortality Assurance and Clinical Improvement Committee (MACIC) was formed in 2017 as a time limited Committee with the aim of monitoring Mortality issues and report areas of concerns to the Board. The Committee met five times with a membership of two Non-Executive Directors and two Executive Directors, the Medical Director and the Director of Nursing and Midwifery. The Committee, by its very nature requires a majority of NEDs, ideally with at least one having a Clinical background. Currently, only the Chair of the Committee has such a background.

Given that there are only two NED members, quoracy could become a problem when convening meetings of the Committee. This may be resolved when the two vacancies are filled.

The NED members of the Committee and the Executive Director Leads have discussed the situation and have suggested that matters normally discussed at MACIC should be subsumed into the Quality and Safety Committee, at least until such time as the vacancies among the NEDs and hopefully with the appropriate skills mix are fulfilled to allow for meaningful meetings of the Committee if the Board feels a need to revert to MACIC as an assurance committee of the Board. MACIC was initially set up as a time limited assurance committee of the Board.

The NEDs and lead Executive Directors have suggested that the Operational Group which was in place before the formation pf MACIC, be revived to allow operational issues to be discussed in detail and report into the Quality and Safety Committee. This Group is to be chaired by the Associate Medical Director for Patient Safety and to be called the *Mortality Operational Group* (MOG).

The Terms of Reference of the Quality and Safety Committee have been revised to reflect the change (**see attached**). A revised and refreshed Terms of Reference for the MOG have also been prepared (**see attached).** A composite Board and committee structure is also attached so the Quality and Safety Committee and its reporting Groups could be seen in context.

The Board is asked to:

Approve the recommendation that MACIC be stood down at this time and issues that would normally be scrutinized there, be subsumed into the Quality and Safety Committee
Approve the revival/reinstatement of the Mortality Operational Group
Approve the revised Terms of Reference of the *Quality and Safety Committee*
Approve the Terms of Reference of the *Mortality Operational Group*

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

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

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

- ✓ Statutory requirement
- ☐ Annual Business Plan Priority
- ✓ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register: (Please give reference no.) __Strategic Risks: 2 and 4_____
- ☐ Service Change
- ✓ Best Practice
- ☐ Other List (Rationale) _____

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

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

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

Previously Presented at:

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

NHS
Southport and Ormskirk Hospital
NHS Trust

MEETING	Quality and Safety Committee
ESTABLISHED BY /REPORTING TO:	Trust Board
Reviewer:	Audley Charles - Interim Company Secretary
REVIEW:	January 2018
ASSOCIATED DOCUMENTS:	Standing Orders Trust Board's Scheme of Reservation and Delegation Quality Improvement Strategy Risk Management Strategy Extreme Risk Register Board Assurance Framework Safeguarding Policy Freedom to Speak Up/Raising Concerns Policy
RELATED COMMITTEES/GROUPS	Trust Board Finance, Performance and Investment Committee Audit Committee Remuneration and Nominations Committee Workforce and Organisational Development Committee **Sub Committees** Clinical Effectiveness Mortality Operational Group Safeguarding Patient and Staff Experience Health & Safety

Document Control	
Document Name	Quality and Safety Committee- Terms of Reference
File Name	**\\datamart1\Shared Files\Company Secretarial. Quality & Safety Committee\Terms of Reference**
Version/Revision Number	V2

Version Control		
Version Ref	**Amendment**	**Date Approved by Trust Board**
V2	1.1 Added authority and responsibility diagram 2.1 Purpose: Added four bullet points on purpose: 4.6 Replace *practical* with *practicable* *4.6 Replace Assistant Company Secretary taking minutes at committee* with *PA to Medical*	

	Director 4.7 Added that the Committee should undertake a review of its performance and effectiveness at mid and year-end Front Page-Added the Mortality Operational Group Added the Safeguarding and Freedom to Speak Up/Raising Concerns Policies	

Terms of Reference for the Quality & Safety Committee

1 Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Quality & Safety Committee, hereafter referred to within this document as the *Committee.*

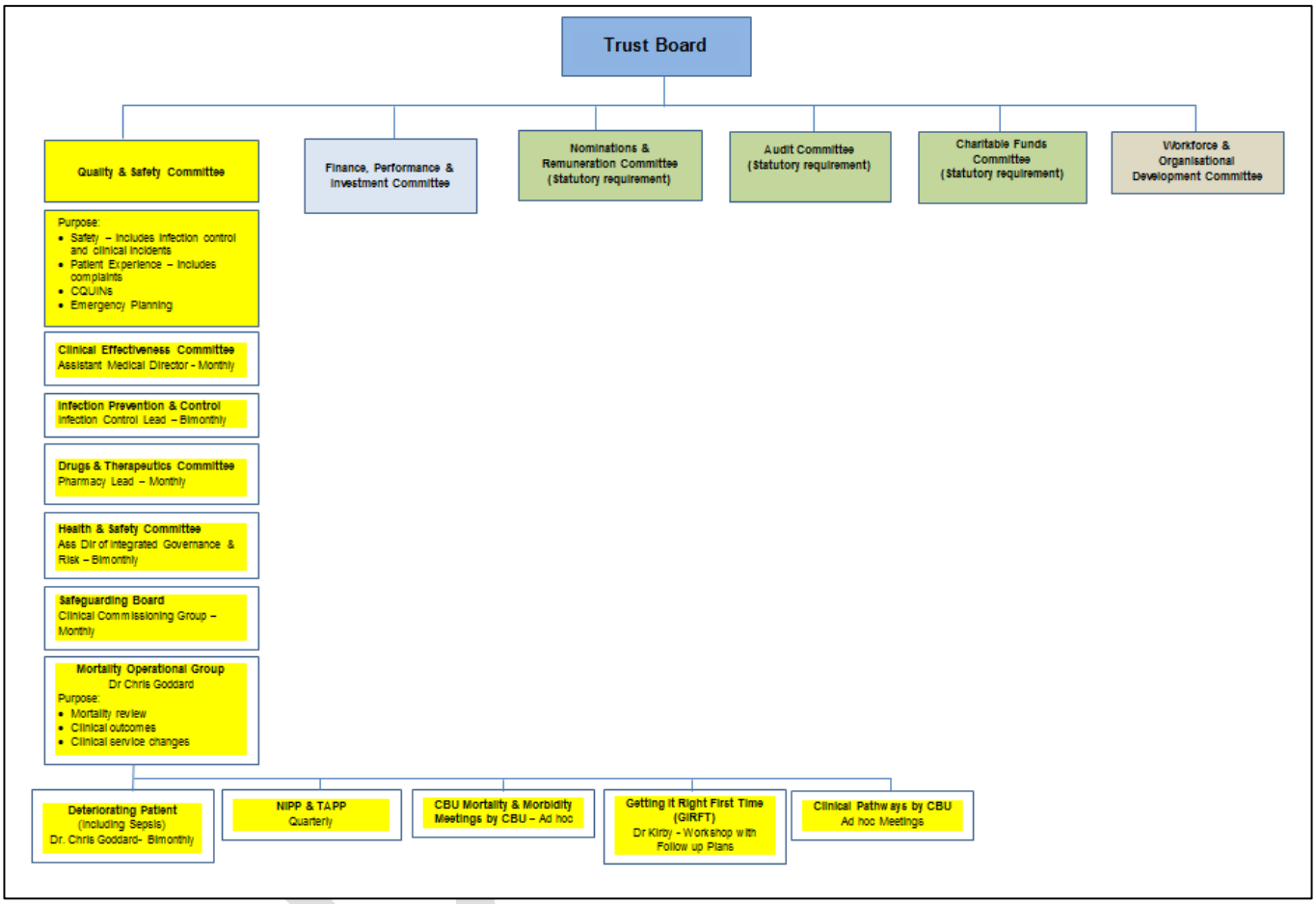


Diagram 1. The relationship between the Quality & Safety Committee, the Board and other Trust committees.

1.2 The Committee is established to provide assurance to the Trust Board on all aspects of quality and safety within the organisation. It has no executive powers other than those specifically delegated in these Terms of Reference. The Committee will operate as an oversight body recognising that the Executives are responsible for day to day operational delivery and management.

1.3 The Committee has the delegated authority to:

a) Seek any information it requires and/or call any employee of the Trust to a meeting of the Committee in order to perform the duties set out below.
b) Obtain, within the limits set out in the Trust's Scheme of Delegation, outside professional advice on any matter within its terms of reference.

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

1.5 The Committee will operate within the Trust's Standing Orders and Standing Financial Instructions.

2 Purpose

2.1 The overall responsibility for quality and safety rests with the Trust Board; however, the Committee will provide the Board with assurance regarding the effectiveness of all aspects of quality and safety, i.e. patient experience, safety and clinical outcomes.

2.2 The Committee will triangulate the available information and knowledge on patient safety, quality and clinical outcomes with operational, financial and workforce performance data in order to address areas of concern or deteriorating performance as required.

2.3 The Group will consider diversity, inclusion and human rights issues throughout its assurance agenda

3 Principal Duties

3.1 The main duties of the Committee are as follows:

- Seeking and providing assurance to the Board on quality and safety matters
- Reviewing the development and implementation of strategies and plans designed to improve quality and safety.
- Ensuring that lessons learned from incidents and events are widely publicised and actions embedded into working arrangements
- Overseeing the work of the sub-committees set up to manage:
  - Clinical Effectiveness
  - Mortality
  - Safety
  - Safeguarding
  - Patient Experience

3.2 Specific duties will include

a) Monitoring delivery of the priorities set out in the Quality Improvement Strategy.
b) Reviewing key performance indicators in order to monitor and evaluate clinical quality and performance within the Trust.

c) Reviewing the Trust Quality Accounts and recommending them for approval by the Board

d) Receiving assurance that appropriate action, included embedding learning, is taken in response to adverse clinical incidents, complaints and litigation.
e) Reviewing trends in complaints, serious incidents, claims and litigation.
f) Overseeing the development of a clinical audit plan and keeping implementation of the plan under review.
g) Recommending to the Audit Committee quality and safety matters that should feature in the annual programme of internal audit work.
h) Oversight of action required to improve mortality and morbidity
i) Monitoring the action taken to address issues arising in patient surveys
j) Ensuring that the Trust has robust arrangements in place to safeguard patients.
k) Ensuring the identification, management and control of clinical risk is robust and cohesive, taking action where necessary and alerting the Board to any areas of concern.

4 Constitution

4.1 Chair

The Committee will be chaired by a Non-Executive Director. In the absence of the Chair another Non-Executive Director member will be nominated in advance of the meeting to Chair it

4.2 Membership

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

- Three Non-Executive Directors, at least one of whom shall have a clinical background
- Director of Nursing and Midwifery
- Medical Director
- Associate Medical Director for Patient Safety
- Chief Operating Officer
- Associate Director of Human Resources & Communications

In attendance:

- Deputy Director of Nursing
- Deputy/Associate Medical Directors
- Company Secretary
- Assistant Director of Integrated Governance
- Patient Representative (from Quarter 3 of 2018/19)

Other Trust clinicians and managers may be invited to attend all or part of any meeting to discuss specific issues. All Board Members have a standing invitation to attend any Committee meeting.

To ensure that the Non-Executive Directors have the majority vote only the Director of Nursing and Quality, the Medical Director and the Chief Operating Officer will have a vote within the Quality & Safety Committee and then only to the extent that numbers match the number of NEDs present. The Chair of the Committee will have a casting vote.

Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting unless formal acting up status has been granted.

All members are required to attend at least 75% of meetings held.

4.3 Quorum

A quorum will be no less than three Members including two Non-Executive Directors (one of whom must be either the Chair of the Committee or the nominated Chair) and one Executive Director who must be either the Director of Nursing & Midwifery or the Medical Director.

In order for the decisions of the Committee to be valid the meeting must be quorate.

4.4 Frequency of meetings

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

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

4.5 Organisation and Reporting Structure

The minutes of Quality and Safety Committee meetings will be made available for escalation to the Board. The Chair of the Committee shall also draw to the attention of the Board significant matters arising at Committee meetings via an Assure, Alert and Advise (AAA) report.

The Committee will report to the Board at least annually on its work in support of the Quality Governance Framework self-certification and relevant Board Statements required by NHS Improvement and the Care Quality Commission.

The Committee will produce an annual work-plan/business cycle for the Board to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

4.6 Conduct of Meetings

The PA to the Medical Director (in their absence the PA to the Director of Nursing & Midwifery) shall provide administrative support to the meeting and duties 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

The agenda and papers for the meeting shall be distributed no less than four days in advance of the meeting.

The agenda for the meeting shall be drawn up by the Chair of the Committee in consultation with the Director of Nursing and Midwifery and Medical Director. Meetings are not open to members of the public.

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

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.

4.7 Review

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

4.8 Review of Performance and effectiveness

The Committee shall also undertake a review of its performance and effectiveness at mid-year and year-end.

Approved by:

Date of approval:

Date for review:

Southport and Ormskirk Hospital NHS Trust

MEETING	**Mortality Operational Group (MOG)**
ESTABLISHED BY /REPORTING TO:	Trust Board via the Quality and Safety Committee
AUTHOR:	Julie Gorry, Non-Executive Director & Chair of Quality and Safety Committee
REVIEWER:	Audley Charles, Interim Company Secretary
ASSOCIATED DOCUMENTS:	Trust Board Scheme of Reservation and Delegation Trust Board Standing Orders Quality Improvement Strategy Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED COMMITTEES/GROUPS/ WORKSTREAMS	Trust Board Quality & Safety Committee Audit Committee Finance, Performance and Investment Committee **Sub Committee** Mortality Operational Group • Clinical Coding • Clinical Pathways relating to high risks **Related Work streams**: Deteriorating Patient (including Sepsis) CBU Mortality & Morbidity Meetings by CBU Clinical Pathways by CBU

Document Control	
Document Name	Mortality Operational Group- Terms of Reference
File Name	
Version Number	**V1**

Version Control		
Version Ref	**Amendment**	**Date Approved by The Quality & Safety Committee**
V1	N/A	TBC

Terms of Reference for the

Mortality Operational Group (MOG)

1 Authority

1.1 The Quality & Safety Committee has established a sub-Committee to be known as the Mortality Operational Group, hereafter referred to within this document as the *Group.*

1.2 The Group has the delegated authority to:

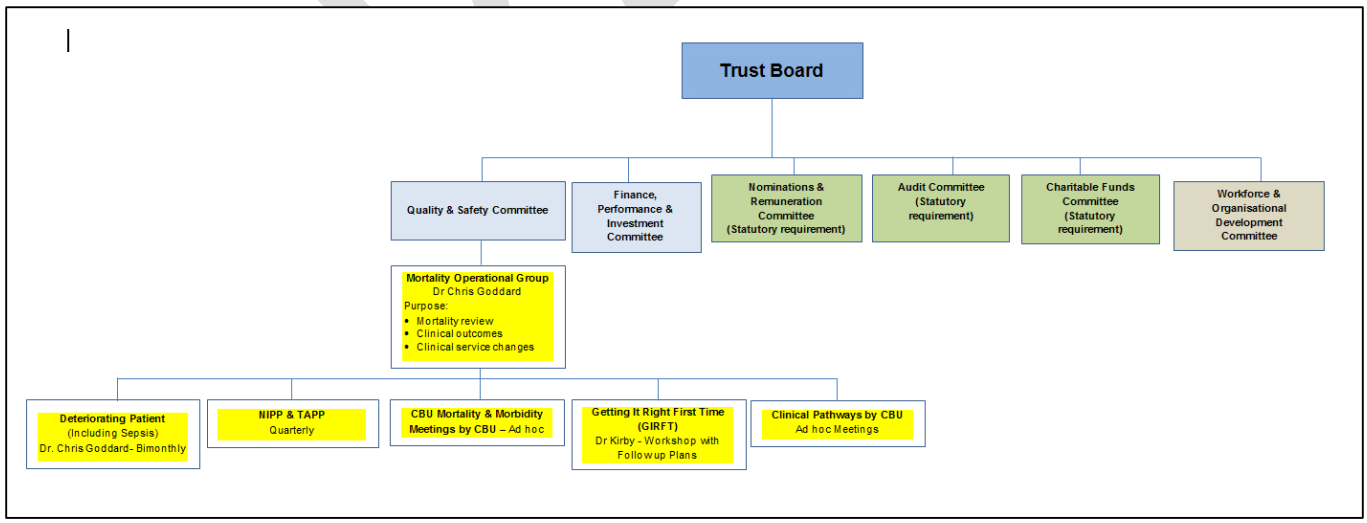
a) Seek any information it requires and/or call any employee of the Trust to a meeting of the Group in order to perform its duties as set out below.
b) Obtain, within the limits set out in the Trust's Scheme of Delegation, outside professional advice on any matter within its terms of reference.

1.3 The Group is a sub-committee of the Quality & Safety Committee and has no executive powers other than those specifically delegated in these Terms of Reference. The Group will operate at an operational level.

1.4 Any changes to these Terms of Reference must be approved by the Quality & Safety Committee and ratified by the Board of Directors.

1.5 The Group will operate within the Terms of Reference of the Quality & Safety Committee.

Diagram 1



2 Purpose

2.1 The overall responsibility for managing and monitoring mortality and patient safety care is the ultimate responsibility of the Trust Board; however, the Quality & Safety Committee has established the Group to provide it with assurance regarding the effectiveness of all aspects of mortality and morbidity at an operational level within the Trust.

2.2 The Group will triangulate mortality and morbidity with patient safety, quality and risk issues with workforce performance addressing areas of concern or deteriorating performance as required.

2.3 The Group will consider diversity, inclusion and human rights throughout its assurance agenda

3 Principal Duties

3.1 The duties of the Group can be categorised as follows:

- Reviewing mortality data
- Reviewing clinical outcomes
- Reviewing clinical service changes
- Seeking and providing assurance to the Quality & Safety Committee in respect of the effectiveness of the Trust's Risk Management arrangements in respect of mortality.
- Reviewing forecasts of future performance and lessons learned from deaths.

3.2 Specific Duties

a) Mortality process and reviews
b) 7 Day working
c) Coding
d) Clinical Pathways
e) Reviewing other key performance indicators in order to monitor and evaluate mortality performance within the trust
f) Making recommendations to the Quality and Safety Committee concerning the annual programme of internal audit work to the extent that it applies to matters within these terms of reference.

4 Constitution

4.1 Chair

The Group will be chaired by the Associate Medical Director for Patient Safety. In the absence of the Chair the Medical Director or their Deputy will be nominated to Chair the meeting in advance of the meeting.

4.2 Membership

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

- Associate Medical Director for Patient Safety (Chair)
- Medical Director
- Director of Nursing & Midwifery
- Deputy Medical Director
- Deputy Director of Nursing
- Associate Medical Director or Patient Safety Lead, Urgent Care
- Associate Medical Director or Patient Safety Lead, Planned Care

In attendance:

- Assistant Director of Integrated Governance
- Head of Audit and Effectiveness
- Assistant Head of Quality
- Head of Risk Management

- Guardian of Safe Working
- Freedom to Speak Up Guardian
- Chief Pharmacist
- Senior Information Analyst for Quality and Datix
- Head of Information
- Quality Information Lead
- Chair, Stroke Information Group
- Chair, Sepsis Task and Finish Group
- Chief Nurse
- Clinical Commissioning Groups Representative

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

Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting unless formal acting up status has been granted.

All members are required to attend at least 75% of meetings held.

4.3 Quorum

A quorum will be no less than three Members (one of whom must be either the Chair of the Group or the nominated Chair) and one Executive Director who must be either the Director of Nursing & Midwifery or the Medical Director. In the event of a tie, the Chair will have a casting vote.

In order for the decisions of the Group to be valid the meeting must be quorate.

4.4 Frequency of meetings

The Group will meet no less than ten times a year.
The Chair of the Group may arrange extraordinary meetings after consultation with the Medical Director or the Director of Nursing or both or at the request of Group members.

4.5 Organisation and Reporting Structure

The minutes of the Group meetings and an *Assure, Alert and Advise (AAAs)* report including minutes and highlighting key risks, shall be formally submitted to the Quality and Safety Committee. The Chair of the Group shall draw to the attention of the Committee any issues, including key risks that require disclosure to the full Committee, or require executive action.

The Group will report to the Committee after each meeting and annually on its work in support of the Mortality Agenda.

The Group will produce an annual work-plan or business cycle for the Quality and Safety Committee to approve at the beginning of each financial year, mapping out how the Group will fulfil its delegated duties.

4.6 Conduct of Meetings

The Personal Assistant to the Medical Director shall provide administrative support to the meeting. In their absence the Personal Assistant to the Director of Nursing and Midwifery will provide that support. Duties with include:

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

The agenda and papers for the meeting shall be distributed no less than five days in advance of the meeting.

The agenda for the meeting shall be drawn up by the Chair of the Group in consultation with the Medical Director.

Meetings are not open to members of the public.

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

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.

Group members may question the presenter.

4.7 Review of performance and effectiveness

The Group shall undertake a review of its performance and effectiveness at least twice annually, mid-year and at the end of the year.

4.8 Review

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

Approved by:

Date of approval:

Date of review:

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
7th February 2018

Agenda Item (Ref):	**TB034/18**	**Report Title:**	**Guardian of Safe Working Report to Board 21/10/17-23/01/18**
Executive Lead	**Acting Medical Director,** Dr Jugnu Mahajan		
Lead Officer	**Guardian of Safe Working,** Dr Ruth Chapman		
Action Required	☐ **Note** **Approve** ☐ **Assure**		

Key Messages of this Report & Recommendations:

Rota gaps and uncovered shifts particularly in Surgery and Paediatrics mean trainees are Double Bleep Carrying with potential safety implications expressed by all grades of doctor from Clinical Director to F1.

Despite an almost fully staffed physician work force, the overwhelming workload in Medicine has resulted in trainees working many extra hours and at times senior support has not been available.

Trainees are unable to attend teaching due to their patient workload. This is of significant concern with the next Health Education North West (HENW) inspection in March 2018

Poor trainee experience will have a negative effect on attracting trainees in the future

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

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

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

- ✓ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register:

(Please give reference no.) _____

☐ Service Change

✓ Best Practice

☐ Other List (Rationale) _____

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

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

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

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

Previously Presented at:

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

THE GUARDIAN OF SAFE WORKING
QUARTERLY TRUST REPORT
19th OCTOBER 2017 – 23rd January 2018

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 Exception reports generated by trainees and I disseminate an anonymised overview to the Assistant Medical Directors, Clinical Directors and trainees on a monthly basis.

1. E-EXCEPTION REPORT TRAINING

Education department have arranged more user friendly Exception Report training as part of induction and an extended time slot for Guardian of Safe Working (GOSW).

2. EXCEPTION REPORT OVERVIEW (20th October 2017- 23rd January 2018)

Exception Reports **95 (+2 duplication) by 15 trainees**
103 Episodes
88 Reports in Medicine
2 Reports in Orthopaedic
3 Reports in Surgery (+1 duplication)
2 Reports in Paediatrics
22/72 Completed on system

See Appendix 1 for Exception Report Breakdown

Each AMD and CD receives a monthly overview report.

There was a significant increase in Exception reports from 11/12/17 to 10/01/18. I have enclosed GOSW data from other Trusts in the Northwest for comparison. It is of concern that this increase has not been mirrored elsewhere. I feel this demonstrates the lack of capacity and resilience in the Medical Workforce at SOHT.

