NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 10:30 – 13:00 on Wednesday 2nd May 2018
Seminar Room, Clinical Education Centre, Southport District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Time
PRELIMINARY BUSINESS			
TB104/18 (V)	**Chair's welcome & noting of apologies** To **note** the apologies for absence	**Chair**	**10.30**
TB105/18 (D)	**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**	
TB106/18 (D)	**Minutes of the Meeting held on 11th April 2018** To **approve** the minutes of the Board of Directors	**Chair**	
TB107/18 (D)	**Matters arising action Log** To **review** the Action Log and receive relevant updates	**Chair**	
STRATEGIC CONTEXT			
TB108/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**10.40**
QUALITY & SAFETY			
TB109/18 (P)	**Patient Story: Mr Lionel Johnson – Patient and Volunteer** To **receive** the presentation and **discuss** learning from the above		**10.50**
TB110/18 (D)	**Quality & Safety (Q&S) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of QSC**	**11.00**
TB111/18 (D)	**Quality Improvement Plan Progress Update** To **receive** the monthly report	**ADoN**	**11.05**
TB112/18 (D)	**Draft Quality Improvement Strategy** To **receive** the strategy	**ADoN**	**11.15**
TB113/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**MD**	**11.20**
TB114/18	**Workforce Committee (WFC): Alert Advise & Assure**	**Chair of WFC**	

Ref No.	Agenda Item	Lead	Time
(D)	**Report** To **receive** a highlight report including any escalated risks from the Committee		11.30
TB115/18 (D)	**Monthly Safer Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	DoN	11.35
TB116/18 (D)	**Director of Medical Education Report** To **receive** the report	Mr Sanjeev Sharma	11.45
TB117/18 (D)	**Guardian of Safe Working** To **receive** quarter 4 report	Dr Ruth Chapman	11.55
PERFORMANCE			
TB118/18 (D)	**Finance, Performance & Investment (FP&I) Committee: Alert, Assure & Advise Report** To **receive** a highlight report including any escalated risks from the Committee	Chair of FP&I	12.05
TB119/18 (D)	**Audit Committee: Alert, Assure & Advise Report** To **receive** a highlight report including any escalated risks from the Committee	Chair Audit	12.10
TB120/18 (D)	**Emergency Care Performance Report Including 4 Hour Access Patient Flow** To **receive** a monthly update report	COO	12.15
TB121/18 (P)	**Integrated Performance Report (IPR)** To **receive assurance** from the current position in relation to national performance targets and integrated governance	DoF	12.25
TB122/18 (D)	**Director of Finance Report** To **receive** the **current financial position at Month 12** and progress on the Cost Improvement Programme / Internal Sustainability and to approve the following	DoF	12.30
TB123/18 (D)	**Financial Plan 2018/19, including 5 Year Capital Plan** To **approve** the 2018/19 Plan	DoF	12.35
GOVERNANCE / WELL LED			
TB124/18 (D)	**Risk Management:** • **Board Assurance Framework** • **Risk Register** To **receive** the quarterly report on the BAF and the monthly report on the Risk Register	Executives	12.45
TB125/18 (D)	**Trust Compliance with Provider Licence** To **receive** an update on evidence for compliance and to **approve** the self-certification declaration to NHS Improvement	ICoSec	12.55

Ref Nº.	Agenda Item	Lead	Time
TB126/18 (D)	**Items for Approval / Ratification:**	**Chair**	
TB127/18 (V)	**Questions from Members of the Public**	**Public**	**13.00**
CONCLUDING BUSINESS			
TB128/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**	
TB129/18 (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**	
TB130/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**	**CLOSE**
TB131/18 (V)	**Date and time of next meetings** Wednesday ***6th June 2018, 10.00am*** Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**	

ACTIONS REQUIRED:

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

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

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

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

For Information: Literally, to inform the Board

Chair: Richard Fraser

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Register of Interests Declared by the Board of Directors 2018/19 AS AT 9 April 2018