NW GOSW Exception Reports for last 30 days on 10/01/18

Southport and Ormskirk	54 (+1 duplication)
NW Boroughs	0
Penine Care	2
Lancashire Care	2

Countess of Chester	16
Wirral	33
Cumbria Partnership	0
Aintree	36
Greater Manchester Mental Health	2
Blackpool	38
Warrington	27
Cheshire and Wirral Partnership	1
Tameside and Glossop	2
St Helens and Knowsley	4
Liverpool and Broadgreen	23 (in December)
Manchester University	38
East Cheshire	2
Liverpool Womens	3

50 of the Exception Reports were raised in Medicine. Dr McDonald and Dr Ahmed are looking at any interventions that could help within the finite medical capacity at their disposal in the short term. Employment of Physicians' Assistants should help reduce the ward workload when they take up post, but employment of more Medical staff is the only long term solution.

Action: ***EMD to work with AMD and CD for Medicine and DME on planning for trainee experience longer term***

Meetings between trainees and Clinical Supervisors were been occurring in a more timely manner until the week before Christmas. However since then workload pressures have made it difficult for Supervisors and trainees to meet. Sign off of completed episodes by trainees is not happening when TOIL cannot be taken. Due to Clinical pressures TOIL has not been practical in recent weeks. GOSW guidance has changed the advice to Clinical Supervisors to Payment unless there is a realistic chance of TOIL being taken within 2 weeks of the review meeting. TOIL from 2017 that was not taken by 14th January 2018 will also convert to Payment. Steve Shanahan is aware of the situation.

Action: ***GOSW to monitor Clinical situation and revert to TOIL as the default as soon as possible***

3. PAYMENT

In January the Finance Department set up tabs which identify payment made as a result of Exception reports and GOSW fines. These will be identified separately on trainee pay slips. It should be possible to present these totals to Board in the May GOSW report.

Action: ***GOSW to present Exception and Fine costs at the May Board Meeting***

4. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

During December and January a significant number of shifts were left unfilled, particularly in Surgery. All levels of Medical staff expressed concern with regards to patient safety when a single doctor was covering 2 doctors work. A GOSW – the Way Forward Meeting was convened by the GOSW. It was agreed that CDs and AMDs would be given data about unfilled shifts a week ahead. This will allow CD/AMDs to make decisions about which unfilled shifts will need covering to ensure patient safety. If shifts cannot not be staffed, the week lead time allows contingency arrangements including, as a last resort, closing the hospital to admissions, to be put in place.

Action: ***EMD to formalise a SOP.***

5. GOSW Fine

It was thought it would be necessary to raise a GOSW fine against the Trust after a trainee worked in excess of 72 hours in a 7 calendar day period. However the last 2 night shifts were contracted through an external agency and was trainee choice, therefore no fine is necessary. The GOSW has reservations about trainees working excessive hours because of safety concerns.

Action: ***GOSW, Interim EMD and HR to agree in-house locum arrangements and write a policy.***

6. DOCTORS NOT ON THE NEW CONTRACT

Medical Staffing identified the 24 doctors not on 2016 contract.

Action: ***Any concerns about safe working from non-trainee doctors will be investigated by GOSW.***

7. DOUBLE/TRIPLE BLEEP CARRYING

This practice has patient safety implications as well as causing significant stress to any trainees involved.

There is a particular concern in Paediatrics; the trainees are finding on half of their shifts, one doctor has to carry the bleep for both children's ward and the neonatal ward. These wards are 3 floors apart and therefore very difficult to manage when emergencies occur.

Prior to December no episodes of double bleep carrying were identified. Unfilled shifts over the Christmas period resulted in double bleep carrying occurring in Surgery and Medicine on a number of occasions.

Action: ***GOSW has and will continue to forward all instances of double bleep carrying to EMD.***

8. VACANCIES (as of 11th January 2018)
See Appendix 2

9. PREDICTED VACANCIES FOR 1ST FEBRUARY 2018
See Appendix 3

10. TRAINEE CONCERNS

The Trainee Doctor Forum continues to meet monthly. The first meeting in Ormskirk was held on 11th January. Trainee attendance remains low. Trainees did not think an alternative day or time would increase attendance. Clinical pressures are given as the main cause of non-attendance. Although TDF time is protected there is no one else to do the trainees' work whilst they are away from their clinical duties.

On a positive note trainees are regularly submitting Exception reports and emailing their concerns to the GOSW.

9.1 Medicine

Winter pressures have resulted in excessive workloads for all physicians from trainee to consultant.

Medical trainees have expressed dissatisfaction with missing clinics and teaching because they cannot be spared from work on the wards. This is of concern because HENW are re-inspecting in March 2018. In line with National Guidelines, the DME is now in charge of reviewing all Education Exception Reports.

Trainees are experiencing difficulty in taking leave even when it has been requested 12 weeks in advance.

There are relatively few rota gaps however the evidence suggests there are not enough medical staff to look after all the patients. There are no plans for the Deanery to allocate more trainees to SOHT. One solution would be to try and recruit more permanent medical staff and reduce trainee work load with para- medical staff.

ACTION: EMD and AMD for medicine to determine safe medical staffing levels for each ward following the principles of safe nurse staffing.

ACTION: EMD and AMD to conduct a Clinical Activity review to ensure safe medical staffing on wards is a priority.
ACTION: DME and AMD to at how attendance at teaching and clinics could be protected such as looking at taking doctors out of clinical activity assessments during dedicated training time

9.2 Surgery

The main cause of problems in Surgery is unfilled shifts leading to double bleep carrying and the resulting safety concerns. The CD has issued clear guidelines about what he considers a safe level of staffing and is now being given detailed advance information about rota gaps.

ACTION*: EMD and GOSW to monitor situation*

9.3 Paediatrics

See previous information on double bleep carrying. Due to rota gaps in Paediatrics trainees are not able to attend teaching sessions. HENW have a particular focus on Paediatrics and could remove trainees if the inspection team feel training is inadequate.

Senior support for Neonatal Life Support during first shifts is still inconsistent.

Action: ***DME and CD to look at how attendance at teaching can be protected such as taking trainees out of clinical activity assessments during training periods***
Action: GOSW has fed back to DME and Paediatric CD about NLS senior support and extra initial support is being organised. GOSW will monitor at next changeover on 1st April 2018

11. ADDITIONAL GOSW CONCERNS

Very poor morale across trainees in all departments is a significant cause of concern, particularly looking forward to recruiting for next year and the future. Contributing factors are excess work load exacerbated by rota gaps and unfilled shifts, difficulty in taking holidays, impact on education opportunities, poor facilities and problems with payment. Many trainees feel undervalued and Southport and Ormskirk NHS Trust is not considered a good place to work.

Action: ***Workforce Committee role is expanded to look at any improvements which could be made***

12. DOCTORS IN DIFFICULTIES

One trainee has re-joined the on call rota and is managing after significant support by her Supervisor. The other trainee returned from sick leave and rotated to a new department where the trainee is being closely monitored. Neither situation is considered to be due to working conditions.

Action: ***GOSW, EMD and DME to monitor situation.***

13. ID BADGES

Task and finish group has been set up to ensure smooth induction.

Action: ***GOSW to check whether there were any issues for new starters in February***

14. LOCAL INDUCTION

Unfortunately time constraints mean this has not been progressed.

Action: ***HR, DME and GOSW to consider possible solutions.***

15. GOSW ROLE

Time allocation of 1 PA is inadequate at present. Extra administration support of 4 hours was agreed. Unfortunately due to Medical Staffing issues this was only provided for 5 weeks over the last 6 months. The EMD has sanctioned additional hours on a monthly basis, this has averaged an additional 4hours/week.

Action: ***Medical Staffing to organise administrative support.***
Action: ***EMD to review extra hours on a monthly basis.***

Dr Ruth Chapman
Guardian of Safe Working
24th January 2018

Appendix1
Exception Episodes

Medicine
103 Episodes
76 Extra Hours Episodes (includes x 8 Breaks missed)
17 Training Episodes
6 Service Support
1 Not an Exception

Extra Hours
18/76 Episodes Completed
36/76 Episode interviews have taken place
23/76 Episode Interviews within 7 days (33 not yet outstanding)
17/40 Awaiting trainee sign off
35.75 Extra hours worked
24.25 hours TOIL agreed
7.75 hours Overtime pay agreed
3.25 No TOIL or Payment (trainee request)
20 Episodes outstanding
0-68 days outstanding

Training
4/19 Episodes Completed
13/19 Episode interviews have taken place
5/13 Episode Interviews within 7 days
7/13 Awaiting trainee sign off
1 Outstanding (5 submitted within last 7 days)
0-63 days outstanding

Service Support
0/6 Episodes Completed
1/6 Episode interviews have taken place
1/6 Episode Interviews within 7 days
1/1 Awaiting trainee sign off
0 Outstanding (5 submitted within last 7 days)

NE
0/1 Episodes Completed
1/1 Episode interviews have taken place
1/1 Episode Interviews within 7 days
1/1 Awaiting trainee sign off
0 outstanding

Orthopaedics
3 Episodes
1 Extra Hours Episode
2 Service Support

Extra Hours
1/1 Episodes Completed
1/1 Episode interviews have taken place

0/1 Episode Interviews within 7 days
0 Awaiting trainee sign off
0.75 Extra hours worked
0.00 hours TOIL agreed
0.00 hours Overtime pay agreed
0 Episodes outstanding

Service Support
1/2 Episodes Completed
1/2 Episode interviews have taken place
0/2 Episode Interviews within 7 days
0 Awaiting trainee sign off
1 Episodes outstanding
6 days outstanding

Surgery
3 Episodes (+2 Duplications)
1 Education
2 Service Support

Education
1/1 Episodes Completed
1/1 Episode interviews have taken place
1/1 Episode Interviews within 7 days
0/1 Awaiting trainee sign off
0 Episodes outstanding -
0 days outstanding

Service Support
0/2 Episodes Completed
2/2 Episode interviews have taken place
2/2 Episode Interviews within 7 days
2/2 Awaiting trainee sign off
0 Episodes outstanding
0 days outstanding

Paediatrics
2 Episodes
2 Extra Hours

Extra hours
0/2 Episodes completed
0/2 Episode interviews have taken place
0/2 Episode Interviews within 7 days
2/2 Awaiting trainee sign off
2 Episodes outstanding
5 days outstanding

Appendix 2 VACANCIES (as of 11th January 2018)

General Surgery

Consultant	0 vacancies in 6 person rota
Second tier (registrar/middle grade)	3 vacancies in 8 person rota (1 l long term locum) (2 awaiting employment checks)
First tier (SHO/CT/FY2)	4 vacancies in 8 person rota - includes 2 Psych and 1 urology CTs (1 longterm locums)
Foundation Year 1	0 vacancies in 3 person rota (1 vacancy in psychiatry involved in on call rota)

No Advanced Nurse Practitioners (ANP)

Urology

Consultant (shared with Whiston)	0 vacancies in 9 person rota
4 SAS and 1 ST	0 vacancies in 5 person rota

Orthopaedics

Consultant	0 vacancies in 7 person rota
Second tier (registrar/middle grade)	0 vacancies in 8 person rota
First tier (SHO/CT/FY2)	4 vacancies in 8 person rota (3 long term locum)
Foundation Year 1	0 vacancies in 3 person rota (1 vacancy in psychiatry involved in on call rota)

No Advanced Nurse Practitioners (ANP)

AED

Consultant	5 vacancies in 9.98 funded (3.5 long-term locums) (1 Sick) (1 restricted duties)
SAS doctors	1.1 vacancy in 10.6 person funded (1 long term sick)
ST3 and above	2 vacancy in 5 person funded
FY2	1 vacancies in 5 funded
GPVTS	2 vacancy in 4 funded
Clinical fellow	3.5 vacancies in 3.5 funded
FY1	0 vacancies in 2 funded

Paediatrics

Consultant	1 vacancy in 6 person rota
Second tier (registrar/middle grade)	0.25 vacancies in 8 person rota

First tier (SHO/CT/FY2)	4 vacancies in 8 person rota
ANP	0 vacancies 3 funded

Obstetrics and Gynaecology

Consultant	0 vacancies in 8 person rota
Second tier (registrar/SAS)	4.8 vacancies in 6 person rota **1 whole time equivalent long term locum working 9-5-no on calls**
First tier (SHO/CT/FY2)	0 vacancies in 8 person rota **9 people on rota - extra Dr to support middle grade vacancy.**

Anaesthetics

Consultant	5 vacancies on a 18.5 person rota
Second tier (registrar/middle grade)	4 vacancies on 16 person rota
First tier (CT)	0 vacancies in a 10.2 person rota

Medicine

Consultant	2 vacancies in 11 person rota (currently filled by Bank Staff)
Second tier (registrar/SAS)	1 vacancies 11 person rota (1 covered by long term locums)
First tier (SHO/CT/FY2)	0 vacancies in a 15 person rota
Foundation Year 1	1 vacancies in 12 person rota (1 awaiting pre-employment checks)

Ophthalmology

Consultant	1 vacancies in 3 person rota
5.6 SAS and 1 ST	0 vacancies in 6.6 person rota

Appendix 3 PREDICTED VACANCIES FOR 1ST FEBRUARY 2018

General Surgery

Consultant	0 vacancies in 6 person rota
Second tier (registrar/middle grade)	3 vacancies in 8 person rota (1 l long term locum) (2 awaiting employment checks)
First tier (SHO/CT/FY2)	4 vacancies in 8 person rota - includes 2 Psych and 1 urology CTs (1 longterm locums)
Foundation Year 1	0 vacancies in 3 person rota (1 vacancy in psychiatry involved in on call rota)

Urology

Consultant (shared with Whiston)	0 vacancies in 9 person rota
4 SAS and 1 ST	0 vacancies in 5 person rota

Orthopaedics

Consultant	0 vacancies in 7 person rota
Second tier (registrar/middle grade)	0 vacancies in 8 person rota
First tier (SHO/CT/FY2)	6 vacancies in 8 person rota (1 long term locum)
Foundation Year 1	0 vacancies in 3 person rota

AED

Consultant	5 vacancies in 9.98 funded (3.5 long-term locums) (1 Sick) (1 restricted duties)
SAS doctors	1.1 vacancy in 10.6 person funded (1 long term sick)
ST3 and above	2 vacancy in 5 person funded
FY2	1 vacancies in 5 funded
GPVTS	2 vacancy in 4 funded
Clinical fellow	3.5 vacancies in 3.5 funded
FY1	0 vacancies in 2 funded

Paediatrics

Consultant	1 vacancy in 6 person rota
Second tier (registrar/middle grade)	0.25 vacancies in 8 person rota
First tier (SHO/CT/FY2)	3 vacancies in 8 person rota
ANP	0 vacancies 3 funded

Obstetrics and Gynaecology

Consultant	0 vacancies in 8 person rota
Second tier (registrar/SAS)	4.2 vacancies in 6 person rota
First tier (SHO/CT/FY2)	0 vacancies in 8 person rota

Anaesthetics

Consultant	5 vacancies on a 18.5 person rota
Second tier (registrar/middle grade)	4 vacancies on 16 person rota
First tier (CT)	0 vacancies in a 10.2 person rota

Medicine

Consultant	2 vacancies in 11 person rota (currently filled by Bank Staff)
Second tier (registrar/SAS)	1 vacancies 11 person rota (1 covered by long term locums)
First tier (SHO/CT/FY2)	1 vacancies in a 15 person rota
Foundation Year 1	1 vacancies in 12 person rota (1 awaiting pre-employment checks)

Ophthalmology

Consultant	1 vacancies in 3 person rota
5.6 SAS and 1 ST	0 vacancies in 6.6 person rota

GOSW 1st November Trust Board Report Action Log

Matters Arising Action Log

February, 2018

Southport and Ormskirk Hospital NHS Trust

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Owner	Original Deadline	Forecast Completion	Status Outcomes	Status
GOSW Nov Trust Board Report	Nov-17	**Exception Report training**	**GOSW to ensure more user-friendly e-Exception reporting training as part of Induction August 2018.**	GOSW	Aug-18	Aug-18		GREEN
GOSW Nov Trust Board Report	Nov-17	**Report Completion**	**GOSW to monitor to see if additional training improves timely completion of Reports.**	GOSW	Feb-18	ongoing	**Report completion was occurring in a more timely manner until Winter pressures affected performance since 20/12/17**	AMBER
GOSW Nov Trust Board Report	Nov-17	**Payment System for Exception Reports and Fines**	**GOSW, HR and Finance to organise a suitable system.**	Fianance, GOSW	Dec-18	May-18	**System set up in January. No payments made as yet**	AMBER
GOSW Nov Trust Board Report	Nov-17	**In-house Locum Arrangements policy**	**GOSW, Interim EMD and HR to agree in-house locum arrangements and write a policy**	GOSW/EMD	Dec-18	Mar-18	**Lack of interim EMD availability has prevented progress**	RED
GOSW Nov Trust Board Report	Nov-17	**List of doctors not on 2016 Contract**	***GOSW to identify trainee doctors not on 2016 contract with Medical Staffing input and ensure 2016 Terms and Conditions are in place.***	GOSW	Dec-17	Mar-18	**24 Doctors identified last week. All on standard pre- 2016 contracts**	GREEN
GOSW Nov Trust Board Report	Nov-17	**Safety concerns from non 2016 contract doctors**	Any concerns about safe working from doctors not on 2016 contract will be investigated by GOSW.	GOSW	Ongoing	ongoing	**No concerns reported to GOSW but needs specfic investigation**	AMBER
GOSW Nov Trust Board Report	Nov-17	**Double Bleep Carrying**	GOSW to email trainees in November about this specific issue before FY2 rotation occurs.	EMD/GOSW	Nov-18	ongoing	**Email sent. Trainees are emailing GOSW with multiple episodes of Double Bleep carrying, particularly in Surgery and Paediatrics. Escalated to EMD**	RED
GOSW Nov Trust Board Report	Nov-17	**Trainee Doctor Forum Attendance**	GOSW has contacted trainees by email to find out if an alternative day and time would make attendance easier – awaiting feedback.	GOSW	Dec-17	Dec-17	**GOSW emailed trainees - no alternative time or day would be better**	BLUE
GOSW Nov Trust Board Report	Nov-17	**Contact OSMs re TDF is protected time**	GOSW has contacted OSMs and DMs to ensure that they are aware this is protected time for trainees.	GOSW	Dec-17	Dec-17	**GOSW emailed all OSMs**	BLUE
GOSW Nov Trust Board Report	Nov-17	**LNC reps attendance at TDF**	GOSW has contacted LNC Chair to find out who the trainee LNC representatives are.	GOSW	Nov-17	Nov-17	**At least 1 LNC representative has attended TDF in Nov, Dec and Jan**	GREEN
GOSW Nov Trust Board Report	Nov-17	**Trainees missing training in clinics due to ward workload**	DME now has access to Exception Report Dashboard	DME	Dec-17	Ongoing	**Excess workload still preventing trainees attending training opportunities**	RED
GOSW Nov Trust Board Report	Nov-17	**Surgery Daytime on call**	GOSW explained to trainees that there is no safety issue with trainees carrying Daytime Bleep more frequently. If this affects training Opportunities or results in extra hours worked, Exception reports should be raised.	GOSW	Nov-17	Nov-17	**Trainees carrying daytime bleeps more frequently**	BLUE
GOSW Nov Trust Board Report	Nov-17	**Doctors in Difficulties**	Monitoring and support have been given	GOSW/EMD/DME	N0v-17	Jan-18	**Both trainees working normally with close supervision**	GREEN
GOSW Nov Trust Board Report	Nov-17	**ID Badges**	Task and finish group to ensure ID badges will be available and working	EMD/HR	Jan-18	Ongoing	**New trainees start in Feb 18. As yet no guarantee that all IT necessary is in place**	AMBER
GOSW Nov Trust Board Report	Nov-17	**Local Induction**	DME/EMD and GOSW to look at how trainees can attend local inductionwhilst service delivery occurs	DME/EMD/GOSW	Jun-18	Jun-18	**Due to staff turnover no meeting has yet occurred**	AMBER
GOSW Nov Trust Board Report	GOSW Nov Trust Board Report	**GOSW Admin support**	HR to provide 4 hours a week admin support	HR	Nov-17	Feb-18	**Due to Medical staffing turnover, GOSW has only had 5 weeks admin support over last 6 months. However new admin support started last week**	RED
GOSW Nov Trust Board Report	Nov-17	**GOSW extra hours reviewed by interim EMDs and payment made**	Extra hours reviewed by interim EMDs and actioned for payment	EMD/Finance	Feb-18	May-18	**Average 4 hours/week extra worked to GOSW at normal rate. Not paid for Nov and Dec**	AMBER

HIGHLIGHT REPORT

Committee/Group Meeting date:	Finance, Performance & Investment Committee 29 January 2018
Lead:	Jim Birrell, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- The ongoing contractual disputes continue with the two local CCGs, despite the input of both NHSI and NHS England. The Committee felt there needed to be further high level engagement between the local organisations and the regulators.
- A review of medical job plans has highlighted a number of instances where consultants may have been overpaid. Unfortunately little progress has been made on resolving the matter so the advice of auditors will be sought.
- The Committee were notified of a "never event" that occurred in November. Concern was expressed that the matter was similar to an event that occurred approximately twelve months ago and that the latest incident had not been drawn to the attention of Board members sooner.
- Emergency care continues to present significant challenges to the Trust, despite great efforts from clinicians and support staff. The availability of winter pressures funding should help in the short term although the Committee were made aware of proposed changes to ambulance handover arrangements that could exacerbate an already difficult situation.
- The Trust continues to face challenges in placing all stroke patients on the Stroke Unit and holding timely TIA clinics. The Committee supported the ringfencing of stroke beds and the removal of beds from the planned rehabilitation unit as two ways in which the service could be improved.

ADVISE

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

- The focus on the in-year financial position has inevitably impacted on the capacity to develop a longer term financial plan. Discussions will take place outside the meeting on how to progress this matter.
- The Committee welcomed the presence of the Turnaround Team and supported their planned work programme. It was noted that the process is proving to be time intensive with most of the demands falling on already hard-

pressed staff. The Committee expressed the view that the importance of the work programme means that additional resources should be employed if necessary.

- National Business Planning Guidelines have not as yet been issued, which is likely to mean reduced time for assimilating the content, contract negotiation, budget preparation etc.
- The content of the Board Assurance Framework risks monitored by FP&I has improved and further information will be included in future iterations.
- The Trust's Reference Costs Index has increased to 111 and the Committee asked that this be looked at alongside Service Level Costing output and the Model Hospital benchmarking data in order to give the Committee a more rounded view on specialty costs within the organisation.

ASSURE

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

- The "deep dive" into Trauma & Orthopaedics has highlighted some potential productivity and efficiency improvements, which will be progressed with the relevant clinicians and managers.
- The Trust has recently started using a medical bank service, which has been helpful in reducing rota gaps.

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

Review of the Risk Register

The Committee agreed with the revised risk ratings reported to the meeting.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 February 2018

Agenda Item	**TB037/18**	**Report Title**	**Emergency Care Performance Report**
Executive Lead	**Therese Patten,** Chief Operating Officer		
Lead Officer	**Jacqui Flynn,** Assistant Director of Operations		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve X To Assure		☐ To Note ☐ For Information

Key Messages and Recommendations

This paper outlines the areas that impact on the Trust's ability to meet the A&E four-hour target. It focuses on:

1. Attendances
2. A&E performance
   a. by site and triage stream
   b. breach reason
   c. performance comparison with other regional trusts
3. Admissions
   a. Emergency admissions from A&E
   b. Medical outliers
   c. Average daily discharges
   d. Average length of stay
4. Discharges
   a. Stranded patients
   b. Medically optimised for discharge
   c. Delayed transfers of care
5. The urgent care action plan

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

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

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

X Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register:
(Please give reference no.)