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Other	Date of entry on register or amendment
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 July 2017** **Updated 25 September 2017**
BRICKNELL, Dr David	Non-Executive Director	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**9 April 2018**
CLARKE, Mr Ged	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Kinsella Clarke Chartered Accountants. A number of Trust's Medical Consultants are clients.**	**1 May 2016**
FRASER, Mr Richard	Chairman	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trust Chairman of St Helens & Knowsley Hospital NHS Trust**	**1 December 2016** **Updated 2 April 2018**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director, Excel Coaching & Consultancy.**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Other	Date of entry on register or amendment
			Provision of coaching services to Directorate and senior NHS Management personnel						
GILLIES, Mr Rob	Executive Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**June 2013**
GORRY, Mrs Julie	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**2 August 2017** **Updated 14 March 2018**
MAHAJAN Dr Jugnu	Interim Medical Director	**Nil**	**Director of M&M Professional Consultancy Services**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**22 January 2018**
MURPHY Mrs Gillian	Acting Director of Nursing	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 April 2018**
NICHOLLS Mr Silas	Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 April 2018**
PATTEN, Mrs Therese	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
ROYDS, Mrs Jane	Associate HR Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**30 May 2017** **Updated 25 September 2017**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Other	Date of entry on register or amendment
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**Owner: providing practice & GMC work**	**Nil**	**Private practice at Ramsay Health**	**Nil**	**Nil**	**Nil**	**9 April 2018**
SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother Mr Peter Shanahan is an Executive Director, Advisory on the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust**.	**Nil**	**Nil**	**25th January 2018**

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Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 11th April 2017

Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 2nd May 2018)

Present

Richard Fraser, Chair
Jim Birrell, Non-Executive Director
David Bricknell, Non-Executive Director
Ged Clarke, Non-Executive Director
Julie Gorry, Non-Executive Director
Gill Murphy, Acting Director of Nursing
Silas Nicholls, Chief Executive
Therese Patten, Chief Operating Officer
Jane Royds, Associate Director of HR*
Steve Shanahan, Director of Finance

In Attendance

Audley Charles, Interim Company Secretary
Samantha Scholes, Interim PA to the Company Secretary
Kevin Thomas, Deputy Medical Director

Apologies:

Pauline Gibson, NED Designate *
Caroline Griffiths, NHSI
Dr Jugnu Mahajan, Interim Medical Director
Mr Gurpreet Singh, Non-Executive Director

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
TB077/18	**CHAIRMAN'S WELCOME AND NOTE OF APOLOGIES**	
	Mr Fraser opened the meeting by welcoming the Board members and explained that the Board meeting had been rescheduled from 4 April, due to his in-patient requirements on that date and the absence of two other NEDs which would have resulted in a non-quorate Board. He introduced Silas Nicholls, the substantive Chief Executive and thanked Ann Farrar, Interim Chief Executive for her work with the Trust. The Chair welcomed Gill Murphy, Acting Director of Nursing and noted that Juliette Cosgrove, substantive Director of Nursing, would commence her role on 7th May 2018. He also welcomed Dr David Bricknell as a new Non-Executive Director and Mr Kevin	

	Thomas, Deputy Medical Director, deputising for Dr Mahajan and noted apologies from Pauline Gibson, Dr Jugnu Mahajan and Mr Gurpreet Singh, new Non-Executive Director.	
TB078/18	**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 Interim Company Secretary.	
TB079/18	**MINUTES OF THE MEETING HELD ON 7h March 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 7th March subject to the following changes which were noted for amendments: Page 1: Add Ged Clarke, Non-Executive Director as present. Page 9: 1st paragraph re*; 'Saying Sorry'.* Duty of Candour should provide this before it was requested. Page 11, TB058/18: paragraph 1; replace 'actual' with 'average', Page 16, TB062/18: remove additional 'that' from the final paragraph. **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the noted amendments	
TB080/18	**MATTERS ARISING ACTION LOG**	
	The Board considered the following matters arising in turn: **TB116/17 Staff Engagement Plan:** Mrs Royds to help revise Cultural Review statement. **TB185/17 Items for Approval, Standard Operating Procedure for the Administration of Meetings:** To be brought to the May Board **TB037/18 Exec Ward Visits:** escalation requirements have improved. **Quality & Safety AAA Highlight Report:** 'Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) issues which have impacted on the Diabetic Eye Screening service will be resolved by end of April 2018. Patient care was unaffected and volume was reducing**.** Highest risk/longest waits have been prioritised. **TB061/18 Security in Pharmacy:** a paper was to be brought to the June Board. **TB067/18 IM&T Strategy:** the paper was to be brought to the May Board.	**ADHR** **ICOSEC** **COO** **COO** **DoF** **DoF**

TB081/18	CHIEF EXECUTIVE'S REPORT	

Mr Nicholls thanked the Chair for the welcome to the Board and to the staff and patients who had extended a warm welcome to him. He was happy to be finally in post.

He related he had been asked why he had left Manchester and taken the role of Chief Executive Officer at Southport. His answer was that this was where he and his family lived and he wanted to ensure that the hospitals and services provided by the Trust in the area were those to be proud of. He acknowledged there had been difficult times in the past, with organisational turmoil however, he and the Board would work together with all teams to resolve these.

In his 7-day tenure to date, he had identified that the Trust had tried to do too much, too fast. This was a great ambition however it would be prudent to focus on two important issues:

1. **Pace**
   Reducing the focus from 'everything' to narrow what the Trust was to achieve to enable faster completion and then give space to focus on other issues.

2. **Engagement**
   Our senior leaders understand what important to staff, the local community, health and social care. The greater our understanding, the better responses and decisions would be.

Key Issues

Executive Leadership
This had been a challenge for the Trust in recent years, resulting in instability. In addition to his own substantive role, Mr Nicholls was pleased to advise that Juliette Cosgrove would commence as Director of Nursing on 7th May.

Quality and Safety
Staff work very hard in their jobs despite the instability, however quality and safety needed improvement. The recent CQC Report and Action Plan would be a springboard for developing those aspects. It was acknowledged that the A&E department was under significant pressure and he was assured that under Ms Patten's leadership, plus investment to expand the department, that would enable a safe environment of quality care. There was concern that that may take some time and the experience of patients in beds on A&E corridors was undignified. Ms Patten had advised that in 12 weeks' time that would be different.

	Financial Position The financial position had stabilised, however significant risk and their subsequent impact remained. To address the issue of patients in corridors the Trust needed to make investments and additional facilities and it would work with Commissioners and Regulators to resolve those challenges. Keeping the hospital safe was detailed in the Trust's response to the CQC and keeping it calm would be achieved by alleviating the heat felt by A&E and the wider hospital pressures, resulting in improvement for patients and staff. The Chair responded that he called into A&E each time he visited the site and he had not seen it quieten in the last 12 months. Record numbers of patients attended in April, which was both unexpected and subsequently unplanned for. Getting the substantive CEO in place for the long-term, to oversee activity and delivery was vital and the Board was delighted to have Mr Nicholls in post. **RESOLVED:** The Board **received** the Chief Executive's Report.	
TB082/18	**QUALITY & SAFETY** **Commissioning for Quality & Innovation (CQUIN) – Health and Wellbeing; Healthy Foods**	
	Simon Williams, Head of Facilities Mr Williams stated that the focus of the presentation related to the National CQUIN Reference Goal 1b: 'Healthy food for NHS staff, visitors and patients.' which is a three-year plan, 2017-2019. This had set the requirements that items with a high level of fat, sugar or salt not being available at the checkout, advertised or included in price promotions in 2017 to 80% of drinks for sale sugar free, confectionary and sweets less than 250kcal per packet and 70% of pre-packed sandwiches and savoury meals being 400kcal per serving, not exceeding 5g of saturated fat per 100g in 2019. That affected the Trust's restaurants, cafes, RVS and League of Friends at Ormskirk. By the end of October 2017, the Trust had removed all sugar sweetened beverages, containing 5g or more of added sugar per 100ml) from retail outlets and informed suppliers that no further orders of this nature would be placed, thereby complying ahead of the 1st July 2018 deadline.	