_____

☐ Service Change
☐ Best Practice
☐ Other List (Rationale)

_____

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

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

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

Previously Presented at:

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

Emergency Care Performance Report

Factors Influencing Delivery of the 4 hour Access Target

Introduction

This paper outlines the areas that impact on the Trust's ability to meet the A&E four hour target. It focuses on:

I. Attendances
II. A&E performance
    a. by site and triage stream
    b. breach reason
    c. performance comparison with other regional trusts
III. Admissions
    a. Emergency admissions from A&E
    b. Medical outliers
    c. Average daily discharges
    d. Average length of stay
IV. Discharges
    a. Stranded patients
    b. Medically optimised for discharge
    c. Delayed transfers of care
V. The urgent care action plan

1 Attendances

Table 1 below denotes the level of attendances, Ambulance Arrivals and Conversion rate from January 2017 – December 2017 for both sites; Ormskirk site reflects paediatric only.

At Southport, the average attendance per month remains steady at around 1509 per month. The conversation rate although peaking at just above 36% in quarter 1, is on average 32% which is 3% lower than previous years.

Table 1

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
SDGH												
A&E Total Attendances	4,016	3,672	4,129	4,073	4,396	4,211	4,537	4,374	4,137	4,401	4,146	4,057
A&E Ambulance Arrivals	1,535	1,410	1,520	1,484	1,545	1,440	1,606	1,492	1,425	1,533	1,522	1,590
Admissions Via A&E	1,455	1,287	1,499	1,451	1,530	1,513	1,430	1,418	1,378	1,376	1,307	1,315
conversion rate	36.2%	35.0%	36.3%	35.6%	34.8%	35.9%	31.5%	32.4%	33.3%	31.3%	31.5%	32.4%
ODGH												
A&E Total Attendances	2,144	2,149	2,545	2,208	2,483	2,311	2,335	1,769	2,193	2,675	2,584	2,302
A&E Ambulance Arrivals	130	132	175	134	147	122	141	125	135	173	176	134
Admissions Via A&E	358	350	405	328	373	321	318	261	382	482	484	389
conversion rate	16.7%	16.3%	15.9%	14.9%	15.0%	13.9%	13.6%	14.8%	17.4%	18.0%	18.7%	16.9%

2 A&E performance

Performance on the Southport site continues to be challenged. The ED estate has been noted as being inadequate to meet demand, particularly given the case mix shift that has seen an increase in major category patients (some weeks have seen an average of 80% of attendances triaged as major category). Combined with this is the challenge of egress from the wards partly due to a steady increase in DTOC and the stranded patients. The Table below shows the split between majors and minors across both sites, there are no issues with the paediatric ED service on the Ormskirk Site, and generally on the Southport site with the exception of the winter months we are able to deliver 95.5% within our minors' stream. During winter because of overcrowding in the department the majors' patients spill out into the minors' area.

Table 2

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ODGH	**99.8%**	**96.8%**	**99.5%**	**97.3%**	**99.0%**	**97.6%**	**99.6%**	**97.5%**	**99.0%**	**95.6%**	**97.8%**	**95.0%**
Majors	99.4%	99.4%	98.4%	98.3%	99.0%	99.6%	98.7%	100.0%	100.0%	98.3%	96.7%	96.0%
Minors	99.8%	99.7%	99.5%	99.8%	99.5%	99.8%	99.7%	99.6%	99.2%	97.7%	97.5%	98.8%
SDGH	**79.0%**	**56.7%**	**69.6%**	**74.5%**	**73.9%**	**84.9%**	**77.7%**	**85.2%**	**58.9%**	**68.3%**	**62.9%**	**63.1%**
Majors	60.6%	57.0%	57.4%	69.9%	72.2%	70.5%	65.6%	68.9%	56.9%	57.3%	43.2%	42.6%
Minors	94.9%	95.8%	93.2%	96.3%	95.5%	97.5%	94.9%	94.7%	94.4%	94.1%	87.9%	89.0%
SkWIC	**99.9%**	**100%**	**100%**	**100%**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
WLHP	**99.9%**	**99.7%**	**99.8%**	**99.9%**	**98.5%**	**99.6%**	**99.8%**	**100%**	**99.9%**	**99.8%**	**99.9%**	**99.4%**
Trust	**88.6%**	**88.0%**	**88.1%**	**91.2%**	**89.4%**	**90.3%**	**88.3%**	**88.4%**	**85.7%**	**85.5%**	**80.7%**	**80.3%**

3 12 Hour Breach reasons (SDGH)

For the first time the Trust has seen a significant rise in the 12 hour breaches , due to lack of flow out of the department the "Delayed by A&E due to capacity" is also bed related; there are no trolley spaces to review patients therefore they queue on ambulances in the corridors or in the waiting areas. The bid for capital monies to support much needed estate work would provide an increase in assessment capacity within ED, which will support some improvement in ED

4 Comparative performance

Southport Trust remains one of the most challenged urgent care systems across the patch although we are not the worst performing Trust in Merseyside and Cheshire. The population we serve coupled with an increase in the proportion of major category patients places great pressure on the emergency system not just within the Trust but across the health economy. There is also some inconsistency in activity from local walk in centres that are attributed to the 4-hour target in a number of Trusts. Southport has seen a reduction since May following the transfer of walk in centres.

Table 3

Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Aintree	79.3%	72.4%	89.9%	86.1%	78.8%	78.4%	80.8%	82.3%	84.5%	84.4%	86.6%	84.8%
Blackpool Teaching	84.7%	61.2%	86.6%	88.7%	85.0%	87.2%	83.3%	80.9%	83.9%	90.8%	84.6%	78.7%
Countess Of Chester	82.7%	86.5%	86.0%	87.6%	84.6%	88.1%	84.8%	86.0%	85.5%	85.8%	82.9%	75.8%
East Lancashire	75.3%	69.8%	82.4%	81.8%	83.4%	83.6%	78.6%	88.6%	88.6%	86.9%	81.6%	84.1%
Lancashire Teaching	82.6%	70.4%	83.6%	90.3%	89.4%	91.7%	88.8%	84.0%	84.1%	82.2%	84.7%	81.2%
Royal Liverpool	86.4%	66.2%	89.6%	90.9%	87.7%	90.2%	87.7%	90.6%	87.7%	90.4%	89.9%	89.1%
Southport And Ormskirk	88.6%	88.0%	88.1%	91.2%	89.4%	90.3%	88.3%	88.4%	85.7%	85.5%	80.7%	80.3%
St Helens And Knowsley	81.2%	74.1%	87.4%	88.9%	85.1%	86.6%	89.4%	90.5%	89.0%	88.1%	88.1%	85.5%
Warrington And Halton	85.9%	76.1%	90.7%	91.4%	92.8%	90.4%	92.8%	94.4%	90.9%	89.5%	87.5%	83.8%
Wrightington, Wigan And Leigh	76.6%	83.9%	87.9%	92.7%	90.7%	85.7%	89.4%	82.9%	85.8%	84.6%	73.1%	80.6%

5 Admissions

Admissions from the Emergency Department have seen a steady reduction for the last year. There has been an increase in senior decision makers within the department and an extension of Consultant Physician presence until 9:30pm Monday–Sunday. It has also contributed to the increase in length of stay within the department as the focus has been heavily on ensuring detailed assessment and actions to prevent admissions. Previously, short stay patients would have been admitted pending senior review. These reviews now take place within ED and consideration is given to alternative pathways, particularly ambulatory.

Table 4

Admissions	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ODGH	371	359	418	340	396	339	322	262	383	482	484	389
SDGH	1,442	1,278	1,486	1,439	1,507	1,495	1,426	1,417	1,377	1,372	1,297	1,226
Grand Total	**1,813**	**1,637**	**1,904**	**1,779**	**1,903**	**1,834**	**1,748**	**1,679**	**1,760**	**1,854**	**1,781**	**1,615**

6 Outliers

Outliers are monitored at each of the bed meetings held across the day, December saw a significant increase as the number of medical admissions increased. A discharge lounge has temporarily opened in the fracture clinic area however it is unfunded and currently staffed by outpatient nurses, freed due to the cancellation of clinics as per the national directive.

7 Daily Discharges

Maintaining discharges remains a challenge to ensure sufficient flow to meet admissions demand. During January a Multi-Agency Discharge Event was facilitated by the Emergency Care Improvement Team (ECIP) and NHSI. For a two week period there was onsite social and community support to try and address barriers for discharges. This did result in a significant improvement in patients discharged during the week and the system is now working on a high impact action to develop an integrated discharge team. However, there is still no commissioned discharge team at weekends and this capacity will need to be developed if we are to stop the pressures building over the weekend and into Monday morning.

8 Length of stay

Length of Stay has increased over the last 12 month period in both elective and non-elective pathways. There are a number of work streams that are being or have recently been established which will contribute to the reduction of LoS across all pathways and both sites and are included as part of the multi-agency High Impact Changes focusing on patient flow they include; SAFER, the implementation of a Surgical Assessment Unit which will support surgery in considering alternative pathways to admission, the opening of the Day-case Unit at Ormskirk on 15 February 2018 and the development of the Integrated Discharge Team which is being piloted at present.

Table 5 (Southport only)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
SDGH	**5.83**	**4.94**	**4.35**	**4.57**	**4.93**	**4.31**	**5.15**	**5.51**	**4.68**	**5.46**	**4.67**	**5.49**
Elective	4.87	3.84	2.80	3.77	4.38	2.83	4.23	4.33	3.23	4.18	3.20	5.76
Emergency	6.78	6.04	5.91	5.37	5.49	5.80	6.08	6.69	6.13	6.74	6.13	5.23
Grand Total	**5.83**	**4.94**	**4.35**	**4.57**	**4.93**	**4.31**	**5.15**	**5.51**	**4.68**	**5.46**	**4.67**	**5.49**

9 Stranded patients

Stranded patients are patients with a length of stay over 6 days. There has been a consistent increase since the start of the summer in the number of these patients within the hospital. There has been continued reliance on escalation usage to meet inpatient demand, despite a month on month reduction in admissions via ED, indicating that the issues are related to length of stay and acuity of admissions.

10 Medically optimised for discharge (MOfD) and Delayed Transfers of Care (TToC)

Medically Optimised

Patients recorded as Medically Optimised for Discharge (MoFD) has fluctuated, with a considerable reduction in January 18. This saw the start of the MADE reviews, with an MDT approach to reducing barriers to discharge – including increasing community bed provision and addressing funding constraints for placements. The number of MOfD patients equates to around a third of our Southport bed base. (January figures not yet based on this site)

Delayed Transfers of Care

The Trust historically had low numbers of patients identified as Delayed Transfer of Care. This has, however, seen a rising trend since August. From January 2018, with support from NHSI, MADE reviews have been implemented to support the identification of barriers to discharging patients and ensuring a full MDT approach with providers from across the health economy.

11 Actions to Improve Performance

The Trust is working with a number of partners to try and improve and embed improvement in flow. As previously mentioned Steve Christian (NHSI) has been on-site two days a week to support the Trust to embed evidenced improvement methodologies.

Ernst and Young have also been commissioned to support a flow improvement programme after having some success locally with Aintree and Wirral hospitals. The work has two phases:

1 Identify and Design: typically 6 weeks - 3 week evidence and observation based review and 3 week validation, action planning, implementation. The approach includes:

- Emergency trend analysis against comparable Trusts, including front door demand trends, ED efficiency (decision making timestamps) and Inpatient demand and efficiency
- Senior Advisor review of key clinical quality, governance and performance management structures such as Command, Beds meetings, escalation triggers
- Model of care review and challenge, including assessment of critical pathways, e.g. Front door streaming models

2 Deliver and Sustain: 18 weeks hands on delivery support. Targeted implementation support consists of:

- Structured design and implementation of workstreams to deliver prioritised improvement initiatives such as Frailty model, Ambulatory care, LoS and discharge improvements
- Emergency Operational/ Clinical Leadership –Review and leadership of 'Command' function (ED, Beds, escalation) and work with senior clinicians and managers to enact changes
- Targeted upskilling of senior operations/clinical management teams to develop internal 'Command' capacity and capability
- Readiness assessment –identification of capability and leadership needs at outset of support and reassessment at project close

The Trust has established a weekly Patient Flow Improvement Board chaired by the COO. The group has established three work streams with senior responsible officers and key actions for delivery.

1. ED processes – Dave Snow and Jacqui Flynn
2. Ambulatory care and assessment – Ashar Ahmed and Nicky Maudsley
3. Flow management – Paddy McDonald and Helen Baythorpe

In addition, due to the challenges faced by the Trust in late December, the regulators have established a Southport System Leaders Board which meets twice weekly. The meeting is chaired by NHS England and has senior representation from all commissioners and providers across the system. Immediate actions have been to introduce and Southport and Ormskirk System Winter Improvement Plan which has five high impact actions:

- To systematically implement the fundamental principles of the SAFER patient flow bundle (i.e. Red to Green) across all adult inpatient wards (acute / community)
- To develop, test and implement a 'system-wide' trusted assessor / professional model/mind set.
- To address the complexity in discharge management and a need to develop an SPA (system-wide) for supported discharge
- To improve the current operational process in managing patient flow at S&O and taking appropriate action at times of heightened escalation levels (trust and system-wide).
- To review the effectiveness of the Southport A&E Delivery Board Sub-Group.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

7 February 2018

Agenda Item	**TB038/18**	**Report Title**	**Integrated Performance Report**
Executive Lead	**Steve Shanahan,** Director of Finance		
Lead Officer	**Lee Threlfall,** Performance and Contracts Manager		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve X To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

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

Indicators within the Integrated Performance Report form part of the Trust's new performance management framework and are discussed with the relevant teams in monthly performance forum meetings.

The front sheet overleaf outlines the key items to note.

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

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

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

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

- **X** Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register:
  (Please give reference no.) _____
- ☐ Service Change

☐ Best Practice ☐ Other List (Rationale) _____	
Impact *(is there an impact arising from the report on the following?)*	
☐ Quality ☐ Finance ☐ Workforce ☐ Equality	☐ Risk ☐ Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee **X** Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

NHS Southport and Ormskirk Hospital NHS Trust

Executive Summary

Safe

			Total Indicators
4	1	3	8

		Month	Target	Trend	Planned	Urgent	Spec
●	TV - Hospital Acquired Pressure Sores - Grades 3-4	1	1	→			
○	Safety Thermometer - Percentage of Patients With Harm Free Care	98.48%	97.99%	↑	●	○	○
●	Realtime Staffing - Staffing against Minimum Compliance - Trust	89.1%	90%	↓	●	○	●

Effective

			Total Indicators
2	1	5	8

		Month	Target	Trend	Planned	Urgent	Spec
	Bed Days Post MOFD	841		↓			
○	DNA Rate - Overall - Trust	7.1%	8%	↑	○	○	○

Caring

			Total Indicators
1	0	2	3

		Month	Target	Trend	Planned	Urgent	Spec
●	Friends & Family - % That Would Recommend - Trust	86%	90%	↓	◉	◉	●
●	DSSA Breaches - Trust	15	1	↑	●		
○	Number of Complaints - Trust	27		↓			

Responsive

			Total Indicators
2	0	4	6

		Month	Target	Trend	Planned	Urgent	Spec
●	A&E - Total Time in A&E - 4 Hour % - Trust Overall	80.3%	94.99%	↓			
●	Diagnostics waiting time: percentage >= 6 weeks - All Tests	2.83%	1.01%	↓			

Well Led

			Total Indicators
5	2	3	10

		Month	Target	Trend	Planned	Urgent	Spec
●	HR - Sickness Absence Rate - Trust	5.83%	3.9%	↑	●	●	●
○	HR - Mandatory Training - Trust	85.96%	79.99%	↓	◉	○	
○	CIP Delivery - Actual	£321,000		↓			

Highlights:

Harm free care returned to compliance in month.

62 day cancer – trust has achieved the standard in month. Currently December looks like it will be compliant meaning the Trust is on track to deliver the quarter.

Mandatory training compliance remains above the threshold for the third consecutive month.

No reported falls with harm in month.

Reduction in the number of bed days used by patients who are medically fit for discharge.

Lowlights:

Activity – underperformance against activity plan and fewer referrals than in the previous December continue to pose challenges to Trust finances.
A&E
Length of stay
90% stroke ward stay continues to be challenging. Due to poor flow across Southport site we are challenged admitting patients within four hours. System-wide solution is being developed across the region
Mortality remains high and outside expected limits. New operational group, supported by AQuA, set up to drive improvements identified within the action plan
Sickness absence has deteriorated in December. A review of the sickness policy is underway

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - December 2017

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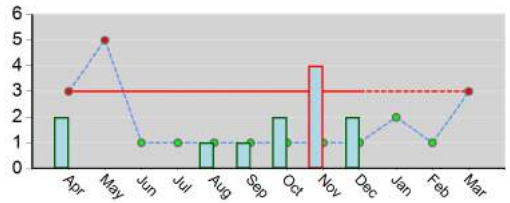
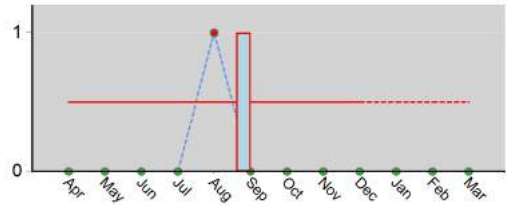
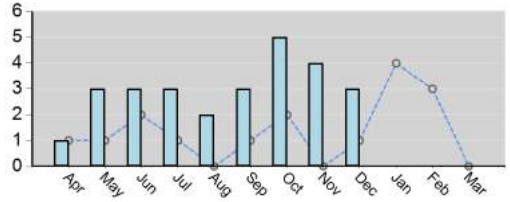
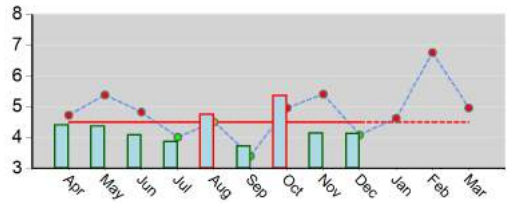
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
C-Diff	Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 36 for the year. Good performance is fewer than 36 for the year. Line = Last Financial Year Bar = This Financial Year	2 C diff cases in December, 1 on FESS and 1 on SSU. The first is eligible for appeal, the 2nd still needs an RCA and was treated initially for an E coli bacteraemia which may of put the patient at increased risk of C diff but treatment for sepsis was unavoidable. At the end of December the Trust was 15 cases under trajectory which doesn't take into account cases eligible for appeal.	Quality & Safety Committee	
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0. Line = Last Financial Year Bar = This Financial Year	No further bacteraemia since the single case in September.	Quality & Safety Committee	
E. Coli	Number of Escherichia coli (E. Coli) infections for patients aged 2 or more on the date the specimen was taken. Indicator is for monitoring purposes as no formal target has been finalised with the CCGs. Good performance is low. Line = Last Financial Year Bar = This Financial Year	The Trust had 3 hospital acquired E coli blood stream infections in December; in addition to this a further 18 cases were treated in the Trust, but were community acquired. The 3 cases were attributed to ITU, FESS and 11B. There is no specific target for this infection, however as a health economy this organism is being monitored and patients reviewed.	Quality & Safety Committee	
Falls	The number of falls within the hospital per 1,000 bed days. Threshold: 4.5 per 1000 bed days. Good performance is lower. Line = Last Financial Year Bar = This Financial Year	No falls reported where the harm level was either moderate, severe or resulted in death. A total of 44 falls were reported through DATIX for Dec' 17 all of which occurred within the Urgent Care CBU - 61% were reported as no harm or near miss, 39% were recorded as low harm. Urgent and Planned Care CBU have shared good practice and falls packs continue to be used to allow staff to access the appropriate resources /documentation/ information leaflets to support falls prevention. Within urgent care FRAP meetings continue to review patient falls with the aim of shared learning and developing best practice. Planned care continue to raise the profile of falls prevention through own CBU meetings and share a 'lessons learnt 'document within the CBU. At risk patients continue to be highlighted throughout safety huddles and the implementation of SAFECARE continues to support safe staffing levels in relation to patient acuity.	Quality & Safety Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - December 2017

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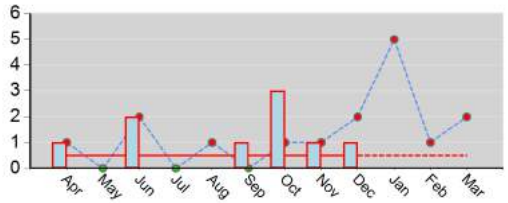
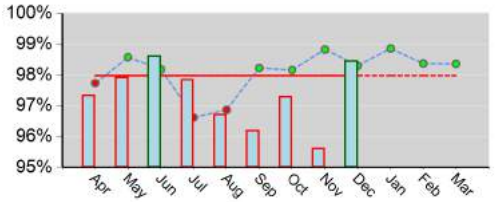
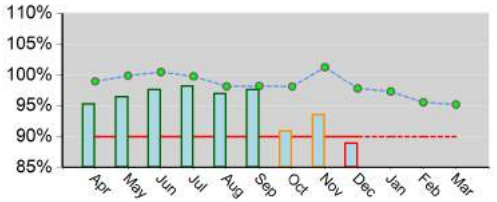
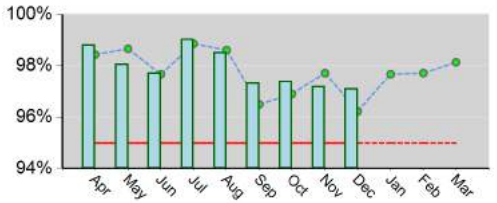
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Hospital Pressure Sores	Number of reported Trust acquired pressure sores graded between 3 and 4. Threshold: 0. Collaborative goal: Elimination of grade 3 and 4 pressure ulcers plus 25% reduction overall. Line = Last Financial Year Bar = This Financial Year	There was 1 grade 3 pressure sore in December on 15A. This Incident is due for review on Thursday 25th January.	Quality & Safety Committee	
Harm Free	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better. Line = Last Financial Year Bar = This Financial Year	Trust performance for December improved and exceeded the national standard of 95%. On the day of census (n=394 patients) there were 6 new harms attributed to the hospital which included 1 x grade 2 (14a) and 1 x grade 2 (NWRSIU) hospital acquired pressure ulcers, 4 falls (11a x 2, 10b x 1, FESS x 1) resulting in low harm to the patient. The remaining harm events related to patients receiving treatment for UTI since being admitted to hospital.	Quality & Safety Committee	
Safe Staffing	The ratio between the proposed number of nursing staff to ensure a safe staffing level and the actual number of nurses working those shifts. Threshold: 95%, Fail 90%. Line = Last Financial Year Bar = This Financial Year	Safe staffing not reported in month as achieved against National accepted level of 90% - Overall Trust fill rate has reduced against previous month - 91% to 89%. Planned Care 81.17% - reduced from previous month (91.67%) Urgent Care 95.18%. Women & Children's 89.41% reduced from previous month (98.43%). Safe staffing maintained across clinical areas supported by temporary workforce incl bank & additional hours worked by substantive staff & Agency block booking to specialist areas incl SIU, AED, Theatres & Critical Care with transparency of booking via NHSp portal. Staffing huddles mitigate risk areas daily & embedding of Health-Roster continues.	Quality & Safety Committee	
VTE (Venous thromboembolism)	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Compliance for VTE assessment remains above the threshold of 95%. The Trust proforma for assessment of VTE continues to be monitored using an audit approach which includes monthly point of prevalence surveys as part of the NHS Safety thermometer. It is also now part of the Southport and Ormskirk Clinical Accreditation Scheme in line with the CQC's Key Lines of Enquiry, of which non-compliance is reported as part of feedback which initiates an individualised area action.	Quality & Safety Committee	