	Mr Williams confirmed that the percentages related to the sales of the products and includes vending machines, with extension to the locations of vending available wider in the Trust. Sales had not declined, indicating that purchasers were satisfied. it was acknowledged that the communication of these changes needs to increase. Catering for patients was flexible and supportive taking into account dietary and physiological needs and endeavours to accommodate patient and clinician requests. Mr Nicholls thanked Mr Williams for an interesting presentation. **RESOLVED:** The Board **received** the presentation.	
TB083/18	**QUALITY & SAFETY COMMITTEE - ALERT, AVISE and ASSURE (AAA) HIGHLIGHT REPORT**	
	Mrs Gorry, as Chair of this committee, presented the report. The new public-facing Trust website should go live by end April 2018. Some of the recorded hospital pressure sores might be due to not undertaking skin bundle assessments in A&E. Audits were being undertaken with a view to improving working practices. The response rate for Friends & Family was 3.7%. Whilst 90% of those responses were positive, consideration was being given as to how to improve the rate. Non-Executive Director links with assurance committees had been agreed and would be reported via the next Quality & Safety Committee. **RESOLVED:** The Board **received** the update.	
TB084/18	**CQC IMPROVEMENT ACTION PLAN**	
	Mrs Murphy presented the Board report following the CQC inspection report published 13th March 2018. During the inspection, the CQC rated six of the Trust's seven services as '*Requires Improvement'* and one as 'Good'. That resulted in three regulatory actions: Regulation 5: Fit and Proper Persons: Directors Regulation 17: Good governance Regulation 20: Duty of Candour The Trust submitted the new CQC Action Plan to CQC, 10th April	

	2018. Lessons learned included involving front-line staff and outcomes measured. Identifying assurance that actions were implemented and that issues were escalated in a timely manner through the appropriate committee. The Chair commented that the CQC would benefit the Trust, patients and staff. The Board was assured that regarding Regulation 5, all current Non-Executive and Executive Directors of the Board were Fit & Proper Persons, however, CQC had not been confident that the process at the point in time of their report had been sufficiently robust which was reflected historically, throughout the NHS. The Chief Executive acknowledged that to achieve '*Good'* by 2020 was a significant challenge to the Trust and whilst everyone had the ambition to achieve that, it would take communication and consistent work to cease the 'them and us' ethos being perpetuated. **RESOLVED:** The Board **received** the report.	
TB085/17	**MONTHLY MORTALITY REPORT**	
	Mr Thomas presented the report on behalf of Dr Mahajan. Mortality work had been undertaken by various groups with the aim of reducing mortality. Structured Judgement Reviews (SJR) training for Departments would conclude 31st May 2018, with full implementation in conjunction with DATIX on 31st August 2018. The outcomes of Dr Chris McManus' review of all pneumonia mortality from September 2017 to March 2018 is to be circulated along with the proposed changes in the clinical process, in the next 4-6 weeks. Hospital Standardised Mortality Ratio (HSMR) data to be clarified relating to exclusion of palliative care including explanation. The Chair observed that progress on reporting was good, despite the frustrations relating to its delay. **RESOLVED** The Board **received** the update.	**MD**
TB086/18	**WORKFORCE COMMITTEE - ALERT, AVISE and ASSURE (AAA)**	

	HIGHLIGHT REPORT	
	Mr Birrell presented the report on behalf of Mrs Gibson: • Medical Education would be assessed externally. • Staff Survey results were at an unacceptable level and would be an agenda item for the Board and full survey results circulated. • Sickness levels remained a concern resulting in financial and stress pressures and the Sickness Policy would be reviewed by the JNC in May 2018 following agreement in principle by the Workforce Committee at the end of April 2018. **RESOLVED:** The Board **received** the report.	
TB087/18	**MONTHLY SAFE STAFFING REPORT**	
	Mrs Murphy presented the month's report. 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 February 2018 against the accepted national level of 90%: • Trust overall 85.09% • 79.87% Registered Nurses (RN) on days • 81.03% Registered Nurses on nights • 90.60% Care staff on days • 97.56% Care staff on nights Trust vacancy: • 11.81% (103.16wte) Registered Nurse vacancies at band 5 and above • 10.46% (39.77 wte) Healthcare assistant vacancies band 2 and above. Trust whole time equivalent (wte) funded establishment versus contracted:	

	Funded WTE	**Contracted WTE**
Registered	852.82	761.13
Non-registered	377.04	342.33
Total	1229.86	1103.46

Whilst completing a 'deep dive' into safe staffing in A&E, it emerged that not all hours worked by registered and non-registered staff were captured on the electronic roster system. That would suggest that we were potentially under reporting the percentage fill rate, as the

	monthly data was acquired from the electronic roster. A full review had commenced and all wards and departments were being supported to ensure ALL hours worked were recorded on the electronic roster system, HealthRoster. The outcome of that review would be reported to the workforce committee in April and in turn to the Board in May 2018. That issue was seen as a potential risk and had been added to the risk register. **RESOLVED:** The Board **received** the report.	**DoN**
TB088/18	**FINANCE, PERFORMANCE & INVESTMENT COMMITTEE – ALERT, AVISE and ASSURE (AAA HIGHLIGHT REPORT**	
	Mr Birrell, as Chair of this committee, presented the report. Average length of stay had increased, which was one factor of increasing bed demand. Investment from the capital programme would be used by the end of the year. **RESOLVED:** The Board **received** the report.	
TB089/18	**CHARITABLE FUNDS COMMITTEE – ALERT, AVISE and ASSURE (AAA HIGHLIGHT REPORT**	
	Mr Fraser, as Chair of this committee, presented the report. Mr Shanahan commented that the Fundraiser post and Volunteer Manager post would be considered as separate roles, Ms Cosgrove, as Director of Nursing would undertake a review of the nursing workforce, including volunteers, as one of her first tasks. An appropriate Business Case with evaluation would be brought to the Executive Team meeting for consideration and subsequently the July Board. **RESOLVED:** The Board **received** the report.	
TB090/18	**EMERGENCY CARE PERFORMANCE REPORT**	
	Ms Patten presented the month's report. Overall performance had remained at 80%, as Easter generally saw an increase in admissions; there was no drop-off in performance which was reassuring. 12-hour breaches dropped significantly in February due to the implementation of a Command and Control system to manage patient flow across both sites. Easter had seen no 12-hour breaches. Outliers continued to be relied upon; how to pro-	