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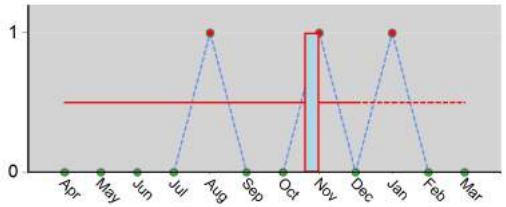
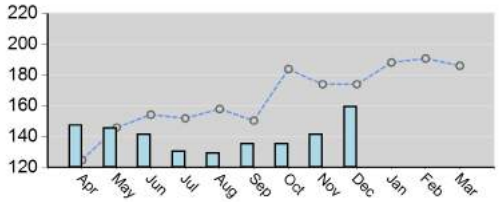
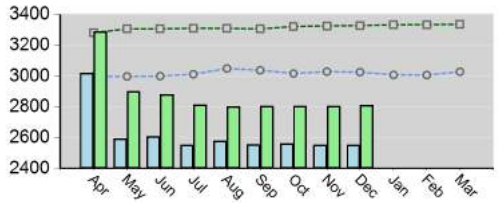
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death. Line = Last Financial Year Bar = This Financial Year	There were no Never Events reported in December.	Quality & Safety Committee	
Nursing vacancies	Number of nursing vacancies in month. Line = Last Financial Year Bar = This Financial Year	The number of nursing vacancies has increased by 18 to 160 in December 2017 (70 vacancies within Planned Care & 86 within Urgent Care	Finance, Performance & Investment Committee	
Establishment vs Actual	Number of WTE posts that are required to staff the Trust against the actual number of post employed substantively. Green = Funded, Blue = Contract Line = Last Financial Year, Bar = This Financial Year	The Trust headline vacancy factor is 9.1% (Up from November 8.8%). Overall vacancy levels are static month on month.	Finance, Performance & Investment Committee	

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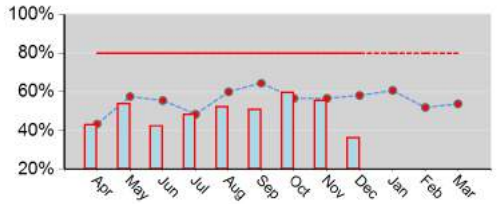
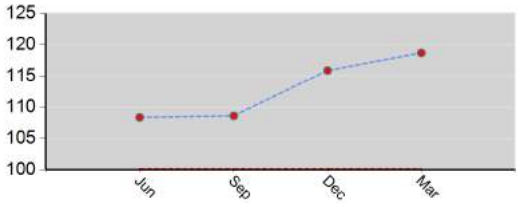
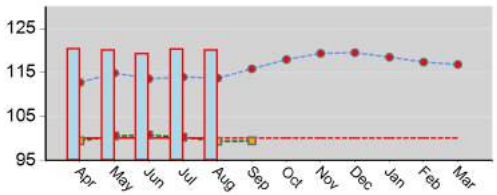
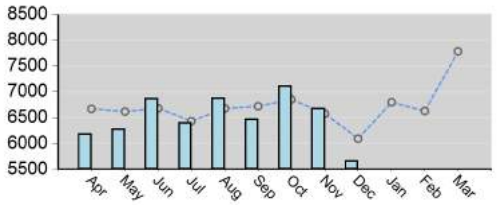
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Stroke 90% ward stay	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Previously reported performance may change as a result of validation. Line = Last Financial Year Bar = This Financial Year	As a result of poor flow across the Southport site the achievement of this target remains challenging. Despite the reconfiguration of stroke beds and the rehabilitation ward no improvement in performance has been achieved. There is also an issue in relation to the therapy area being used for escalation during the winter period further impacting on our ability to support patients to faster recovery and earlier discharges. In addition the lack of an early supported discharge team means that some patients cannot be moved out of hospital thus freeing up space for admissions onto the ward within four hours. We are working as part of a system-wide solution to stroke care across the North Mersey region.	Finance, Performance & Investment Committee	
SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly and is 6 months behind due to when Dr Foster publish the data. Good performance is 100 or less. Line = Last Financial Year	The 12-month rolling SHMI, at 118.7, remains high and outside expected limits, and the reasons for this are being investigated. It is being addressed by a comprehensive action plan, managed and monitored by the Mortality Operational Committee which reports to the Trust Board through Quality & Safety Committee. AQuA predicts that the SHMI will begin to fall from its next release.	Quality & Safety Committee	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100. At Trust level, good performance is 100 or less. Source = Dr. Foster. Please note: This indicator is reported monthly and is 3 months behind due to when Dr Foster publish the data. Line = Last Financial Year, Green = Previous Value, Blue = Corrected Value	The 12-month rolling HSMR, at 120.3, remains high and outside expected limits, and the reasons for this are being investigated. The latest monthly HSMR (for August) is 107.8. It is being addressed by a comprehensive action plan, managed and monitored by the Mortality Operational Committee which reports to the Trust Board through Quality & Safety Committee.	Quality & Safety Committee	
Referrals	Number of referrals received into the Trust. This will include referrals from GPs, other hospitals and internal referrals. Line = Last Financial Year Bar = This Financial Year	The number of referrals continues to be lower than in the previous year. There were 6,256 referrals in December 2017 compared to 7,440 in December 2016. The number of GP referrals has fallen by 29% from 3,887 to 2,772 comparing December 2017 and 2016. As part of the paper switch off programme we have a focus on improving our offer to GPs through the e-referral system.	Finance, Performance & Investment Committee	

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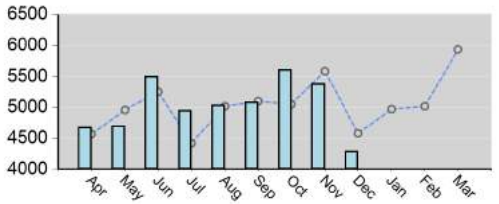
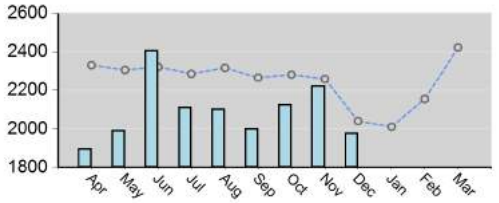
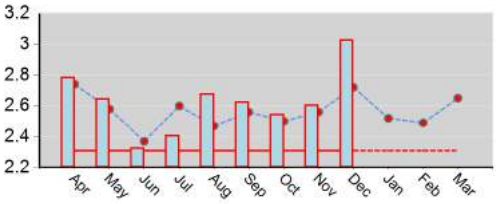
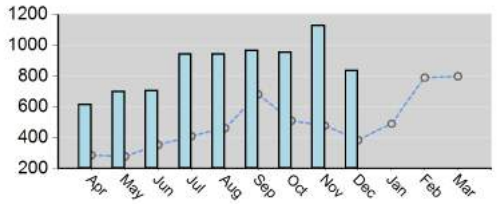
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
First Appointments	The number of patients seen in a first appointment including where the patient is seen in an outpatient clinic and has a procedure undertaken. Line = Last Financial Year Bar = This Financial Year	First appointments continue to be below our contracted activity plan. December position was down 539 attendances equating to £85k. Year-to-date the Trust is currently below plan by 4,681 or £798k. The Trust-wide outpatient programme is underway which aims to increase throughput of outpatient clinics. All areas have also been instructed to over-book clinics.	Finance, Performance & Investment Committee	
Daycase/Inpatient	The total number of patients treated as either a day case or an elective inpatient in month. Line = Last Financial Year Bar = This Financial Year	Performance against plan remains poor. Underperformance in December was by 20 cases or £116k. The year to date position is a financial impact of £2m. The Trust also performed fewer DC/EL procedures than the previous December.	Finance, Performance & Investment Committee	
Average Length of Stay	The average length of stay for all patients across the Trust. Lower is better. Line = Last Financial Year Bar = This Financial Year	Average length of stay saw a significant increase in December 2017, with high bed occupancy levels and large numbers of patients identified as MOFD. Intensive support was provided by Chief Nurses of both CCGs in December in attempting to unblock some of the barriers to discharge, particularly checklist completion and funding applications prior to placements commencing, and increasing community capacity available. The outcomes of the MADE (Multi-Agency Discharge Events) reviews will address this further.	Finance, Performance & Investment Committee	
Bed days post MOFD (Medically Optimised for Discharge)	Number of beddays used for inpatients who have passed their medically optimised for discharge date. It is taken as a snapshot on the last working day of the month. Lower is better. Line = Last Financial Year Bar = This Financial Year	This figure remains a concern with large numbers of bed days for patients who have been identified as no longer requiring acute hospital care. There is now collective support from both CCGs, as well as system partners, in driving improvements in the inpatient pathway, challenging avoidable delays to next steps for patients to enable timely discharge, and reviewing community capacity available. Daily MDT board rounds are key to maintaining this, with appropriate escalation where required	Finance, Performance & Investment Committee	

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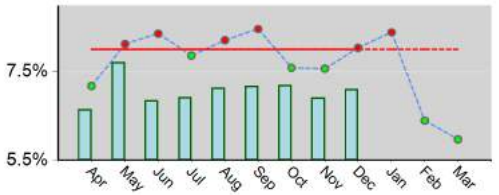
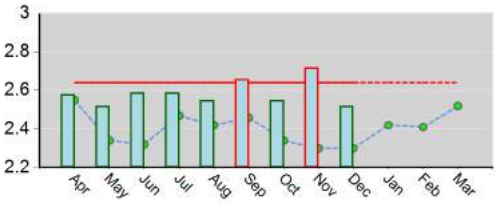
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better. Line = Last Financial Year Bar = This Financial Year	The DNA Rate for the Trust has increased slightly to 7.1% in December with the Trust maintaining a compliant position since Feb'17.	Finance, Performance & Investment Committee	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor. Line = Last Financial Year Bar = This Financial Year	New: FU ratio has decreased this month to 2.52 which is the best monthly figure since May 2017.	Finance, Performance & Investment Committee	

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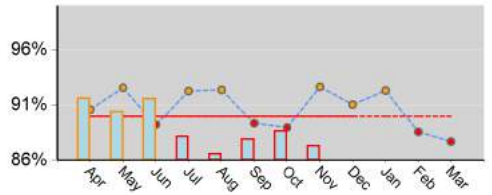
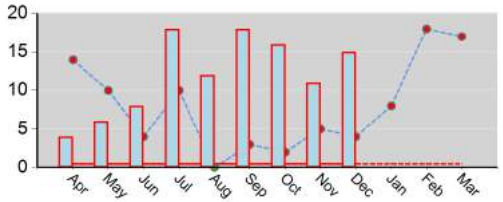
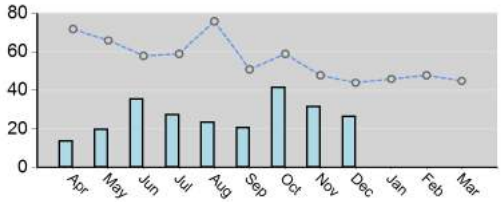
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Friends and Family Test	Friends and Family Test. The proportion of patients that would recommend the Trust to their friends and family. Threshold: 94%, Fail: 90%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	The Percentage of patients that would recommend the Trust to Friends & Family decreased in December to 86% from 87.4% in November. Decembers figure is against a response rate 7.3% which is a decrease from 8.9% in November. Specialist Services have the lowest CBU recommendation rate at 76.4% against a response rate of 3.4%.	Quality & Safety Committee	
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours. Line = Last Financial Year Bar = This Financial Year	In December there were 15 Mixed Sex Accommodation breaches, all on critical care, due to awaiting transfer to acute beds within the hospital.Actions to address poor flow are both system-wide and internal. Details are included within the separate urgent care performance report.	Quality & Safety Committee	
Complaints	The total number of complaints recieved. A lower number is good. Line = Last Financial Year Bar = This Financial Year	The complaint numbers are 27 for the month of December, this is 5 less than the previous month. The complaints will be reported in the Quality and Safety reports for each Clinical Business Unit. The Clinical Business Units continue to work through the complaints within the required timescales, and the adherence to these timescales is monitored through the monthly Quality and Safety reports.	Quality & Safety Committee	

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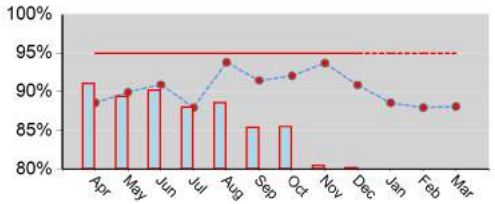
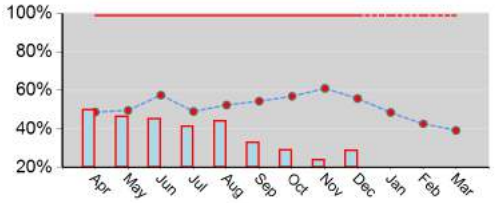
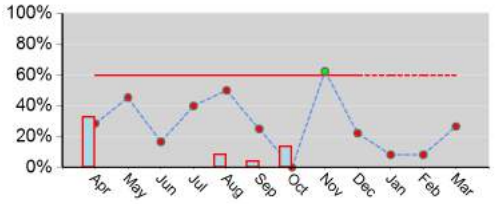
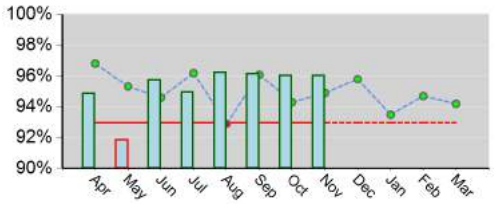
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher. Line = Last Financial Year, Bar = This Financial Year	Performance against the 4-hour target remains a challenge, particularly given the inpatient pressures and high occupancy of beds at Southport. Attendances remained relatively static compared to last year. Enhanced support from ECIP and EY are currently on site undertaking diagnostic reviews of urgent care flow, whilst the A&E Sub Delivery Group has been redesigned to focus on 5 key areas to reduce bottlenecks in inpatient flow.	Quality & Safety Committee	
Ambulance Handovers <=15 Mins	All handovers between ambulance and A&E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes. Line = Last Financial Year Bar = This Financial Year	Ambulance handover performance remains a concern. The current ED estate is insufficient to meet demands of the current case mix, given the month on month increase in majors category patients. Winter monies for a modular build to enable some much needed estates work later this year is critical. Attendances remained relatively static compared to last year. In addition, enhanced support from ECIP and EY, and dedicated workstreams reporting through the A&E Sub Delivery Group will drive improvements.	Quality & Safety Committee	
TIA (Transient ischaemic attack)	Proportion of patients diagnosed with a TIA Treated within 24 hours. Threshold 60%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	0% compliance in December. There were 22 referrals, 9 of which were TIA's, 7 of which were reportable. The additional clinics that had been established to increase our ability to meet the target did not run in December as a result of staff being utilised to support the Trust during increased urgent care pressure.	Finance, Performance & Investment Committee	
14 day GP referral to Outpatients	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. Target 93%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	The 93% target was again met in November (96.1%) for the sixth month running.	Finance, Performance & Investment Committee	

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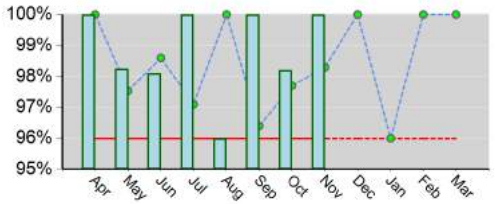
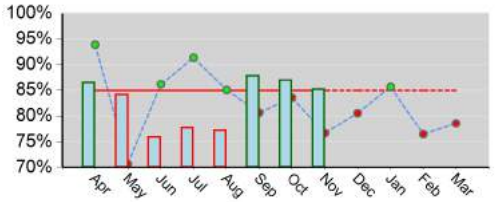
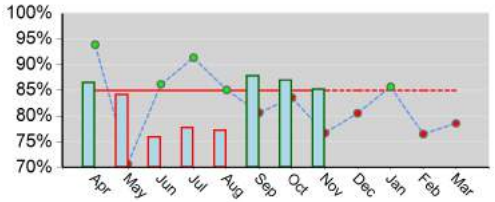
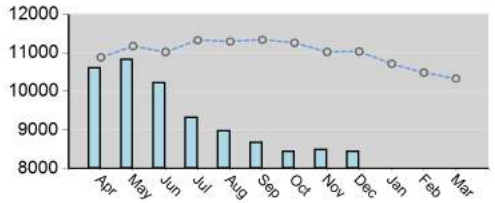
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
31 day treatment	Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Target 96%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	100% compliance was achieved in November.	Finance, Performance & Investment Committee	
62 day GP referral to treatment	Percentage of Patients receiving first definitive treatment for cancer within two months (62 days) of urgent GP referral for suspected cancer. Target 85%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	The 62 day performance target has been met for three consecutive months with the total number treated in November was 46 with 7 breaches. We are confident that we will meet December and quarter 3. January performance historically dips due to patients who have deferred their treatment during the Christmas period, but it is not anticipated that performance will return to previous low levels..	Finance, Performance & Investment Committee	
62 day pathway view	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment. Target 85%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	The Trust reported 7 accountable patient breaches in November. This consisted of 1 half gynae, 2 half head & neck, 2 full colorectal, 1 full skin and 3 half urology. RCAs will be completed on all these patients.	Finance, Performance & Investment Committee	
Waiting list size	The number of RTT patients currently waiting. Line = Last Financial Year Bar = This Financial Year	Total RTT Waiting List size has decreased by slightly by 49 in December to 8466.	Finance, Performance & Investment Committee	

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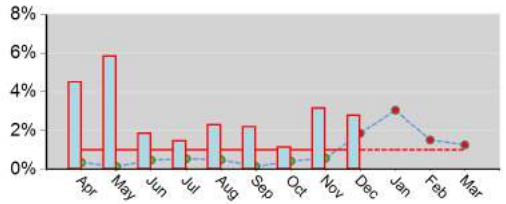
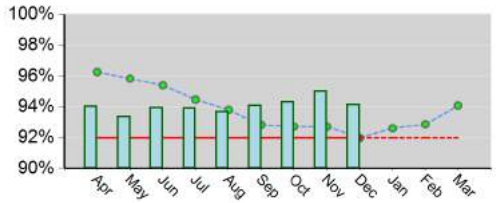
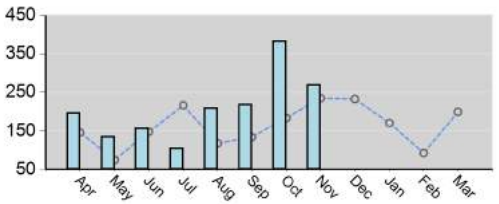
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower. Line = Last Financial Year Bar = This Financial Year	Compliance was 2.83% in December, above the 1% target. MRI - Breaches occurred because patients were offered appointments less than 3 weeks to fully utilise capacity but patients subsequently cancelled. Dexa - There were delays in booking appointments because the Dexa scan rook was required to be refurbished & a new scanner was installed. Cardio-respiratory - Increased demand for investigations, service review taking place. Endoscopy - Improvements with productivity & utilisation of lists ongoing & a weekly scheduling meeting takes place. Due to sickness within the medical & nursing team has resulted in WLI sessions in core sessions to meet diagnostic demand. Your Medical has been insourced to clear all the backlog by June 18.	Finance, Performance & Investment Committee	
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Trust Performance has again met the 92% threshold for December which was recorded at 94.2%. Patient are still being booked in chronological order. This does not reflect the challenges faced in some sub-speciality areas i.e. Endo 82%, General Surgery 86.9%, Respiratory 86.2% and Rheumatology 75.9%.	Finance, Performance & Investment Committee	
DTOC (Delayed Transfers of Care)	Total number of Delayed Days during the reporting period. A patient is ready for transfer when: a. A clinical decision has been made that patient is ready for transfer; and b. A multi-disciplinary team decision has been made that patient is ready for transfer;and c. The patient is safe to discharge/transfer. Line = Last Financial Year Bar = This Financial Year	In November there were 272 delayed bed days due to delayed transfers of care. 123 bed days were due to patient/family choice, 80 due to awaiting further non-acute NHS care, 44 due to awaiting care package in own home, 23 due to awaiting community equipment/adaptations and 2 days due to awaiting assessment.	Quality & Safety Committee	

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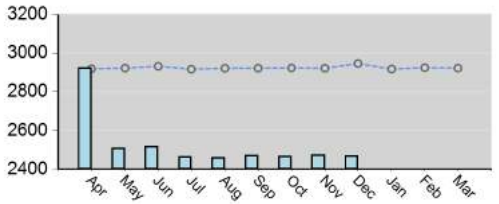
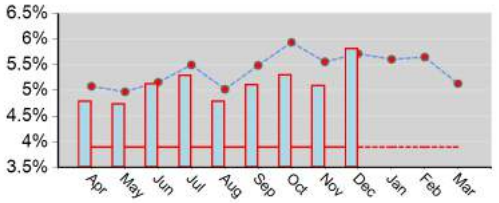
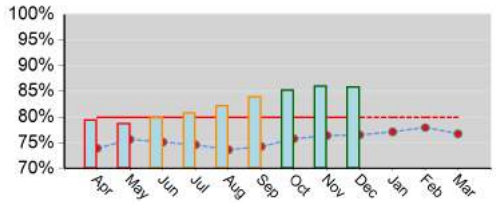
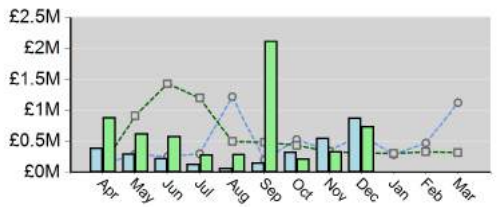
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
WTE (Whole time equivalents) in post	The number of WTE staff with substantive and fixed-term contracts employed directly by the Trust. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.	The number of WTE staff with substantive and fixed-term contracts has decreased slightly in month to 2473.	Finance, Performance & Investment Committee	
Sickness rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better. Line = Last Financial Year Bar = This Financial Year	The sickness level in December increased significantly in month to 5.83%. A new Sickness Absence Administration team has been implemented to support HR and Managers in managing sickness absence from October 2017. The team is currently ensuring compliance with the Trust's current policy and that sickness absence reasons are recorded properly. A review of the sickness absence policy is underway.	Finance, Performance & Investment Committee	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Line = Last Financial Year Bar = This Financial Year	Mandatory training compliance remains static above the 85% target since October 2017. The project to roll our ESR Manager & Employee Self Service and eLearning continues on target to be completed by the end of March 2018 with 64% of the organisation registered users to date. Most core mandatory training subjects are now accessible 24/7 from anywhere and any device allowing staff more flexibility to remain up to date and to complete online assessments improving the quality of the training. Work continues to review job specific mandatory training subjects such as resuscitation with the aim of improving compliance in these subjects to ensure safe working practices for staff and our patients.	Finance, Performance & Investment Committee	
Spend against capital plan	Actual spend against the capital budget plan for the year. Green = Budget, Blue = Actual Line = Last Financial Year, Bar = This Financial Year	Despite 3 months of spending exceeding the budget, the Trust is still behind cumulatively in its capital programme. It is likely that the Trust will need to pull forward some 18/19 plans to avoid any potential underspend as this cannot be carried forward. In addition with recent bids submitted for A&E further alterations to the 17/18 capital plan may be required.	Finance, Performance & Investment Committee	