	actively manage this was being considered. Length of stay for emergency arrivals improved with elective increasing slightly. Super Stranded and Stranded Patients continue to be problematic and the Trust was working with CCG and the Local Authority on practical improvements to be launched from April 2018. The Chair asked if the recent email request sent to the whole Trust to discharge two patients on each ward resulted in success. Ms Patten responded that this information was not routinely available however a plan was in place to make it so. Mr Nicholls concurred; whilst managing a crisis was achievable that could not be normalised behaviour/action. Patients not receiving specialist care resulting from not being on the most appropriate ward and vulnerable and/or frail patients being moved in the middle of the night to accommodate other patients were unsuitable and would potentially result in disorientation and subsequent falls. Mrs Gorry cautioned that discharging some patients might result in a 'revolving door' of readmission. Ms Patten outlined that at present there was no contemporaneous information on patients. This was being addressed by Ernst Young (EY) in a four-week programme of work to establish who was in the hospital, where they were and where they had gone to, at discharge. This would also enable people to be held responsible. The Chair observed that the 12-hour breach data was green on the Integrated Performance Report (IPR), which did not correlate with the information supplied in Ms Patten's report. The IPR report would be discussed as the next item. Ms Patten circulated the document '*Reprioritised – Patient Flow Improvement Programme & Mobilisation'*. This programme clearly outlined that the Trust needed to do to give staff, clinicians and Clinical Business Units (CBUs) the mechanisms to remove the need to have patients on beds in corridors. Additional medical capacity, resources, beds and funding were needed to deliver that by the end of May 2018 and for June 2018 to evidence improvement. Mr Nicholls thanked Ms Patten and her team for the complex work undertaken. The key was recognising patient safety and dignity and to examine what was needed for change to occur. Medical capacity was possibly less than expected and Performance Management would go	

	down when that was resolved and targets were not being chased. He added that he had confidence that that was the right thing to be doing and related his experience in different Trusts where that had been achieved. Southport & Ormskirk were not different. Mr Birrell commented that moving a patient from one ward to another was not a solution, however, seven-day working and early intervention might be. He related his experience as a visitor to an in-patient who had waited over a week to be seen by a Consultant, which impacted on their length of stay. Waiting on a bed in a corridor might be considered less worse than being on a ward with no treatment. The Chair and Mr Nicholls agreed that patient safety was the highest priority along with availability of care. Mr Birrell added that the programme did not appear to include mechanisms for 'Calm' in the Hospital, which, in light of the difficulties faced by staff, was important. Mr Nicholls concurred with Mr Birrell, stating engagement was a priority and the CEO's blog would be produced on a weekly basis to inform all staff what the Board and the wider Trust was and would do. Ms Patten commented that with additional funding and resources, Matrons would lead ED Co-ordination, with some of their current workload picked up by other team members to enable that to be achieved. Mrs Gorry added that Ward Managers needed to be considered in that proposal and the Quality & Safety Committee would include it as part of its monitoring workload **RESOLVED** The Board **received** the report.	
TB091/18	**INTEGRATED PERFORMANCE REPORT (IPR)**	
	Mr Shanahan presented this report. The current iteration of the Integrated Performance Report was identified as needing improvement. The report format was being re-developed with the Business Intelligence Team and in consultation with Caroline Griffiths, NHSI Improvement Director. A draft version of the new report format would be circulated to the Executive Team Meeting and brought to May's	**DoF**

	Private Board. **RESOLVED** The Board **received** the report.	
TB092/17	**DIRECTOR OF FINANCE REPORT**	
	Mr Shanahan presented this report. **a) Current financial position at Month 11** Month 11 year to date deficit of £28.0m indicates an improved forecast outturn of £29.2m to be delivered. The final cut off would be Friday, 13th April. The potential sanctions to be imposed could now be £0.5m from £3m. The result of the Expert Determination Process will be delivered 17th April 2018. Cost Improvement Programmes (CIP) shortfall was forecast to be £2.3m against target plan. Mr Shanahan agreed to circulate the final year-end numbers to the Non-Executive Directors and would be reviewed at the Financial Performance and Investment Committee on the 23 April Thanks were recorded for Mark Wilson and Suzanne McGrath for their work in contributing to the report. Mr Shanahan added that February 2018's actual income almost matched the planned income; March 2018 was expected to be held up; and the control total for agency staff in Month 11 was £6.2m against anticipated £7.2m. Mr Birrell commented that the Trust was still overspending, with a need for more beds, staff etc., which would only be feasible if Commissioners paid for these extra resources. Mr Nicholls agreed that there needed to be sensible conversations with all parties about how to manage the specified needs of the population which would cost a specified amount of money. The Chair concurred stating that there needed to be a better working relationship between the Trust and its Commissioners. **b) To approve the 5 Year Capital Plan** Amendments were made to the Plan due to delay in surgical assessment unit. Plan was 'as is', utilising £100k to start work on a discharge lounge. It was confirmed following a question from Mr Clarke that the majority of capital funds were generated from the in-year depreciation charge.	

	It was recognised that some CQC 'must dos' would require capital funds in 2017/18. **RESOLVED:** The Board **approved** the plan.	
TB093/18	**RISK MANAGEMENT: RISK REGISTER**	
	Mrs Murphy presented the report. The Extreme Risk Register had been reduced by two as they have been amalgamated into current similar ri/sks. The potential under reporting of Safe Staffing data had been added to the appropriate risk on the Risk Register as there was a gap in controls in relation to data capture and reporting. Mrs Royds advised that appointments to the roles of Equalities Lead and Freedom to Speak Up Guardian had been made. **RESOLVED** The Board **received** the report.	
TB094/18	**TRUST'S COMPLIANCE WITH PROVIDER LICENCE**	
	Mr Charles presented the report. The Trust was required to self-certify its compliance with Provider Licence Conditions: G6 and FT4 by 31 May and 30 June 2018 respectively. The Trust was not required to send the self-certification to NHSI but from July 2018, a Trust may be asked to provide evidence of its compliance as part of a sample test being done by NHSI. Mr Charles stated that as per the evidence provided in the report he was asking the Board to approve compliance with both Conditions Mr Birrell questioned compliance with Condition F4 given the recent CQC report questioning the robustness of governance arrangements in the Trust. Members agreed and asked Mr Charles to declare non-compliance against that Condition with an Action Plan to achieve compliance and bring back to the May Board. **RESOLVED** The Board **reviewed** the evidence and approved compliance with Condition 6 but recommended a non-compliance position for Condition FT4.	**ICOSEC**

TB095/18	**BOARD DEVELOPMENT PROGRAMME**	
	The Chair presented the programme to the Board. He drew attention to the Options Appraisal in the Report outlining advantages and disadvantages of each. The Report's recommendation was for Option 1. Discussion took place regarding the constraints of time; what the regulator's view was likely to be especially with regards to having bi-monthly public boards and it was asked if the change was too far, too soon. It was suggested that it might not be feasible to have time out sessions without agreeing to Option 1. The Chair agreed to speak with Jill Copeland of NHSI to seek the Regulator's view about the two options and report back to the Board in May. **RESOLVED** The Board **received** the report.	**CHAIR**
TB096/18	**DRAFT ANNUAL GOVERNANCE STATEMENT 2017/18**	
	Mr Charles presented the report. The current CEO was required to sign the Annual Governance Statement for 2017/18 despite coming in to post at the beginning of April 2018 and was not in office during the reporting period. This draft was taken to Audit Committee earlier on 11th April and following feedback the draft would be revised to include feedback from External Auditors, Mazars. A further draft would be brought to the Board in May as part of the draft Annual Report. **RESOLVED:** The Board **received** the report.	**ICOSEC**
TB097/18	**TERMS OF REFERENCE FOR BOARD OF DIRECTORS & BOARD'S ANNUAL ASSESSMENT OF ITS PERFORMANCE AND EFFECTIVENESS TOOL**	
	Mr Charles outlined that the Board aimed to improve its individual and collective effectiveness as a means of improving the overall performance of the Trust. A Tool had been developed to measure the performance and effectiveness and it was recommended that took place bi-yearly. Once mid-year to review current practice and once at end of year. The end of year assessment may involve the use of an external	