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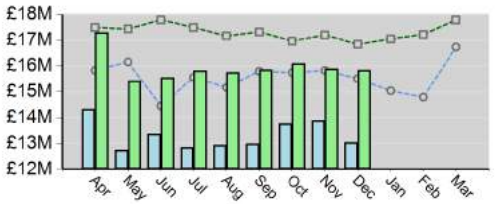
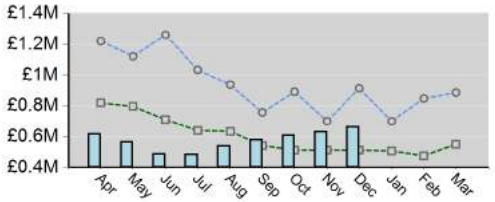
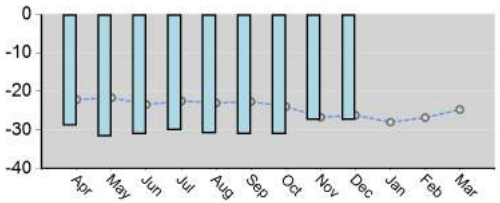
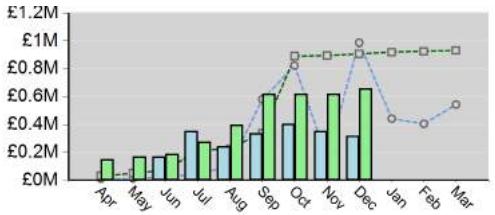
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Income & Expenditure	This indicator looks at the relationship between Trust income and Trust expenditure at monthly intervals. Green = Expenditure, Blue = Income Line = Last Financial Year, Bar = This Financial Year	The plan for December was a deficit of £1.23m. The actual in month deficit was £2.8m an n adverse variance of £1.57m. The month 9 year to date (YTD) deficit is £23.65m against a plan of £14.23m giving an adverse variance of £9.4m. £532k of the adverse variance relates to income underperformance, which has worsened in month compared to previous months. Month 9 also saw an increase in expenditure. pay increased relating to further arrears relating to PAs and accrued annual leave payments to all staff that worked additional hours in 2016 £270k in month. In addition, adverse variance on pay has been incurred through non-delivery of the month 9 CIP.	Finance, Performance & Investment Committee	
Agency Spend	The Total spend on agency staff compared to previous year. Line = Last Financial Year, Bar = This Financial Year Green = Trajectory, Blue = Actual	For 2017/18 NHSI set the Trust a full year agency spend target of £7.2m (same as 2016/17). The Trust has now been informed by NHSI that a revised target will be imposed although the figure has not been confirmed. Given the month 9 YTD financial position (£5.2m) it is likely that any revised target will not be achieved if there is a significant reduction in the target. The metric remains rated amber as in previous months until the revised target has been confirmed. The introduction of the Trust's new bank system (TempRE) is expected to have a positive impact on the level of medical agency staff being recruited. Work is ongoing to fill gaps in problem specialties with more medium term solutions rather than relying on premium rate agency tariffs.	Finance, Performance & Investment Committee	
Liquidity	Liquidity (days) Liquidity indicates whether the provider can meet its operational cash obligations.	Performance has remained relatively static (-27.4 days in December against -27.3 days in November). The Trust can meet its operational cash obligations as it is being supported with loan funding which would indicate a green rating. However, given that liquidity in the single oversight framework should be better than -14 days, this metric has been highlighted amber.	Finance, Performance & Investment Committee	
CIP (Cost Improvement Programme) delivery	Actual delivery in financial terms vs. the plan for delivery over the same period. Line = Last Financial Year, Bar = This Financial Year Green = Plan, Blue = Actual	The CIP plan for 2017/18 is £5.6m. The original plan profiled £3.5m to be delivered at the end of the third quarter of the year but actual delivery is £1.95m; an adverse variance on the plan of £1.55m. Following a revision to the CIP plans the new trajectory will not deliver at the rate originally envisaged. The plan is now forecast to deliver a risk adjusted figure of £2.7m.	Finance, Performance & Investment Committee	

NHS
Southport and Ormskirk Hospital
NHS Trust

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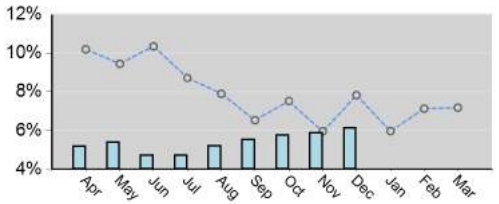
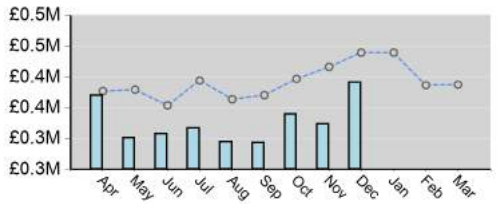
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system. Line = Last Financial Year Bar = This Financial Year	The proportion of the workforce cost made up of Agency workers increased significantly to 6.18% in December 2017 however this was significantly lower than December 2016 whereby it was 7.83%. The 6.18% is broken down by 4.26% for Doctors, 1.25% Nurses, 0.37% Admin, 0.12% AHP and 0.17% Other.	Finance, Performance & Investment Committee	
Cost of staff sickness	In month based on staff sickness records. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.	The cost of sickness absence has increased for the first time in 7 months to £0.4m.	Finance, Performance & Investment Committee	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
7TH FEBRUARY 2018

Agenda Item	**TB039/18**	**Report Title**	**Director of Finance Report Month 9**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☑ To Receive ☐ To Approve ☐ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

Key Messages:

- The deficit at the end of month 9 was £23.6m; £9.4m worse than plan
- Income shortfall of £5.4m is the main contributor; £4.0m relates to commissioning income.
- Agency spend forecast to be below £7.2m control total
- CIP shortfall is forecast to be £2.7m
- Forecast Outturn for 2017/18 approved by the Board is £31.7m
- Trust's two main Commissioners did not agree offer to settle outstanding disputes from previous years and 2017/18 dispute on a coding and counting issue (GP Assessment Unit);
- Expert Determination process activated by regulators to resolve all the disputes by 31 March 2018; value of dispute £6.4m.
- Trust notified by two main Commissioners required to impose sanctions as the Trust did not sign up to its 2017/18 deficit control total; full year forecast £3.0m

Recommendations:

The Board is asked to note that the Forecast Outturn deficit of £31.7m approved by the Board is before the application of sanctions and the outcome of the Expert Determination process.

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

- ☐ **SO1** Agree with partners a long term acute services strategy
- ☐ **SO2** Improve clinical outcomes and patient safety
- ✓ **SO3** Provide care within agreed financial limit
- ☐ **SO4** Deliver high quality, well-performing services

☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
☐ **SO6** Establish a stable, compassionate leadership team

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

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

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

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

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

Previously Presented at:

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

1. Introduction

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

1.2. The report asks the Board to discuss the contents, note the performance and the month 9 financial position.

1.3. The Trust has planned for a deficit of £18.1m (the control total of £15.1m was not accepted) a revised forecast of £31.7m was agreed at the December Trust Board.

1.4. NHS Improvement expectation with the appointment of a Financial Improvement Director is that the Trust will outturn below £30 million deficit.

2. Month 9 Financial Performance

2.1. The Trust has performed as follows:

- **In month -** Deficit of £2.808m against a £1.234m deficit plan delivering an adverse variance of £1.573m.
- **Year to date (YTD) -** Deficit of £23.649m against a £14.243m deficit plan delivering an adverse variance of £9.408m.

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

2.3. The table below is the I&E statement for December:

I&E (including R&D)	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
Commissioning Income	149,923	112,899	108,864	(4,034)	12,037	11,741	(296)
PP, Overseas & RTA	2,319	1,738	1,146	(592)	194	144	(50)
Other Income	14,267	10,747	9,933	(814)	1,351	1,165	(186)
Total Income	**166,508**	**125,383**	**119,943**	**(5,441)**	**13,582**	**13,050**	**(532)**
Operating Expenditure							
Pay	(122,470)	(92,853)	(96,009)	(3,157)	(9,635)	(10,802)	(1,167)
Non-Pay	(52,911)	(39,842)	(40,258)	(416)	(4,412)	(4,240)	172
Total Expenditure	**(175,381)**	**(132,695)**	**(136,267)**	**(3,573)**	**(14,047)**	**(15,042)**	**(995)**
EBITDA	**(8,873)**	**(7,312)**	**(16,324)**	**(9,014)**	**(465)**	**(1,992)**	**(1,527)**
Non-Operating Expenditure	(9,237)	(6,927)	(7,804)	(877)	(769)	(811)	(42)
Retained Surplus/(Deficit)	**(18,110)**	**(14,239)**	**(24,128)**	**(9,891)**	**(1,234)**	**(2,804)**	**(1,569)**
Technical Adjustments	(5)	4	479	483	0	(4)	(4)
Break Even Surplus/(Deficit)	**(18,115)**	**(14,243)**	**(23,649)**	**(9,408)**	**(1,234)**	**(2,808)**	**(1,573)**

2.4. Once again, expenditure is the main cause of the in month adverse variance against plan, although income is still contributing adversely to December's in month position.

2.5. Whilst the YTD adverse position continues to be dominated by activity and income shortfalls the proportion relating to expenditure is increasing.

2.6. Pay expenditure pressures are now being exposed more as the profile for CIP impacts more towards the latter half of the year and the budget is reduced.

2.7. Non pay expenditure is similar to previous months; the monthly expenditure run rate has remained fairly consistent over the last five months as the supporting appendices demonstrate.

3. Income

3.1. Commissioning Income

3.2. Commissioning income levels fell in December compared to the last two months, however, this was expected and built into the forecast.

3.3. The improvement is being sustained by the review of all patients who are over 75 years of age with co-morbidities; this has been expanded to all those patients over 70 years of age and other specialties.

3.4. Private Patients (PP), Overseas and Road Traffic Accident (RTA)

3.5. Income from Road Traffic Accidents (RTA) has under-performed again against budget in December.

3.6. Private patients and overseas visitors remain at a consistent level.

3.7. Urgent Care are working with A&E reception staff to promote the compensation recovery scheme to encourage patients to give details to enable the Trust to work with HCR to recover income due, however, patients are reluctant to pursue any claims.

4. Expenditure

4.1. Pay Expenditure

4.2. All pay budgets are overspent in month.

4.3. The physicians and A&E consultants have been paid additional arrears relating to last year's job planning round £200k.

4.4. Across the non-medical staff groups for staff who were contracted to work part time hours but worked additional hours in the calendar year 2016 were paid for their accrued annual leave.

4.5. Other medical pay increased in month with a rise in bank and agency spend.

4.6. CIP unachieved in month £275k with the programme now being more heavily profiled towards the end of the year.

4.7. The back pay for consultant PA's (wef 1st April 2017) was unfunded and this will continue to be part of the monthly adverse variance (circa £58k per month).

5. Agency spend

5.1. At the month 9 YTD position the Trust has spent £5.2m on agency staff compared to £8.8m in the same period last year.

5.2. The Trust is on target to achieve its agency control total set by NHS Improvement (£7.2m) although agency levels are increasing month on month with pressures within medical staff and other staff such as key senior manager and A&C posts.

5.3. Nurse Agency

5.4. Nurse agency levels fell marginally in December (£136k spend) but remain at half the levels that were being incurred last year.

5.5. Bank levels remain high and the focus continues to be recruiting to substantive posts and filling in with bank wherever possible with agency being the last resort.

5.6. Spinal Injuries unit, theatres and emergency care directorate account for the majority of the nurse agency spend to date.

5.7. Medical Agency

5.8. The Trust has introduced a medical staff bank using the TempRE platform from November 2017; this should ensure more shifts are filled at the bank rate.

5.9. A new set of rates has been set for bank staff which is consistent with the rates offered by St Helens and Knowsley NHS Trust.

5.10. In December both bank and agency usage increased as fill rates improved.

5.11. The Trust has also been pursuing the recruitment of temporary staff on longer term contracts to reduce the reliance on daily agency rates.

6. Cost Improvement Plan (CIP)

6.1. The Trust's efficiency requirement for 2017/18 is £5.6m.

6.2. The table below gives the updated detailed performance by CBU the forecast outturn is the risk adjusted figure based on confidence of delivery.

CBU	Plan			MONTH 9 YTD PERFORMANCE Identified Plan			FOT		
	Plan £000	Identified £000	Gap £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Corporate	524	1,181	657	888	868	(20)	524	1,183	659
Planned	2,100	1,017	(1,083)	893	337	(556)	2,100	615	(1,485)
Specialist	930	733	(197)	455	502	47	930	692	(238)
Urgent	2,046	719	(1,327)	425	243	(182)	2,046	451	(1,595)
Total	**5,600**	**3,650**	**(1,950)**	**2,661**	**1,950**	**(711)**	**5,600**	**2,941**	**(2,659)**

6.3. As can be seen above, the CIP delivery at month 9 YTD is not achieving the planned position with a shortfall of £711k against the identified plan.

6.4. The forecast outturn position is £2,941k giving an overall shortfall of £991k against the identified plan and £2,659k against target plan.

6.5. Progress on the Four Eyes Insight cross cutting schemes is set out below:

Project	Annual Plan £000	YTD Plan £000	YTD Actual £000	Comment
Job Planning	225	15	15	Recharge of one session only achieved to date
Theatre Efficiency	93	55	55	On track to deliver
Outpatient Programme	300	150	50	Saving from WLI reduction only, more lost in income
Endoscopy WLI	217	87	0	Delay in implementation due staff sickness
Total	**835**	**307**	**120**	

6.6. The opportunities identified by Four Eyes have not been delivered by the Trust at the pace required for financial recovery.

6.7. Other cross cutting schemes:

Project	Annual Plan £000	YTD Plan £000	YTD Actual £000	Comment
Reconfigure G,H & E wards	356	223	0	Now likely to start Feb 18
Reduce Drugs Expenditure in CBU	300	181	252	Some savings realised earlier than anticipated
Procurement Work Plan	180	113	97	Ongoing
Total	**836**	**517**	**349**	

6.8. The Trust has introduced fortnightly run rate meetings for each CBU/Division, chaired by the Turnaround Director; these commenced 9th January 2018; these meetings will be used to identify further savings to reduce the run rate in 2017/18 and also develop 2018/19 plans.

6.9. The CBUs have been tasked with producing plans to reduce bank, agency, overtime and waiting list initiatives and putting these plans into action from February.

7. Cash

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

7.2. A rolling 13 week cash forecast is updated monthly and sent to NHS Improvement usually in the second working week of the month and this forms the basis of any cash draw downs in the future month (December's cash flow was sent on 9th November).

7.3. The Trust borrowed £2.687m in December, an amount similar to the projected in month deficit.

7.4. Note that as the Trust has not agreed its control total with NHS Improvement, there is a punitive interest rate charge of 3.5% (normally 1.5%).

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

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	1,225	Note this is the value in the general ledger. Cash book is closer to target at £1,064k.
Cash inflows	17,820	18,386	Better than expected VAT recovery together with receipts from multiple debtors.
Cash outflows	-17,820	-17,916	Not able to fully utilise additional cash inflow as NHS Professionals catch up payment not as much as anticipated and large capital payments didn't materialise.
Closing balance	**1,000**	**1,695**	

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

7.7. January's loan request of £2.199m approved under Board emergency powers was drawn down on 15th January.

7.8. The revised forecast outturn approved by the Board on 10th January 2018 has enabled a more accurate cash flow to be forecast.

7.9. The premise of this is that the Trust will draw down in 2017/18 loans to match the value of the forecast outturn i.e. £31.7m.

8. Capital

8.1. Whilst spending has increased in month (£886k) it has to be said that the majority related to radiology equipment (£605k).

8.2. Note a further £461k of equipment is due on site in January as part of the managed service contract.

8.3. Cumulatively the Trust has spent a total of £3.1m against an annual target of £6.3m (including donated assets (est £268k) and radiology equipment (forecast £1.9m)). This reflects the national position which indicates that 50% of the capital budget remains to be spent in the last quarter of the financial year.

8.4. The Trust has recently been successful in bidding for capital from the A&E streaming fund (£850k).

8.5. This funding will need to be spent by the end of March 2017 and thus a change will be required to the 2017/18 capital programme (dependant on whether the Trust is successful) to ensure monies can be spent as there is no opportunity to carry forward any underspend.

8.6. Capital Investment Group agreed the following allocations for 2018/19 capital spend:

IT	£1.1m	
Estates	£1.1m	(including laundry)
Facilities	£0.3m	(including heated food trolleys)
Med equip	£1.5m	(including anaesthetic machines
Contingency	£0.2m	
Total	£4.2m	

8.7. At its meeting in February, the Capital Investment Group will produce the final 2018/19 capital plan to go to Finance Committee and Trust Board for final approval.

9. Commissioning for Quality and Innovation payments (CQUINS)

9.1. The next update will be provided to February's committee after quarter 3 results are known.

10. Forecast Outturn

10.1. The Trust submitted a projected forecast outturn of £31.7m deficit to NHS Improvement in October 2017.

10.2. Following board approval 10th January 2018, the Trust has now submitted this forecast as part of its month 9 financial return to NHS Improvement.

10.3. The month 9 forecast deficit was £2.61m and the Trust delivered £2.8m; month 9 YTD is £0.47m better than the recovery plan deficit forecast.

10.4. In discussion with NHS Improvement on 22 January 2018, the Trust through the appointment of a Financial Improvement Director is expected to reduce its deficit before the end of this financial year to below £30.0m

10.5. The Trust has been advised that Tranche 1 A&E monies (£496,000) will now be made available to the Trust which reduces the forecast to £31.2m.

10.6. Further actions to reduce the deficit are being collated by the Financial Turnaround team.

10.7. If the year-end deficit is reduced to below £30m then any risk associated with this year's contract performance (sections 11.8 and 11.15 below) and the Expert Determination process (section 11.2 below) would be in addition to this. The worst case is that this would worsen the deficit by a further £9.4m. (£3m for penalties and £6.4m if the Trust was 0% successful in the Expert Determination process)

11. Risk

11.1. The following risks have not been included in the forecast outturn deficit of £31.7m.

11.2. **Previous years outstanding contract disputes**

11.3. The Trust is in dispute with both Southport & Formby CCG and West Lancashire CCG relating to CQUIN and coding and counting issues from 2015/16 and 2016/17.

11.4. The CCGs have turned down an offer to settle and the issues will now be resolved by Expert Determination.

11.5. A 2017/18 dispute will also be considered as part of this process (GP assessment unit-GPAU)

11.6. NHSE AND NHSI have appointed the Expert and it is anticipated that the process will be concluded by 31 March 2018.

11.7. The value of the dispute for the Expert Determination process is £6.4m

11.8. **2017/18 Sanctions (penalties)**

11.9. As reported last month, the Trust was notified on 17th December 2017 that the CCG's would be applying sanctions against the Trust for breaches against operational and national standards.

11.10. The value of the penalties is forecast for the full year at £3.0m (the amount is capped at 2.5% per quarter of CCG contract value) with the majority of the target relating to the four hour A&E target and ambulance handovers

11.11. The Trust asked the CCG how they intended to reinvest the sanctions and their response has been that they are not obliged to respond to our question.

11.12. Appendix 1 contains an extract from the 2017/18 and 2018/19 NHS Standard Contract Technical Guidance.

11.13. This details the expectations on commissioners for reinvestment.

11.14. Given the lateness of the CCG's notification of their intention to deduct funding the Trust believes that it will be impossible for the CCG to reinvest this funding in full.

11.15. **2017/18 CQUIN performance**

11.16. No deductions have been made in respect of CQUIN underperformance as quarter 1 and 2 do not show any material impact.

11.17. The Trust is currently awaiting quarter 3 performance.

12. Recommendations

12.1. The Board is asked to note that the Forecast Outturn deficit of £31.7m approved by the Board is before the application of sanctions and the outcome of the Expert Determination process.

Appendix 1
NHS Standard Contract 2017/18 and 2018/19 Technical Guidance

Extracts form the guidance regarding the application of penalties (sanctions) in respect of non performance of certain quality standards.

The guidance states that where, in respect of both 2017/18 and 2018/19, a provider:

> (1) Is granted funding from the general element of the Sustainability and Transformation Fund (STF) and agrees an annual financial control total with NHS Improvement; and
>
> (2) With regard to its performance against key national quality standards either agrees performance improvement trajectories with NHS Improvement and NHS England, and/or provides those bodies with assurance statements, then the operation of certain contractual sanctions will continue to be suspended for both 2017/18 and 2018/19.

Southport & Ormskirk NHS Hospital Trust did not agree to its control total at the start of the 2017/18 financial year. Therefore, the Trust could have penalties applied by CCG's for non-performance against certain quality measures.

The following sections are extracted from the technical guidance and relate to the imposition of sanctions for non-performance of quality standards and the expectation on commissioners to reinvest:

Public reporting of sanctions applied by commissioners

40.2 For the last two years, we have required commissioners to publish on their websites details of the sanctions applied to each of their major providers for failure to achieve national standards. Given that application of the majority of these sanctions has been suspended for 2017-19 under the STF arrangements, we have decided to remove the publication requirement, in the interests of reducing reporting burden.

Use by the commissioner of funding retained through sanctions

40.3 The guidance below sets out how commissioners may use funding they retains a result of the application of contractual sanctions, whether for failure to achieve national quality standards or for other contractual breaches.

40.4 Essentially, it is for each commissioner to determine the use of funding retained, within the ambit of the purposes for which it uses its overall financial allocation. Where there has been a breach of a national standard, however, we strongly recommend that the commissioner considers whether it is possible to invest the withheld funding in a way which will help to rectify the performance problem. This could mean, for instance:

(1) Where 18 weeks standards have been breached, commissioning additional activity (either from the provider where the breach occurred or from other providers) and paying for this under the normal National Tariff rules; or
(2) Where the A&E waiting times standard has been breached, commissioning additional community-based alternative services to reduce the pressure on A&E; or

(3) Where an acute provider has breached its element of the ambulance handover standard, providing additional resource to the ambulance services provider to address the consequences.

40.5 As can be seen from the examples above, reinvestment of this nature need by no means necessarily be with the provider where the original breaches occurred. We are aware, however, that commissioners may sometimes consider reinvesting sanctions funding with the same provider, without commissioning any additional services, but with conditions attached relating to the implementation of a Remedial Action Plan and the subsequent ongoing achievement of the relevant national standard. Commissioners should be mindful that this approach may in some circumstances amount to a top-up to National Prices – and will therefore only be legitimate if it is agreed as a Local Variation under National Tariff guidance. This means it must meet the criteria for a Local Variation and that the commissioner must submit a written statement of the Local Variation to NHS Improvement in the required format.

Appendix 2

Southport and Ormskirk Hospital NHS Trust

Statement of Comprehensive Income (Income & Expenditure Account)

I&E (including R&D)	Annual Budget £000	Year to Date			In Month			
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	
Operating Income								
Commissioning Income	149,923	112,899	108,864	(4,034)	12,037	11,741	(296)	• Although still underperforming the adverse variance has reduced in recent months
PP, Overseas & RTA	2,319	1,738	1,146	(592)	194	144	(50)	• RTA income improvement seen in quarter 3
Other Income	14,267	10,747	9,933	(814)	1,351	1,165	(186)	
Total Income	**166,508**	**125,383**	**119,943**	**(5,441)**	**13,582**	**13,050**	**(532)**	
Operating Expenditure								
Pay	(122,470)	(92,853)	(96,009)	(3,157)	(9,635)	(10,802)	(1,167)	• YTD adverse variance consists of CIP underperformance along with pressure in month from all staff groups.
Non-Pay	(52,911)	(39,842)	(40,258)	(416)	(4,412)	(4,240)	172	• Reduction in month on clinical supplies and services and services from other NHS bodies (mainly the pathology contract with St Helens & Knowsley Trust following contract discussions).
Total Expenditure	**(175,381)**	**(132,695)**	**(136,267)**	**(3,573)**	**(14,047)**	**(15,042)**	**(995)**	
EBITDA	**(8,873)**	**(7,312)**	**(16,324)**	**(9,014)**	**(465)**	**(1,992)**	**(1,527)**	
Non-Operating Expenditure	(9,237)	(6,927)	(7,804)	(877)	(769)	(811)	(42)	
Retained Surplus/(Deficit)	**(18,110)**	**(14,239)**	**(24,128)**	**(9,891)**	**(1,234)**	**(2,804)**	**(1,569)**	
Technical Adjustments	(5)	4	479	483	0	(4)	(4)	
Break Even Surplus/(Deficit)	**(18,115)**	**(14,243)**	**(23,649)**	**(9,408)**	**(1,234)**	**(2,808)**	**(1,573)**	

Statement of Financial Position (Balance Sheet)

Appendix 3

Southport & Ormskirk Hospital NHS
NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2017	31/12/2017		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,991	121,981	(2,010)	398
Other assets	1,267	1,381	114	(137)
TOTAL NON CURRENT ASSETS	**125,258**	**123,362**	**(1,896)**	**261**
CURRENT ASSETS				
Inventories	2,586	2,388	(198)	72
Trade and other receivables	8,042	6,338	(1,704)	2,653
Cash and cash equivalents	1,623	1,565	(58)	(130)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**12,251**	**10,291**	**(1,960)**	**2,595**
CURRENT LIABILITIES				
Trade and other payables	(21,083)	(19,258)	1,825	(2,424)
Provisions	(164)	(135)	29	8
Borrowings	(1,559)	(1,667)	(108)	(108)
DH Capital loan	(400)	(400)	0	0
TOTAL CURRENT LIABILITIES	**(23,206)**	**(21,460)**	**1,746**	**(2,524)**
NET CURRENT ASSETS/(LIABILITIES)	(10,955)	(11,169)	(214)	71
TOTAL ASSETS LESS CURRENT LIABILITIES	**114,303**	**112,193**	**(2,110)**	**332**
NON CURRENT LIABILITIES				
Trade and other payables	0	0	0	0
Provisions	(303)	(320)	(17)	(8)
Borrowings (incl working cap facility)	(40,031)	(63,043)	(23,012)	(2,687)
PFI/Finance lease liabilities	(15,716)	(15,231)	485	(442)
DH Capital loan	(1,800)	(1,400)	400	0
TOTAL NON CURRENT LIABILITIES	**(57,850)**	**(79,994)**	**(22,144)**	**(3,137)**
TOTAL ASSETS EMPLOYED	**56,453**	**32,199**	**(24,254)**	**(2,805)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	96,202	96,202	0	0
Retained earnings	(49,977)	(74,108)	(24,131)	(2,805)
Revaluation reserve	10,228	10,105	(123)	0
TOTAL TAXPAYERS EQUITY	**56,453**	**32,199**	**(24,254)**	**(2,805)**

In month material movements are as follows:

Note that some of the large in month movements are due to the fact that at month 9, the Trust is required to produce practically a full set of accounts. This has led to a review of what is classified as receivable and payable and this is one of the primary drivers for material movements beside the in month deficit.

The Trust borrowed £2.687m in December and this was fully utilised to cover the in month £2.805m deficit.

Statement of cash flows

Appendix 4

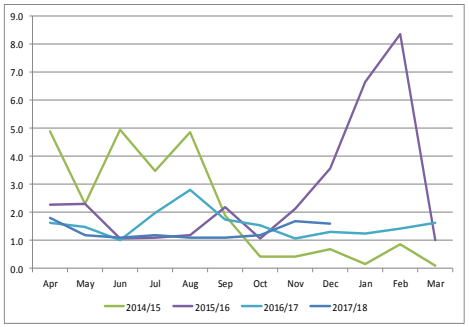
NHS Southport and Ormskirk Hospital NHS Trust

	Actual Apr-17 £'000s	Actual May-17 £'000s	Actual Jun-17 £'000s	Actual Jul-17 £'000s	Actual Aug-17 £'000s	Actual Sep-17 £'000s	Actual Oct-17 £'000s	Actual Nov-17 £'000s	Actual Dec-17 £'000s	Plan Jan-18 £'000s	Plan Feb-18 £'000s	Plan Mar-18 £'000s	Total £'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,681)	(2,357)	(1,859)	(2,688)	(2,501)	(2,556)	(1,938)	(1,640)	(2,481)	(2,334)	(2,334)	(2,335)	(27,704)
Income recognised in respect of capital donat	0	(13)	(5)	(14)	(25)	0	(91)	(30)	(17)	0	(60)	(13)	(268)
Depreciation and Amortisation	486	485	486	485	487	489	487	487	489	492	492	493	5,858
Impairments and Reversals	0	0	0	0	0	0	0	0	0				0
(Increase) in Inventories	(37)	59	100	(45)	130	(3)	72	(6)	(72)	34	34	34	300
(Increase) in Trade and Other Receivables	2,279	796	(593)	565	769	674	(487)	103	(2,640)	260	(680)	(504)	542
Increase in Trade and Other Payables	(614)	(927)	(486)	(1,077)	(744)	80	924	(2,297)	3,178	(334)	1,542	(4)	(759)
Increase in Provisions	(24)	0	(6)	(21)	8	26	8	(3)	(6)	25	58	8	73
Net Cash Inflow/(Outflow) from Operating Activities	(591)	(1,957)	(2,363)	(2,795)	(1,876)	(1,290)	(1,025)	(3,386)	(1,549)	(1,857)	(948)	(2,321)	(21,958)
Cash Flows from Investing Activities													
Interest Received	2	2	0	2	(1)	1	1	1	3	1	1	2	15
(Payments) for Intangible Assets	(165)	(80)	(12)	(25)	(66)	(14)	(13)	(11)	(64)	(180)	(370)	(150)	(1,150)
(Payments) for PPE and investment property	(177)	(314)	(93)	(136)	(137)	(118)	(416)	(6)	(894)	(539)	(539)	(539)	(3,908)
Receipts from disposal of fixed assets	0	13	0	(13)	49	0	3	0	0				52
Receipt of cash donations to purchase capital assets	0	0	0	36	21	0	91	30	17	0	60	13	268
Net Cash Inflow/(Outflow) from Investing Activities	(340)	(379)	(105)	(136)	(134)	(131)	(334)	14	(938)	(718)	(848)	(674)	(4,723)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	0	0	0	0	0	0	0	0
Public dividend capital repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	1,413	1,800	2,436	3,355	1,998	2,532	2,743	4,048	2,687	2,199	2,545	3,944	31,700
Loans repaid to DH	(200)	0	0	0	0	0	(200)	0	0	0	0	0	(400)
Capital element of finance leases	0	0	0	(32)	32	0	(505)	(109)	0	0	(377)	0	(991)
Capital element of PFI, LIFT	(6)	(6)	(6)	(130)	(6)	(6)	(130)	(6)	(131)	(6)	(5)	(131)	(569)
Interest Paid	(30)	0	(56)	(8)	(57)	(371)	(53)	(33)	(100)	(134)	(131)	(451)	(1,424)
Interest element of finance lease	0	0	0	0	0	0	(283)	(9)	0	0	(187)	0	(479)
Interest element of PFI, LIFT	(49)	(49)	(50)	(116)	(66)	(15)	(100)	(49)	(99)	(49)	(49)	(100)	(791)
PDC dividend (paid)/refunded	0	0	0	0	0	(721)	0	0	0			(234)	(955)
Net Cash Inflow/(Outflow) from Financing Activities	1,128	1,745	2,324	3,069	1,901	1,419	1,472	3,842	2,357	2,010	1,796	3,028	26,091
NET INCREASE/(DECREASE) IN CASH	**197**	**(591)**	**(144)**	**138**	**(109)**	**(2)**	**113**	**470**	**(130)**	**(565)**	**0**	**33**	**(590)**
Cash - Beginning of the Period	1,623	1,820	1,229	1,085	1,223	1,114	1,112	1,225	1,695	1,565	1,000	1,000	1,623
Cash - End of the Period	**1,820**	**1,229**	**1,085**	**1,223**	**1,114**	**1,112**	**1,225**	**1,695**	**1,565**	**1,000**	**1,000**	**1,033**	**1,033**

The Trust held enough cash to cover 3 days of operating expenditure at the end of December 2017 (November = 3 days).

Now that the Trust has amended its forecast outturn, cashflow forecasting is more realistic. The loan line represents the requests sent to NHSI.

Month end cash balances held in the last 3 years



Capital Programme

Appendix 5

Gross capital spend	Mth 9 YTD Actual	Ordered not received	Committed	Estimated future spend	Remaining balance	Total forecast
	£000's	£000's	£000's	£000's	£000's	£'000s
Electronic Patient Record (EPR)	72	54	59		280	465
Telephony system replacement	438				2	440
Data warehouse infrastructure incl storage	41				34	75
Desktop devices/network readiness	19	5			36	60
Vitalpac	0	2			43	45
eDMS (Evolve)	31	50			83	164
Wheelchair Database * ±	6	25			14	45
Capital Team	112			38		150
Estates schemes	37	12			1	50
Fire precautions - Dampers	0					0
Fire Precautions - Compartmentation	373			14		387
Xray room works	37					37
Ward Reconfiguration * ≥	72	8	35	130		245
Risk - Catering equipment	7	21		22		50
Risk - Legionella preventions	42			150	33	225
UPS Theatre	7			153		160
Medical equipment including beds	647	78		265	155	1,145
Contingency / Prior Year	173	127			82	382
Board approved capital programme	**2,114**	**382**	**94**	**772**	**763**	**4,125**
Donated assets	195			73		268
GE radiology equipment	775	461	696			1,932
Gross Capital Spend	**3,084**	**843**	**790**	**845**	**763**	**6,325**
Available capital resources						**6,325**
Remaining capital resources						**0**

* New scheme for 2017/18
± Funded by a reduction in EPR planned spend
≥ Funded by a reduction in planned spend on medical equipment

Capital expenditure has been calculated and presented in a different way to provide assurance to the Committee and to the Board that the Trust will achieve the plan.

There is no carry forward of capital allowed, so the Trust is currently reviewing all schemes with a potential to bring forward 2018/19 capital expenditure to absorb any potential shortfall in 2017/18. In addition there may be changes required to 2017/18 plans due to bids for winter pressure and A&E streaming monies.

Key

YTD Actuals - includes paid invoices, Good received not yet invoiced and additional Non PO accruals

Ordered not received - PO raised but the goods have not been received

Committed - either a letter of intent has gone out or the CIG has made a purchase decision but PO been raised yet.

Estimated future spend - To be based on discussions with the relevant Project Managers. Over time this column will be populated more fully.

Remaining balance - Value left against the revised budget agreed by the Board.

Southport and Ormskirk Hospital NHS Trust

Public Board of Directors

7 February 2018

Agenda Item	**TB040/18**	**Report Title**	**Risk Management: Board Assurance Framework (BAF) & Extreme Risk Register**
Executive Lead	Ann Farrar, Interim Chief Executive		
Lead Officer	Audley Charles, Interim Company Secretary		
Action Required *(Definitions below)*	☑ To Receive ☐ To Approve ☐ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

Summary and Recommendations:

The purpose of the report is to present an update report on the BAF dealing with the principal risks that could threaten the achievement of the Trust's strategic objectives and Extreme Risk Register which deals with the operational risks.

The BAF now goes to the Audit Committee quarterly and to the Board also quarterly. The Extreme Risk Register comes to the Board on a monthly basis and risks related to workforce, quality and finance go to the relevant assurance committee,
Discussions have taken place with the Senior Information Analyst for Quality & Datix Project Lead to upload the BAF onto Datix, the Trust's risk management system so that the strategic risks can be managed and updated on the system. The process has begun and each risk will be allocated a Datix number in the next week. Executive Risk Owners will manage the risks with the Company Secretary having oversight of all risks with the ability to challenge.

The BAF has been modified to:

- Define the various sections of the information required
- A Raw score, Current score and Target scores are now in the BAF Template as opposed to being shown elsewhere
- A status column has been added to show no change or positive and negative change since the last report

Principal risk 3- *Failure to live within resources leading to increasingly difficult choices for commissioners* remains the same and is red, although a number of positive actions have taken place to mitigate the risks as shown on the BAF. The other five Principal risks are more positively portrayed as shown on the BAF.

The Extreme Risk Register is attached and respective Executive Leads will highlight updates.

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

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

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

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

☑Statutory requirement
☑Annual Business Plan Priority
☑Linked to a Key Risk on BAF / HLRR Ref: ALL PRINCIPAL RISKS
☑Service Change
☑Best Practice
☑Other List (Rationale) _____

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

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

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

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

To cascade, train relevant groups and individuals and embed on the significance and use of the BAF at appropriate levels in the Trust.

Previously Presented at:

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

INTRODUCTION

The objectives for 2017/18 and the associated principal risks were approved by the Board at its 4 October 2017 meeting. They are shown below at **Table 1**.

Table 1

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

Board Assurance Framework (BAF)

Board assurance is a systematic method of:

- Identifying
- Analysing
- Evaluating, treating (mitigating), monitoring and reviewing
- Communicating clinical and non-clinical risks and the integration and management of both.

Risk management by the Board is underpinned by four (4) interlocking systems of internal control:

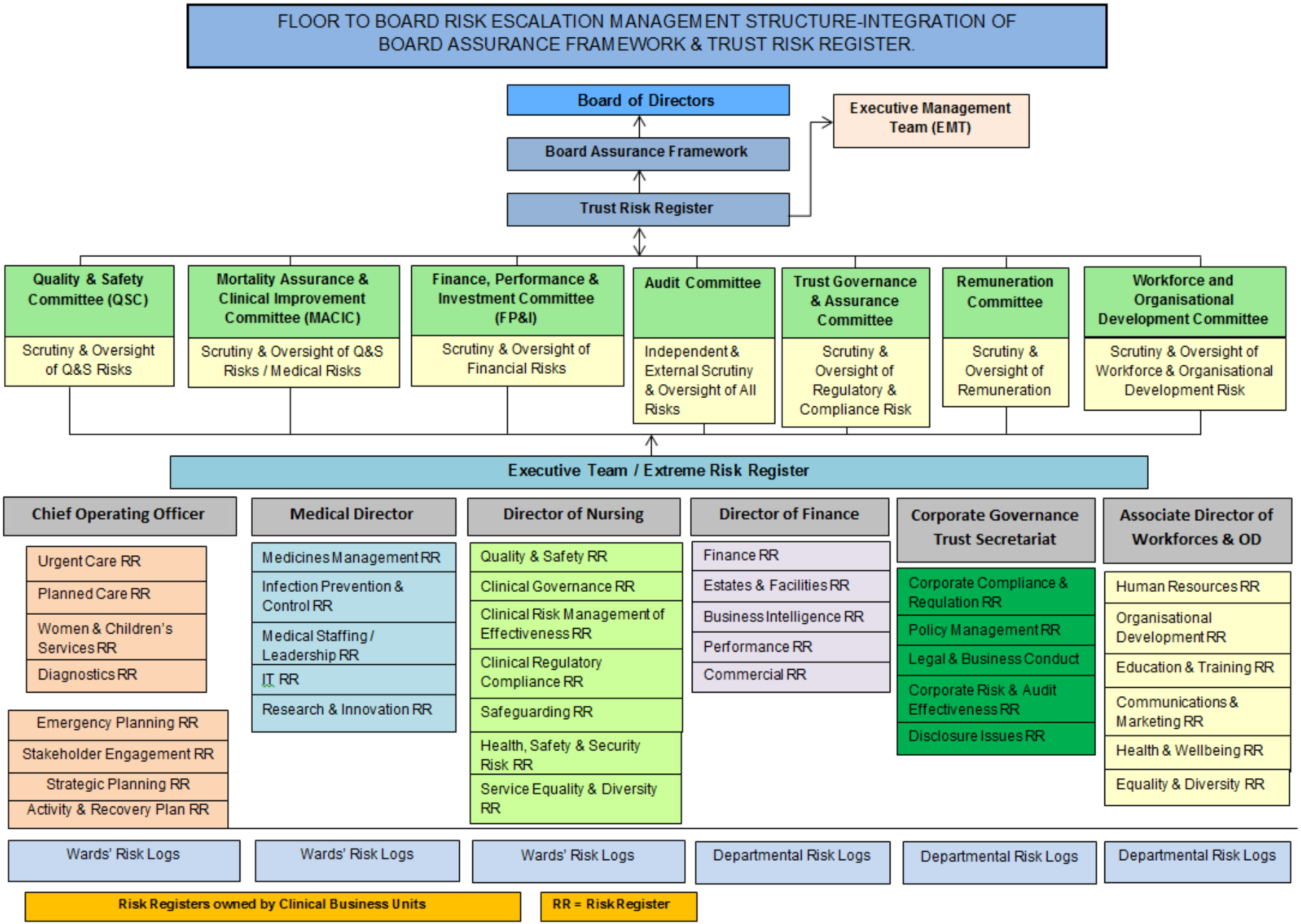
- BAF
- Extreme Risk Register (informed by Directorates, Clinical Business Units (CBUs) and Teams)
- Audit Committee
- Annual Governance Statement

This Board Assurance Framework is designed and operates to meet the requirements of the 2017/18 *Annual Governance Statement*. The BAF, which is board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved. Risks to be monitored over the year include are listed above and in the BAF at Appendix 1b. Properly designed, the BAF is the basis for the Board agenda and vice versa.

The BAF is determined by the Board of Directors and is approved by the Trust Board. It is the means by which the Board holds itself to account and identifies the principal risks that could prevent the Trust delivering its strategic objectives and therefore the operational plan. It also provides a structure for the evidence to support the Chief Executive's *Annual Governance Statement (AGS)* within the *Annual Report.* The BAF maps out the control systems in place to mitigate these risks and confirms the assurances that the Board wishes to receive either directly or via its statutory and assurance Committees (Audit; Quality & Safety; Nomination & Remuneration; Finance Performance & Investment (FP&I) and Workforce & Organisational Development) to evidence the effective operation of these controls.

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

Allied to the management of risk is learning from situations. There needs to be a clear system of shared learning that rapidly transfers knowledge across the organisation. The Trust should be able to demonstrate this with practical examples of how working practices have changed as a consequence of good risk management allied to shared-learning. The Risk Management Strategy and Policy should reflect this. **Figure 1** below shows the *Floor to Board Risk Escalation Process*:


FLOOR TO BOARD RISK ESCALATION MANAGEMENT STRUCTURE-INTEGRATION OF BOARD ASSURANCE FRAMEWORK & TRUST RISK REGISTER.
Board of Directors
Board Assurance Framework
Trust Risk Register
Executive Management Team (EMT)
Quality & Safety Committee (QSC)
Scrutiny & Oversight of Q&S Risks
Mortality Assurance & Clinical Improvement Committee (MACIC)
Scrutiny & Oversight of Q&S Risks / Medical Risks
Finance, Performance & Investment Committee (FP&I)
Scrutiny & Oversight of Financial Risks
Audit Committee
Independent & External Scrutiny & Oversight of All Risks
Trust Governance & Assurance Committee
Scrutiny & Oversight of Regulatory & Compliance Risk
Remuneration Committee
Scrutiny & Oversight of Remuneration
Workforce and Organisational Development Committee
Scrutiny & Oversight of Workforce & Organisational Development Risk
Executive Team / Extreme Risk Register
Chief Operating Officer
Urgent Care RR
Planned Care RR
Women & Children's Services RR
Diagnostics RR
Emergency Planning RR
Stakeholder Engagement RR
Strategic Planning RR
Activity & Recovery Plan RR
Medical Director
Medicines Management RR
Infection Prevention & Control RR
Medical Staffing / Leadership RR
IT RR
Research & Innovation RR
Director of Nursing
Quality & Safety RR
Clinical Governance RR
Clinical Risk Management of Effectiveness RR
Clinical Regulatory Compliance RR
Safeguarding RR
Health, Safety & Security Risk RR
Service Equality & Diversity RR
Director of Finance
Finance RR
Estates & Facilities RR
Business Intelligence RR
Performance RR
Commercial RR
Corporate Governance Trust Secretariat
Corporate Compliance & Regulation RR
Policy Management RR
Legal & Business Conduct
Corporate Risk & Audit Effectiveness RR
Disclosure Issues RR
Associate Director of Workforces & OD
Human Resources RR
Organisational Development RR
Education & Training RR
Communications & Marketing RR
Health & Wellbeing RR
Equality & Diversity RR
Wards' Risk Logs
Wards' Risk Logs
Wards' Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Risk Registers owned by Clinical Business Units
RR = Risk Register

ASSURANCE

A schedule of assurances received during the month against each BAF's high risk agreed by the Board is shown. These assurances are derived by taking into account the content of reports to the Board's statutory and assurance committees, Assure, Alert and (AAA) Highlight Reports to Board, assurance reports delivered directly to the Board and reports from Operational Groups reporting to statutory and assurance committees. Assurances are also received from external bodies like external audit, inspectors and regulators.

An overall assurance RAG rating is assigned to each risk. The risk rating is determined by using the Risk Scoring Matrix, by using the product of Likelihood x Severity. Each risk owner (Executive Director) determines the score of the risk for which they are responsible based on the controls in place and the assurances received.

Assurances received are listed and where they were obtained and where there are gaps an action plan will be included (see **Appendix 1**).

Assurance Summary

1. Board Assurance Framework for the delivery of Objectives

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

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

Level 1-assurances received by Groups reporting to Committees, Executive Management Team, Leadership Executive Group	Operational (management)
Level 2-assurances received by the board and its statutory and assurance committees	Oversight functions-Board Committees
Level 3-assurances received by independent external bodies, regulators, inspectors, and internal and external audits	Independent (Audits/Reviews/Inspections)

The assurances received are weighted as per the descriptions in the Table above

Risk Scoring Matrix

Likelihood (L)	Severity (S) Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	5 (M)	10 (H)	15 (Ex)	20 (Ex)	25 (Ex)
Likely (4)	4 (M)	8 (H)	12 (H)	16 (Ex)	20 (Ex)
Possible (3)	3 (L)	6 (M)	9 (H)	12 (H)	15 (Ex)
Unlikely (2)	2 (L)	4 (M)	6 (M)	8 (H)	10 (H)
Rare (1)	1 (L)	2 (L)	3 (L)	4 (M)	5 (M)

Risk equals Likelihood (L) multiplied by Severity (S)

RISK GRADE	LOW RISK (Score of 1- 3)	MODERATE RISK (Score of 4- 6)	HIGH RISK (Score 8- 12)	EXTREME RISK (Score > 15)

The scores and RAG ratings are shown whilst the risk scoring matrix and scoring range for **Likelihood** and **Severity** are shown above. After reviewing the controls and assurances received since and analysing the effectiveness of controls, noting gaps in assurances and controls and reviewing action plans to mitigate risks, the risks' scores have been adjusted and a current and target score allocated.

The BAF is at **Appendix 1** and the Extreme Risk Register at **Appendix 2**

NHS Southport and Ormskirk Hospital NHS Trust

SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST-BOARD ASSURANCE FRAMEWORK AS AT 7 FEBRUARY 2018

Datix ID	What could *prevent* the objective *from being achieved*	Raw Risk Score (L x C) (Showing the likelihood of a risk & its consequence)	What *controls*-systems, processes, policies, procedures, training, performance and effectiveness measures are in place *to assist in the delivery of the objective*	Where the Trust can *gain evidence that the controls* relied on *are effective* (E.g.: Internal & External Audit)	*Evidence exists* showing that the Trust is reasonably *managing its* risks *and its objectives are being delivered.* (Internal & External Reports)	Current Risk Score	Where the *Trust is failing to put controls in place* and/or failing to make them effective	Where the *Trust is failing to get evidence* that its controls are effective	Risk Owner	*Actions needed* to address gaps, ensuring proper mitigation of risks	Target *Date* for delivery of *actions and updates*	No Change ⟺ Positive Change ⇧ Negative Change ⇩	RAG Target Status
	Key Risks	**Risk Score**	**Key Controls**	**Potential sources of assurance**	**Assurances received**	**Current Score**	**Gaps in control**	**Gaps in assurance**	**Executive Lead**	**Action Plan/Update**	**Timelines**	**Status change since last report**	**Risk Target Status**
	Strategic Objective !: ***Agree with partners a long term acute services strategy***												
	Principal RISK 1:. ***Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards may result in:*** **Potential Cause:** Activity levels unaffordable to the health economy due to the failure to deliver QIPP levels • Lack of robust plans across healthcare systems • Loss of Commissioner support • Inability to respond to requirements to flex capacity as there is a mismatch with their plans. **Potential Effect:** Loss of existing market share. • Stranded fixed costs due to poor demand management / QIPP. • Difficult to manage capacity plans. **Potential Impact:** Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance.	**(LxC)** **3x5** **15**	Strategy developed with commissioners. • Compliant Contracts in place for 2017/18. • Commissioner alignment meetings in place. • Contingency plans for withdrawal from services developed. • Quarterly review against plan.(Titration system) • Monthly meetings with CCGs • Care For You Initiative • STP Board to Board meetings with CCGs Local Delivery Systems x 2 Alliance. Care for You Tri- Board with CCGs Healthwatch Developing Experience of Care Strategy Listening Events Friends and Family Test Staff Survey Local patient questionnaires and feedback Environment data from Hospedia system Patient representation at meetings. Patient survey Volunteers Dementia friends Peer support worker feedback Staff / Team Meetings New starters are always	Reported to Board: • CE reports to Board **(L1**) • Director of Clinical Services reports re review of services (**L 1**). • Finance Reports include contractual and commissioning issues, where relevant. (**L1**) • Progress of agreeing contracts reported via Finance to Board annually (**L1)** • Business Cases involving commissioners reported, where these occur (**L1)** Reported elsewhere • Minutes of Network/Alliance meetings (**L2**). • Update reports from Community Partnership Network (**L2**). • Minutes of Monthly Contract Review Meetings (**L2)**) CEO Patch Meetings-monthly **(L2)** Substantive CEO appointed to begin 1 April 2018	Board October CBUs Governance meetings October FP&I; Board October CEO Report CEO Patch Meetings-monthly Executive Team meeting-weekly Ditto	**(LxC)** **3x4** **12**	No long-term sustainable leadership-CEO Annual Plan not visible and sighted Some processes need embedding within CBU and across the organisation to ensure robust Ward to Board communication and escalation Communication and Engagement Strategy not in Place	Review of relationship management processes may be required . Periodic reports on externally facing activities	**CEO/COO**	Chief Operating Officer to: • Consider the need for review of strategic planning (**31 Jan. 2018)** • Produce reports on Annual Plan to the Board Substantive CEO Appointed-to commence 1 April 2018 Continue to embed good governance Develop, implement, embed and review Communication and Engagement Strategy To be arranged	**February 2018** **January 2018** **February 2018**	⇧	**(LxC)** **3x3** **9**

Datix ID	What could *prevent* the objective *from being achieved*	Raw Risk Score (L x C) (Showing the likelihood of a risk & its consequence)	What *controls*-systems, processes, policies, procedures, training, performance and effectiveness measures are in place *to assist in the delivery of the objective*	Where the Trust can *gain evidence that the controls* relied on *are effective* (E.g.: Internal & External Audit)	*Evidence exists* showing that the Trust is reasonably *managing its* risks *and its objectives are being delivered.* (Internal & External Reports)	Current Risk Score	Where the *Trust is failing to put controls in place* and/or failing to make them effective	Where the *Trust is failing to get evidence* that its controls are effective	Risk Owner	*Actions needed* to address gaps, ensuring proper mitigation of risks	Target *Date* for delivery of *actions and updates*	No Change ⟺ Positive Change ⇧ Negative Change ⇩	RAG Target Status
	Key Risks	**Risk Score**	**Key Controls**	**Potential sources of assurance**	**Assurances received**	**Current Score**	**Gaps in control**	**Gaps in assurance**	**Executive Lead**	**Action Plan/Update**	**Timelines**	**Status change since last report**	**Risk Target Status**
			asked to bring ideas from their previous employment Complaints and Compliments Policy Care for You Safe At All Times Vanguard and partnership working- mutual aid STP Attendance at Local Authority Scrutiny Committee A&E delivery Group Commissioner Contract and Quality Meetings Merseycare Presence (Core 24)on site in future Discharge to assess with community providers and commissioners ICRAS GIRFT Governance Structures Healthwatch Quality Account Trust Website										
	Strategic Objective 2: Improve clinical outcomes and patient safety												
	Poor clinical outcomes and safety records may result in: **Potential Cause:** • Failure of national performance target (cancer, RTT) • Failure to reduce delayed transfers of care in the changing NHS environment **Potential Effect:** • High numbers of people waiting for transfer from inpatient care. • Delays in patient flow, patients not seen in a timely way. • Reduced patient	**(LxC)** **3x5** **15**	Staff engagement strategy. Quality Visits by NEDs and EDs Meet the Chief Executive Sessions Duty of Candour Healthwatch Review Executive Blog Freedom to Speak Up Speak Up Champion Speak Up Guardian Stakeholder Engagement Strategy	Workforce & Organisational Development Committee (**L3**) STEIS and Incident Reporting (**L2**) Developing gap in Care Strategy (**L1**) FPPT Report (**L3**) Governance Reports (**L2**) Staff Magazine (**L1**) Integrated Performance Report Director of Clinical Services reports re review of services (**L 1**). • Emergency Planning	Quality and Safety Committee Board Clinical Effectiveness Committee Workforce and OD Committee Quality Improvement Development Group –weekly	**(LxC)** **3x4** **12**	Lack of robust Feedback from Staff and patients Clinical leadership development to provide a culture of trust and candour. Perceived inequity of treatment or rewards between and within staff groups. Communication and Engagement Strategy not in Place Workforce and Organisational Development Strategy not in place	Workforce Strategy Engagement Strategy	**DoN/MD**	Freedom to Speak Up Policy Appoint FTSU Champions across the Implement Recommendations of Culture Review (**31 January 2018)** Robust medical job planning process to be in place Strategic & Annual Plans to be be finalised to include all service pathways. Develop, implement,	Completed **November 2017** **Completed November 2017** **March 2018** **March 2018**	⇧	**(LxC)** **3x3** **9**

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	experience. • Failure of KPI's and self-certification • Reputational damage leading to difficulty in recruitment. **Potential Impact**: • Services may be unaffordable. • Quality of care provided to patients may fall. • Loss in reputation. • Failure to meet contractual requirements.		Developing the Experience of Care Strategy (including FFT). Monthly CBU Quality and Safety Reports Incident Reporting Quality Account Raising Concern Policy CQC Improvement Plan Partnership working across STPs Care For You Trust SCOPE Values Apprenticeship Strategy Partnership working with Vanguards IMT strategy, annual plan Estates & Facilities Governance meetings Performance meetings & performance dashboard. "Safe at all times" Programmes established. Weekly sustainability scrutiny meetings with plan monitoring/ QIA process. Embedded Governance structure and processes National surveys for service users. Patient forum and patient groups. You said, we listened, we did boards. Lessons learned feedback. CBU has recruited additional resource within the Governance team. GITrust Vision and Values Strategic Objectives Board Assurance Framework Extreme Risk Register Operational Plan Apprenticeship Strategy HR Policies Care for You programme Staff Engagement	Annual Report (**L1**) Quality Improvement Development Group –weekly **(L1)** Patient Flow Project-EY (**L3**)			Quality Improvement Strategy not in Place	Workforce & OD Strategy		embed and review Strategic Plan Develop Workforce and OD Strategy	**March 2018** **March 2018**		

Datix ID	What could *prevent* the objective *from being achieved*	Raw Risk Score (L x C) (Showing the likelihood of a risk & its consequence)	What *controls*-systems, processes, policies, procedures, training, performance and effectiveness measures are in place *to assist in the delivery of the objective*	Where the Trust can *gain evidence that the controls* relied on *are effective* (E.g.: Internal & External Audit)	*Evidence exists* showing that the Trust is reasonably *managing its* risks *and its objectives are being delivered.* (Internal & External Reports)	Current Risk Score	Where the *Trust is failing to put controls in place* and/or failing to make them effective	Where the *Trust is failing to get evidence* that its controls are effective	Risk Owner	*Actions needed* to address gaps, ensuring proper mitigation of risks	Target *Date* for delivery of *actions and updates*	No Change ⟺ Positive Change ⇧ Negative Change ⇩	RAG Target Status
	Key Risks	**Risk Score**	**Key Controls**	**Potential sources of assurance**	**Assurances received**	**Current Score**	**Gaps in control**	**Gaps in assurance**	**Executive Lead**	**Action Plan/Update**	**Timelines**	**Status change since last report**	**Risk Target Status**
			Maternity services Strategy										
Strategic Objective 3: Provide care within agreed financial limits.													
	Failure to live within resources leading to increasingly difficult choices for commissioners may result in: **Potential Cause:** • Failure to deliver the required levels of CIP . • Failure to effectively control pay and agency costs . • Failure to generate income from non-core healthcare activities • Failure tomanage outstanding historic debt. • Services display poor cost-effectiveness *Failure to streamline corporate services. **Potential Effect**: • Additional CIPs may need to be identified and delivered. **Potential Impact:** • Reductions in services or the level of service provision in some areas. • Potential loss in market share and or external intervention.		5 year long term financial model Cash support through agreed loan arrangements Annual Financial Plan including target to reduce underlying deficit Care for You programme Financial governance arrangements in place at a number of levels :- -Trust (FPI committee) -Division (monthly governance meeting and performance meetings with execs) -Directorate (budget scrutiny at this level) CIP Board, CIP planning processes and PMO co-ordination of planning and delivery Financial Turnaround Director Director of Finance Report	Finance, Performance & Investment Committee (**L2**) NHSI Quarterly Review Meeting (**L3**) Internal and External audit reviews (**L3**) Fortnightly Sustainability Scrutiny meetings (**L1**) FPI-monthly **(L1)** BAF-Quarterly to Board and Audit Committee (**L1**)	Finance, Performance & Investment Committee Internal and External audit reports and opinion at Audit Committee Performance Meetings Executive Team Meeting Weekly Update	**(LxC)** **4x4** **16**	Planning guidance for 2018/19 not yet received; results of Care for You not known; difficult to forecast future savings from any reconfiguration Although cash support is provided through DoH it is only on a month by month basis and future arrangements are not clear. Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU/divisions.	No CIP plan for 2018/19 or beyond Lack of robust Financial recovery Plan that delivers an acceptable I&E deficit positon Financial Turnaround Director 3 month appointment-need continuity post April 2018. Turnaround Director	**DOF**	Discussion with NHSI regarding review of control total Modelling of options likely to emanate from Care for You programme Close working with DoH /NHSI teams to ensure timely applications for cash support Ensure consistency of financial analysis, reporting and control across all areas within the Trust. Roll out of HFMA modules to all relevant staff and reinstate budget holder workshops Turnaround Director appointed in January 2018	**On-going** **February 2018** **On-going** **On-going** **February 2018**	⟺	**(LxC)** **3x4** **12**
Strategic Objective 4: *Deliver high quality, well-performing services*													
	Principal Risk 4: ***Failure to meet key performance targets leading to loss of services may result in:*** **Potential Cause:** • Failure to meet the Trust's Quality Poor Contractual standards • Failure to deliver the quality aspects of contracts with the commissioners • Patients experience indicators may show a decline in quality • Breach of CQC regulations • CIPs impact on safety or unacceptably reduce	**(LXC)** **3x5** **15**	Performance Management framework (awaiting sign-off following changes to NHSI's SOF and CQC inspection regime) Performance Development Framework (signed-off by Board) Data quality policy Governance arrangements Trust Board (IPR) Integrated performance report Team Brief Trust News Trust Vision and Values PDR staff forums	Performance and Investment Committee Monthly Mortality Operational Group Monthly Performance Forum Governance report to CBU governance meetings Action plans for poor performance Various performance dashboards and scorecards The IMT plan and supporting EPR business case sets out the investment plans to improve clinical systems digital maturity. Additional in-house development of the SAAT electronic whiteboards	Report to FP&I committee (last Monday each month) Report to Q&S (last Wednesday of each month) Report to mortality operational group Trust-level and CBU-level dashboard for performance forum (first Thursday of each month) Reports presented to CBU governance meetings (various dates) Weekly to executive committee	**(LXC)** **3x4** **12**	Structures to support the Trust to drive improvements IT Strategy needs to be embedded	A&E 4 hour longstanding issues in relation to poor patient flow and subsequent impact on this target Sickness absence amongst the worst rates of all acute Trusts. Poor performance a longstanding issue Mixed sex accommodation –due to poor patient flow across the hospital estate, no assurance can be given in relation to breaches within critical care when patients are ready	**DoN**	Action plans to be developed and agreed through governance structures (April 2018) Engagement of EY to address this problem-January 2018 HR to take urgent steps to address EY engaged to address this	**February 2018** **January 2018**	⇧	**(LxC)** **3x3** **9**

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	Key Risks	**Risk Score**	**Key Controls**	**Potential sources of assurance**	**Assurances received**	**Current Score**	**Gaps in control**	**Gaps in assurance**	**Executive Lead**	**Action Plan/Update**	**Timelines**	**Status change since last report**	**Risk Target Status**
	service quality. • Poor Bed Management processes impact on patient safety **Potential Effect:** • Poor patient outcome and standards of care. • Inaccurate or inappropriate media coverage or reputational damage Duplication of services with negative impact on CIP **Potential Impact:** • Potential loss of licence to practise. • Potential loss of reputation. • Financial penalties may be applied. • Poor NHSI Governance Risk Rating Increased Agency Fees		Governance processes Risk Registers Quality and Safety report Ward to Board Communications LEG team Team Meetings Committee Structure Clinical Audit Datix reporting Lessons learned Risk Register MIAA Audits Mandatory Training Any data breaches are investigated thoroughly and lessons learnt Provided by information governance team Eric Returns and Compliance monitoring spreadsheets IG training for all staff. Caldecott Guardian *Investigations (including* mortality) Referrals to professional bodies with report identifying any actions IT services manager attends IG and IT leads groups and reports / actions issues within the service Safe At All Times NHSI Single Oversight Framework Timelines Board Annual Business Cycle CQUIN HENW LDA Reports (on request) National audits submissions Freedom of information Wider alliance IMT plan, cyber attack National data returns (Unify)	is a good example of developed IT systems to improve the quality of care.				to be moved to a general ward. Diagnostic wait times Communication and Engagement Strategy not in Place Continue to embed good governance Some processes need embedding within CBU and across the organisation to ensure robust Ward to Board communication and escalation No clear and concise integrated performance framework and associated report 62 day cancer performance-some improvements have been realised but underlying issues within certain tumour groups remain Mortality-above expected limits for some time		Some processes need embedding within CBU and across the organisation to ensure robust Ward to Board communication and escalation Clear and concise integrated performance framework and associated report Communication and Engagement Strategy not in Place Continue to embed good governance Develop, implement, embed and review IPF and IPR (under development with support from NHSI Improvement Director) Action plans to be developed and agreed through governance structures (April 2018) Mortality Operational Group formed to address at operational level and sending assurance to Quality & Safety Committee	**February 2018** **February 2018** **March 2018** **On-going** **February 2018** **February 2018** **February 2018**		

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	Key Risks	**Risk Score**	**Key Controls**	**Potential sources of assurance**	**Assurances received**	**Current Score**	**Gaps in control**	**Gaps in assurance**	**Executive Lead**	**Action Plan/Update**	**Timelines**	**Status change since last report**	**Risk Target Status**
			Discharge planners- Data protection/ Information governance. Dedicated information team with staff roles to submit external reports and data Integrated Performance Report Commissioner Contract and Quality submissions										
Strategic Objective 5: Ensure staff feel valued in a culture of open and honest communication													
	Principal Risk 5, ***Failure to attract and retain staff may result in:*** **Potential Cause:** • Difficulty recruiting and retaining high-quality staff in certain areas • Low levels of staff satisfaction, health & wellbeing and engagement • Insufficient provision of training, appraisals and development. **Potential Effect:** • Low levels of staff involvement and engagement in the trust's agenda. • High than average vacancy rates. • Failure to deliver required activity levels / poor staff effectiveness • Higher than average sickness rates **Potential Impact:** • Poor patient experience and outcomes. • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation embed new ways of working. CEO/Senior Team Visits CEO Focus Group • Reduced ability to	**(LxC)** **3x4** **12**	Organisational Development Strategy Staff • Improved recruitment and induction processes. • Staff engagement and awareness programme in place. • Divisional Staff . • Education and development processes in place. • Appraisal compliance and training attendance monitored Sickness Absence Policy Robust employment checks Disclosure Barring Service Professional Bodies Checks and Balances for clinicians Staff engagement strategy. Quality Visits by NEDs and EDs Meet the Chief Executive Sessions Duty of Candour Healthwatch Review Executive Blog Freedom to Speak Up Speak Up Champion Speak Up Guardian Stakeholder Engagement Strategy	Reported to Board • Director of Workforce Reports to Board (**L1**), • Integrated Performance Report to the Board (**L1**). • Staff survey and values update work reported specifically and through Quarterly workforce reports (**L1**). • Annual H&S Report (**L1**) Annual NHS Staff Survey (**L3**) NHSI's Single Oversight Framework-Workforce metrics (**L3**) Appraisal and PDRs (**L1**) Staff Induction (**L1**) Board Development Plan Board Development Workshops Business Planning Cycle Communication Strategy Board Induction	October Workforce & OD Committee October Remuneration Committee Executive Team Meeting October Corporate Induction JCNC Meeting-October Big Office by CEO CEO Walkabout Monthly Monthly Joint Quality Visits by NEDS and Executive Directors (Weekly)	**(LxC)** **3x4** **12**	Lack of local in year feedback in relation to staff views / staff surveys IPR to include information in relation to vacancy levels by CBU and by staff group Temporary status of staff in leadership roles can have an adverse impact on staff engagement Recruitment & Retention of staff. Strategy No formal comprehensive Exit Interview Procedure	Staff Communication & Engagement Strategy Organisational Development Strategy Survey Action Plans. • Value based interviewing project Inability to finance key projects relating to staff development Board Development Strategy	**CEO/ ADHR**	New Policy to be Developed, approved, cascaded and embedded Workforce Strategy to be developed Succession Planning Strategy in Workforce & OD Plan CIP/Sustainability Plan Communication & Engagement Strategy to be developed Work with NHSI to improve Recruitment and Retention Workforce to be a key part of the planning cycle Exit Interview Procedure Board Development Plan Drafted	**March 2018** **February 2018** **March 2018** **On-going** **February 2018** **On-going March 2018** **March 2018** **February 2018** **February 2018**	⟺	**(LxC)** **3x3** **9**

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Strategic Objective 6: Establish a stable leadership team, deliver a living, compassionate leadership in the Trust and embed a culture of openness & honesty													
	Principal Risk 6: ***Inability to provide direction and leadership may result in:*** **Potential cause:** • Ineffective leadership • Inadequate management practice **Potential Effect** • In low staff morale, • Poor outcomes & experience for large numbers of patients; • Less effective teamwork; • Reduced compliance with policies and standards; • High levels of staff absence; and • High staff turnover **Potential Impact** • Poor quality of patient service • Poor recruitment and retention of staff • Inability to provide viable patient care	**(LxC) 3x4 12**	Trust's Mission & Values Single Leadership Plan Substantive CEO appointed Robust Plan in place to cover for contingencies between directors leaving and starting Training, education and develop strategy & programmes based o needs analysis. Leadership and people manage policies, processes & professior (including management training Staff support and occupational h wellbeing arrangements at Trust service levels . Monthly and quarterly monitorin workforce performance . Deep dive reports to Committee investigating specific issues whe Staff communication Grievance & Disciplinary Policie Freedom of Information Policy Data Protection Policy Staff Survey Employment checks FPPT & Code of Conduct Personal Development Review Non-Executive directors' (NED) Academic & Professional qualif Unitary Board-Non-Executive a Executive directors are jointly r for decisions taken by board Governance Structure Board Development Session Board Timeout Sessions HR Governance Meetings Workforce Committee HR Away Days Job descriptions Healthcare Leadership Model - assessment tool 360 degree appraisals Edward Jenner online leadersh programme Management & Leadership Apprenticeships Essential HR skills for manager	Workforce & Organisational Committee (**L1**) **NHSI Approval (L3)** Staff Survey (**L2**) Staff Side Meeting with Management (**L2**) Trust's Vision and Values (**L2**) Internal Audit Reports (**L3**) Fit and Proper Persons' Test(FPPT) (**L3**) Directors' Code of Conduct (**L2**) Declaration of Interest for Board and Senior Managers (**L2**) Standard of Business Conduct and Conflict of Interest Policy (**L2**) Gifts and Hospitality & Commercial Interest Policy (**L2**) PDRs (**L1**) Board of Directors Annual FPPT and Code of Conduct (**L2**) Internal Audit Checks (**L3**) Workforce & OD Committee (**L2**) Audit Committee (**L3**) External Auditors Reports(**L3**) Counter Fraud Report to Audit Committee(**L3**) Declaration of Interests at every Board and Committees(**L2**)	October Workforce & Organisational Committee October Remuneration Committee October Leadership Executive Group Weekly Executive Team Meeting NEDs' Orientation and Induction Pack being reviewed OD Plan at November Board Regular reports to Board: • Integrated Performance Report (• Annual H&S Report) • *HR & Workforce Report* Ad hoc reports to Board: • Staff Survey • Board Development Board Induction Corporate Induction NEDs Development Bi-Annual Staffing Report	**(LxC) 3x4 12**	Lack of local in year feedback in relation to staff views / staff surveys IPR to include information in relation to vacancy levels by CBU and by staff group Temporary status of staff in leadership roles can have an adverse impact on staff engagement Recruitment & Retention of staff. Organisational Development Strategy. Workforce Strategy. Equality & Diversity Policy Monitoring and reporting to Board and committees Access to leadership development programmes for clinicians	Staff Engagement Strategy Workforce Strategy Staff Survey Action Plan New Conflict of Interest Guidance not yet formalised in an approved policy NEDs' Induction Pack Some processes need embedding within CBU and across the organisation to ensure robust Ward to Board communication and escalation Communication and Engagement Strategy not in Place	**CEO/ ADHR**	Board Development Programme Diversity Training for staff Develop Staff engagement strategy Develop Organisational Development Strategy(Presented at Board-to be embedded Draft new Conflict of Interest Policy to be circulated for consultation then approved NEDs' Induction Pack to be completed by **week 8 November** .. Equality & Diversity Policy Monitoring and reporting to Board and committees to be developed New Engagement Policy to be developed Develop and Implement R & R Strategy Implement Work on above with NHSI's Workforce Lead Board Quality Visits to be established using 15 steps challenge methodology, reporting outcomes and monitoring actions through • CBU Quality & Safety Reports Board Reports	**February/March 2018** **March 2018** **March 2018** **28 Feb 2018)** **Approved November 2017** **Approved by Chair February 2918** **March 2018** **31 Mar 2018)** **32 March 2018** **31 March 2018**	⇧	**(LxC) 3x3 9**

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			Managers Net Workshops FPPT & Code of Conduct IMT strategy, IT team of the year 2016 Unitary Board-Non-Executive and Executive directors are jointly responsible for decisions taken by board TAG Training Group Compliance with Estate Code HTM 00-08 Recruitment and retention policy Use of Trac System- standardising assessment against criteria. DBS checks, Registration checks Employment checks Assessed at interview, reference checks. 360 appraisal Practice Educator Role introduced within CBUs									

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services				Link to BAF			
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
29/09/2017	1641	Chief Operating Officer	Ruth Stubbs	Bed Occupancy in excess of 100% on Southport site (106% in Aug/Sept 17)					
Description	If bed occupancy remains in excess of 90%, then the Trust's capacity to manage patients safely is compromised								
Controls	Full to capacity protocol for AED List Planning Processes for planned elective admissions (TCI's) Monitoring of occupancy through Escalation Management System (EMS) Escalation Policy Ready for Discharge (RFD) Meetings/ Monitoring of Delayed Transfer of Care (DTOC) Emergency Planning / Business Continuity Plans Winter Plan in place Infection Control policy Daily huddles and huddle records in place to escalate issues Integrated Common Reablement Assessment Service (ICRAS) North Mersey in place - discharge lanes identified based on complexity level to aid discharge planning Discharge Planning Team includes Acute & Community with escalation to CCG & ADO Opened 19 additional beds at Ormskirk to facilitate step down patients and flow Ernst and Young commissioned to support service improvement for flow Southport System Leaders Group established by NHSI to enable system support and change						**Gaps in Controls**	Ability to assess the effectiveness of ICRAS due to lack of identified process for data analysis Issues with patient flow causing wasted bed days Ensuring the right patient is in the right place at all times, too many patient outliers		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	12	High Risk	24/01/2018	23/02/2018
Assurance	Delayed Transfer of Care monitoring Benchmark length of stay Infection control reporting Monitoring of occupancy levels/EMS Monitoring of cancelled operations Safecare/ accuity/ Staffing monitoring Monitoring of pre op bed days Bed Management Meetings 3 x daily Daily Board Rounds with Clinicians and Bed Management						**Gaps in Assurance**		
Action Plan	Deliver and embed the 'Safe At All Times' project. To improve the recognition and response to the deteriorating patient.						**Action Plan Due Date**	01/06/2018 08/08/2018	**Action Plan Rating** Moderate Progress Made

	New ICRAS electronic system in place to identify appropriate 'discharge lane' for all patients within 24 hours of admission. Action to embed the use of this system for all patients. Development of a Winter Plan in collaboration with the CCG's. Deliver the 'Safer' Project, which will increase productivity and improve patient flow through identification of 'green' and 'red' days thus reducing wasted bed days. Establish reporting and data analysis requirements from the ICRAS system.		31/10/2017 30/04/2018 28/02/2018		Moderate Progress Made Completed Moderate Progress Made Actions Almost Completed

Strategic Objective		SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
25/04/2017	1549	Executive Medical Director	Sanjeev Sharma	Postgraduate Medical Education 'enhanced monitoring' GMC/HENW				
Description	Health Education England and the GMC have placed Southport & Ormskirk NHS Trust under enhanced monitoring. 'Enhanced monitoring' is the process the GMC uses to ensure resolution of significant concerns that that they believe could adversely affect our patient safety, doctors' progress in training, or the quality of the training environment. If we fail to meet the compulsory requirements that HEE and the GMC have set then this may lead to the removal of trainees from the Trust with the resulting impact of the inability to provide safe patient care, sustainability of services, reputational damage and potential recruitment and retention issues.							
Controls	Medical Education is discussed at CBU Governance Monthly Meetings Junior Doctors Forum (monthly) - trainees able to raise concerns directly with the GOSW GOSW presents a monthly exception report to Board Quarterly online healthcheck requesting trainee views- shared with Specialty Leads						**Gaps in Controls**	Trainees are not completing their Work place based assessments in a timely way The Trust fails to respond to the GMC Survey specifically its red outliers Trainers do not maintain up to date trainer status with the GMC Job planning for educators has not been fully reviewed to ensure sufficient time to support their roles Improvement to the trainee in Paeds and O&G has not been made No confirmed action leads to own and drive the HENW Action Plan Lack of CBU ownership of action plan and its resolution Insufficient number of trainees to fill the rotas safely Trainees failing to complete critical incident forms as they do not like the Datix system Trainees do not receive timely feedback following submission of Datix reporting No evidence to support that trainees are learning from critical incident reporting Service pressures adversely impact on trainees experience and stop trainees attending local and regional teaching Lack of evidence of effective supervision in clinics and constructive feedback Trainees being asked to work without supervision or working outside of their level of competence Trainer disengagement - not responding to GMC Survey or completing/returning Specialty lead quarterly/annual reports Medical Education Committee does not address the HENW Action Plan The Trust does not have safe and compliant rotas to allow for a good trainee experience There is little evidence of how trainees input in to education governance Poor education governance structures and reporting in place - lack of CBU understanding Impact of TUPE transfer of administrative team to StHK

Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	15	15	Extreme risk	5	Moderate risk	22/01/2018	22/02/2018
Assurance	Medical Education Committee minutes of meetings						**Gaps in Assurance**		

	Medical Education Governance Reports - CBU Governance Meetings (monthly) Workforce Committee papers - minutes of meetings				
Action Plan	The Trust must provide evidence that it is on track in ensuring that all named clinical and educational supervisors have 'full' recognised status by the GMC deadline of July 31st 2016. The Trust must ensure that SAS doctors meet the requirements to be a named supervisor and that the HEE NW policy on SAS doctors as supervisors is applied accordingly. The Trust must ensure that long-term locum consultants with clinical supervision responsibilities are competent to do so and meet the necessary criteria. The Trust must work to eliminate the use of the term SHO and GPVTS to ensure all staff understand the differing roles and responsibilities of foundation, hospital specialty and GP specialty trainees. The Trust must ensure that all documentation and rotas use the correct nomenclature for each level of trainee to ensure clear differentiation between roles. The Trust should ensure that all trainees understand the process for submitting critical incident forms and the importance of doing so in respect of patient safety and lessons learned. The Trust should also ensure that trainees know how to seek feedback following submission of a critical incident form and that feedback enhances learning. The Trust should ensure that the system is not used by other healthcare professionals as a threat to manage the trainees. The Trust must ensure that trainees are appropriately supervised in clinics and that they receive constructive feedback on their work. ST3 paediatric trainees must not be left to run solo clinics without direct supervision. The Trust must ensure that trainees are able to complete the required Work-Place Based Assessments The Trust should respond to the issues highlighted in the Junior Doctors Advisory Team (JDAT) report to ensure safe and compliant rotas. The Trust must ensure that service pressures do not impact adversely on the training experience of medical trainees and that trainees are able to gain sufficient experience to meet the requirements of their curriculum. The Trust must ensure all trainees at both sites are able to access formal regional and local teaching. The Trust must continue to improve its internal quality control process including systematic collation of information from departments, to evidence that postgraduate medical education is being delivered effectively. This must include a process for ensuring that actions are taken to address negative outliers that may result from the GMC NTS with measures put in place to identify improvements. The Trust must ensure that all trainees at both sites are able to access formal regional and local teaching The Trust must present HEE with comprehensive evidence of how trainees input into educational governance with examples of improvements being made, by the beginning of March 2018 The Trust must present HEE with comprehensive evidence of how the senior team has addressed a lack of trainer engagement by the beginning of March 2018 The Trust must review their governance structures to ensure they are fit for purpose in relation to education matters. The Trust must present HEE with comprehensive evidence of Board engagement and examples of how the structures are working by the beginning of March 2018. The Trust produce comprehensive evidence which shows how it has resolved the issue of the impact of the transfer of the education and training department on the administration of education by the beginning of March 2018. The Trust must present HEE with comprehensive evidence on how trainees are learning from critical incidents following its new process by the beginning of March 2018. The Trust must present HEE with comprehensive evidence that shows the job planning process is appropriately supporting educators to undertake their roles by the beginning of March 2018. The Trust must present HEE with comprehensive evidence of improvement in the trainee experience in the Paediatrics and O&G programmes by the beginning of March 2018.	**Action Plan Due Date**	04/01/2018 04/01/2018 31/01/2018 04/01/2018 04/01/2018 31/01/2018 31/01/2018 30/11/2017 31/01/2018 02/03/2018 02/03/2018 02/03/2018 02/03/2018 02/03/2018 02/03/2018 02/03/2018	**Action Plan Rating**	Moderate Progress Made Moderate Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Moderate Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made Little or No Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services			Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**		
28/09/2017	1638	Chief Operating Officer	Myrtle Henderson	Optometry Service Vacancies		
Description	The only Optometrist has left their post, last working day was 14/09/17. There is now no Optometrist to undertake, contact lens clinics, Refraction clinics, low vision clinics therefore unable to assess and treat patients with sight threatening and poor sight conditions. We have a Bank Optometrist in post who is currently covering the contact lens clinic. All vacancies are out to advert and the closing date for this is 19/02/18.					
Controls	Patients identified and on optometry review list Bank member of staff Specialist Optometrist began clinics on 08/11/17 and this will help reduce the backlog.			**Gaps in Controls**	Bank member of staff is only undertaking contact lens clinics No absence cover for sickness There is no Optometry cover for low vision clinics	

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Almost Certain (5)	Major (4)	20	20	Extreme risk	2	Low risk	22/01/2018	01/03/2018

Assurance	Need for bank post being presented to scrutiny committee on 03/10/17 Planned care clinical governance	**Gaps in Assurance**		
Action Plan	DM met with finance director to present case for external solution, awaiting approval. Develop Risk stratification for Ophthalmology to accurately monitor how many patients have been missed to follow up. Prioritise patients to be seen on the review list Substantive post to be filled	**Action Plan Due Date**	28/02/2018 31/12/2017 30/04/2018 30/04/2018	**Action Plan Rating** Moderate Progress Made Completed Moderate Progress Made Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services					Link to BAF		
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
29/09/2017	1640	Chief Operating Officer	Claire Shepherd	Backlog of diabetic patients waiting for eye screening					
Description	Due to staff vacancies we cannot undertake the diabetic eye screening of patients in a timely manner and 98 patients per week are not being screened. If a patient is not seen in the appropriate timeframe and then as a result suffers complications due to diabetic retinopathy, they may lose vision								
Controls	A member of staff from Aintree will commence in SDGH from the end of October to undertake the backlog						**Gaps in Controls**	Member of staff only starting at the end of October. Staff member will only be working 2 days a week. No staff cover for sickness	
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)	Catastrophic (5)	20	20	Extreme risk	2	Low risk	12/01/2018	13/02/2018
Assurance	Aintree are going to send a member of staff 1 day per week, start date unknown. Meetings held with Comissioners for diabetic eye screening service Accessmeeting/back log review meetings Backlog updates with CQC & NHSI Planned Care Clinical Governance Ophthalmology update meeting						**Gaps in Assurance**		
Action Plan	Develop Risk stratification for Ophthalmology to accurately monitor how many patients have been missed to follow up. DM met with finance director to present case for external solution, awaiting approval. Liaise with HR SDGH as to where the transfer of the diabetic service is up to.						**Action Plan Due Date**	31/12/2017 28/02/2018 30/11/2017	**Action Plan Rating** Completed Moderate Progress Made Completed

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services					Link to BAF		
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
20/10/2017	1664	Chief Operating Officer	Therese Patten	Inability to provide outpatient review appointments in the required timescales.					
Description	If the Trust does not review patients in Out Patients in the time frames identified by their treating clinicians, then there is a risk that patients may be harmed due to delays instigating required treatment.								
Controls	Only accept choose and book out patient referrals Review staffing in all affected services To analyse each waiting list and prioritise patient based on clinical need.						**Gaps in Controls**		
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	4	Moderate risk	24/01/2018	23/02/2018
Assurance	Review at Governance Committees						**Gaps in Assurance**		
Action Plan	To source external support to assist the Trust in prioritising and treating the patients. Risk stratification complete for all areas and plans in place to clear backlog. Weekly calls with NHSI and NHSE continue with assurance from them to CQC.						**Action Plan Due Date**	30/03/2018	**Action Plan Rating** Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF	BAF010
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
22/09/2016	1368	Director of HR	Jane Royds	Safe Staffing Levels - Impact on Quality and Finance				
Description	If the Trust is not able to attract and recruit nursing and medical staff with the knowledge, skills and experience required there is a risk to the Trust of not providing safe levels of staffing and an impact on finance due to reliance on agency staff.							
Controls	Introduction of a nationally capped rate for agency for both medical and nursing staff Policies and processes around bank/agency staff usage Development of a nurse bank in conjunction with existing NHSP bank supply Edge Hill additional cohort for training nurses Executive oversight at weekly meetings Monthly review at FP & I Committee Monthly review at Board Individual authorisation of requests above cap for agency staff Strategic Alliances with other health care providers Targeted advertising campaign for qualified nursing staff (HEI) Workforce planning methodology agreed Planned recruitment campaigns agreed NHSP cohorts for HCA recruitment Recruitment and Selection Policy Assistant Director of Nursing role leads on Nurse recruitment Discussions with Southport College regarding "Acorns" project for Nurse development Consider joint consultant appointments with local partners, either in specialty units or within the Local Delivery Service framework						**Gaps in Controls**	Draft HR Strategy requires approval Further work to be commenced around more robust workforce planning, engaging service managers. Continuing staff groups that are difficult to recruit to requiring different solutions
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	12	High Risk	25/01/2018	19/03/2018
Assurance	Monitoring of fill rates of bank and agency staff through weekly ED meetings Monitoring of fill rates through monthly Trust Board Shared arrangements with other Trusts for Consultant posts Agency Spend Review Undertaken. Project Co-Ordinator appointed for 6 months to progress actions Monitoring of Recruitment Action Plan through quarterly HR Report to Trust Board Workforce Plan submitted to HE England as approved by the Medical Director. Ongoing targeted advertising campaigns. Trust HR Governance Committee provided with information on Workforce Plan Nurse recruitment campaigns in Higher Education institutes. DON working with NHSP Joint appointments for Senior Consultant with St Helens & Knowsley Hospital NHS Trust, Liverpool Heart & Chest Exit interview process review carried out, with action plan as a result. 2017 - 2019 Workforce Plan submitted to NHSI						**Gaps in Assurance**	Status of workforce plan	
Action Plan							**Action Plan Due Date**		**Action Plan Rating**

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services					Link to BAF	BAF002
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
04/07/2012	482	Chief Operating Officer	Jane Lawson	No Outflow from AED for Admitted Patients				
Description	No outflow from AED for admitted patients. Resulting in : Delays offloading Ambulances, Delays in clinical assessment and treatment Potential for Serious Untoward incident occurring whist waiting for assessment/ treatment and or bed.							
Controls	Emergency Department escalation policy Request for diverts from UCAT Open escalation beds Consider suitability for AEC Ensure all aspects of community support is available Implementation of A/E site performance action plan Monitor ambulance turn around times Pilot for ED safety checklist with Patient Safety Collaborative Intentional Rounding in place for patients in ambulance queue Daily huddle at 11am focusing on performance and ward discharges to improve discahrges and flow Ernst and Young commissioned to support with ED improvement programme Plans in place and £ secured to improve and increase ED physical environment						**Gaps in Controls**	Limit to the number of trolleys which we have the capacity to accept from NWAS crews Delay to see patient may cause harm to the patient Real time data	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	8	High Risk	24/01/2018	23/02/2018
Assurance	Policies and procedures 3 x daily Trust escalation meetings/bed meetings Real time staffing levels assessed daily by Matron CBU Governance meetings HARM meetings 1/52 ED performance meetings						**Gaps in Assurance**		
Action Plan	Review of discharge medicines pathway to be undertaken by ECIP Trial of patient transfer Nurse Develop case for Discharge lounge and implement discharge lounge model Options for implementing real-time information management should be explored to increase visual management and minimise the slow process of hunting and gathering data by senior staff. An electronic bed management system may support this and an options Matrons to attend at least 2 board rounds per week to coach and provide managerial support. Establish and Embed a ready for Discharge Forum Introduciton of ED Safety Checklist with support from Patient Safety Collaborative Re-launch and Pilot SAFER Test/ pilot the model for using red/green days on Wards 14a and 14b Home for Lunch .						**Action Plan Due Date**	28/06/2017 31/07/2017 30/06/2017 31/08/2017 29/09/2017 31/10/2017 29/07/2016 22/05/2018 31/08/2017 28/09/2017	**Action Plan Rating**	Completed Completed Completed Completed Completed Completed Completed Moderate Progress Made Completed Completed

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
12/09/2017	1624	Director of Nursing & Quality	Jacqui Flynn	Lack of evidence of professional curiosity				
Description	A reduction in safeguarding referrals from Emergency Care and a Local Authority audit into Child Criminal Exploitation lead to a Trust safeguarding audit to benchmark on professional curiosity where attendance to the Trust would indicate further questioning should be required / evidenced. Audit results indicated a lack of routine enquiry / lack of documentation if enquiry occurs into high risk cases.							
Controls	Safeguarding training and monitoring of compliance Safeguarding Audit Safeguarding policy Review and monitoring of incidents and compliants					**Gaps in Controls**	Missed opportunities- no real time monitoirng	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	5	Moderate risk	01/02/2018	01/03/2018
Assurance	Mandatory training reports Safeguarding Board- reporting of Audit finndings Audit CQC inspection Incident/ SUI reviews- reported in Q&S						**Gaps in Assurance**		
Action Plan	To incorporate checks into audit of casenotes monthly AED mandatory safeguarding training needs to be completed by all staff The Safeguarding team will increase visibility in department and be on hand to offer advice and support Harm meeting will involve safeguarding incidents and management of cases will be reflected on in order to learn lessons from incidents/ complaints						**Action Plan Due Date**	28/02/2018 20/03/2018 01/10/2018 09/01/2018	**Action Plan Rating**	Moderate Progress Made Moderate Progress Made Actions Almost Completed Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team					Link to BAF		BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).					
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, high turnover.								
Controls	Leadership Master Classes Annual Pride Awards Workforce Strategy Junior Doctors Survey Engagement and Culture Strategy Equality and Diversity Working Group New post created for support of records system, recruitment process is on going.						**Gaps in Controls**	Uncertainty of CEO post	
Risk Levels	**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	07/11/2017	05/02/2018
Assurance	Quarterly HRD report to Trust Board Result of Staff Attitude Survey Coaching in the workplace Values based recruitment based on guidance from NHS England PDR Process which includes Trust values Charter for Staff and Managers Review of culture in the Trust, being carried out by external adviser. HR Director agreed extension of project, report is expected in February 2017.						**Gaps in Assurance**	Nil Identified	
Action Plan	Cultural Review as commissioned by the Board						**Action Plan Due Date**	02/02/2018	**Action Plan Rating** Actions Almost Completed

Strategic Objective		SO3 - Provide care within agreed financial limit						Link to BAF	BAF007
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
10/05/2016	1329	Director of Finance	Steve Shanahan	Returning to financial balance by 2021					
Description	If we do not have a plan to return to financial balance by 2021, then potentially the Organisation will not exist in it's current form.								
Controls	We now have a long term financial model and an estate solution from the Deloitte sustainability report. The Care for You programme will build on the Deloitte work with a view to achieving a more financially sustainable service. Trust is part of the Cheshire & Mersey Health & Social Care Partnership and a member of the Alliance local delivery system (LDS) Implementing the 5 year forward view locally.						**Gaps in Controls**	We need to feed the STP/LDS assumption into our LTFM We need to update LTFM for 2016/17 outturn and 2017/18 plan	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	6	Moderate risk	25/01/2017	19/03/2018
Assurance	Monthly report to Trust Board re STP and Alliance Transformation Committee Work with the Alliance LDS and the Cheshire & Mersey STP						**Gaps in Assurance**	No agreed clinical model for reconfiguration of services within the STP.	
Action Plan	Development of Estate plan for reconfiguration of services; identification of land sales to support capital development costs Development of a financial revenue plan with savings for the reconfiguration of services Submission of Trust 2 year operational plans by 23/12/16. Submission of STP plan.						**Action Plan Due Date**	01/09/2018 23/12/2016 16/10/2016	**Action Plan Rating** Moderate Progress Made Completed Completed

Southport and Ormskirk Hospital Trust
Committees Cycle 2018

NHS Southport and Ormskirk Hospital NHS Trust

Board of Directors
Audit Committee
Finance Performance & Investment Committee
Quality & Safety Committee
Workforce Committee
Mortality Assurance & Clinical Approvement Committee
Board Development Session

2018	MON	TUE	WED	THU	FRI	SAT	SUN
JANUARY	1 BH	2	3	4	5	6	7
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
FEBRUARY				1	2	3	4
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
MARCH				1	2	3	4
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
APRIL							1
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
MAY		1	2	3	4	5	6
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
JUNE					1	2	3
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
JULY							1
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
AUGUST			1	2	3	4	5
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
SEPTEMBER						1	2
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
OCTOBER	1	2	3	4	5	6	7
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
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2018	MON	TUE	WED	THU	FRI	SAT	SUN
DECEMBER						1	2
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	31						

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Ann Farrar - Interim Chief Executive Officer
Richard Fraser - Chair
Southport and Ormskirk Hospital NHS Trust
Southport and Formby District General Hospital
Town Lane
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PR8 6PN

23 JAN 2018

Dear Ann and Richard,

I am writing to congratulate you and your team on the improvement at the Southport and Ormskirk Hospital NHS Trust, that has come together to mean that you improved the proportion of cancer patients receiving definitive treatment within 62 days of referral in the period September 2017 to November 2017 compared with the period June 2017 to August 2017.

Moving from 77.6% to 87.1% is an achievement to be proud of. In this sense, the trust is a real example to others, demonstrating how to improve performance in a short space of time and ensure that your patients get the care that they deserve. Whilst it is encouraging that you have improved in the latest published data on cancer 62 day performance, it is important that this is part of a sustainable cancer recovery plan to deliver and maintain the standard.

From visiting organisations throughout the country, I know that the immense amount of work that will have been behind this outcome cannot be underestimated. Improvement like this are impressive and testament to the hard work and dedication of the trust's staff. Please do pass on my congratulations to all those who work at the trust; the service they give makes a real difference to the lives of many of the area's sickest and most vulnerable patients.

I hope that you will share your learning and experiences with other trusts as the whole NHS strives to improve its cancer service. Again, please pass on my personal congratulations and thanks to everyone who has made this happen.

Yours ever

Jeremy

JEREMY HUNT