	facilitator. The Board agreed to undertake the process and Mr Charles would issue the Tool for completion and a composite report presented at the June Board. **RESOLVED** The Board **approved** the Tool.	
TB098/18	**ITEMS FOR APPROVAL/RATIFICATION**	
	Items for Approval / Ratification: **Uncommitted Support Loan** The Emergency Powers taken by the Chair and CEO to approve the submission of an Emergency Loan to the Secretary of State for Health was ratified by the Board **Statutory Instruments** Mr Charles advised that drafts of the documents: Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation were taken to Audit Committee earlier in the morning and following feedback a few areas would be revised. As the documents were developed some time ago and a required before the May Board, the Board approved them, subject to agreed amendments. *The Anti-Fraud, Bribery and Corruption Policy* was ratified. **Risk Management Safety** Mrs Murphy stated that the Risk Management Strategy had been updated to reflect incorporation of corporate risk alongside clinical risk. Mr Charles thanked Mr Birrell for his feedback on the strategy. Mrs Gorry asked how the strategy would be rolled and awareness made possible in the Trust. Mrs Murphy responded that clinically there were various policies which underpin the Risk Management Strategy and via the escalation process links would be maintained. CBUs report their risks to the Quality & Safety Committee. Mr Charles added that the Policy has also been strengthened with the addition of a robust monitoring process. I response to Mrs Gorry's query he stated that the Communication department would inform the Trust of the updated Policy.	

TB099/18	**QUESTIONS FROM MEMBERS OF THE PUBLIC**	
	There were no questions raised.	
TB100/18	**ANY OTHER BUSINESS**	
	Mr Charles asked the Board to consider standing down the exceptional Board meeting scheduled for the afternoon of 23rd May to approve the final end of year documents as it was not felt it was best use of Board Members' time., Instead, he suggested that all Board members, not normally members of the Audit Committee, which would meet in the morning to review the end of year documents and make recommendations to the Board, be invited to the Committee to contribute to the discussions. Formal approval of the documents by the Board to be delegated to the Chair and the the CEO with the support of two NEDs, who were not normally members of Audit Committee. The next Public Board in June would be asked to ratify the decision taking by the Chair and CEO..	
TB101/18	**ITEMS FOR THE RISK REGISTER/CHANGES TO THE BAF**	
	There were no items or changes.	
TB102/18	**MESSAGE FROM THE BOARD**	
	There was no message from the Board.	
TB103/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 6th June, 10.00am **Seminar Room, Clinical Education Centre, Southport District General Hospital**	

There being no other business, the meeting was adjourned

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 2 May 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

OUTSTANDING ACTIONS

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
JUNE 2017	**TB116/17 Staff Engagement Plan**	**ADHR June 2018**	Staff Engagement Strategy to be brought to the Board after discussion with the CEO.	**Awaiting CEO agreement**	**AMBER**
June 2017	**Cultural Review**	**ADHR June 2018**	Board members to be apprised of the review's findings and implications	**On-going process - not concluded**	**AMBER**
SEPT 2017	**TB185/17 Items for Approval - Standard Operating Procedure for the Administration of Meetings**	**ICoSec April 2018**	A further version including the dates for the Board Development Workshops to come to the March Board.	This has been further deferred pending consultation with the new substantive CEO and Executive Team. **To be brought to the June Board.**	**AMBER**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 2 May 2018

OUTSTANDING ACTIONS

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
MAR 2018	**TB061/18 Audit Committee AAAs Report-Security in Pharmacy**	**DoF April 2018**	Security in Pharmacy and Spinal Unit alongside CCTV camera review to be assessed by Local Security Management Specialist, (Information Governance with Assistance from the Anti-Fraud Specialist if required to address this).	**To be included in the Internal Audit Work Plan 2018/19. Update to June Board.**	**AMBER**
MAR 2018	**TB067/18 Information Management & Technology (IM&T) Strategy**	**DoF April 2018**	The IM&T Contract to be brought to the April Board. **Note: Contract needs to be signed by October 2018**.	**Contract discussions not concluded and should be ready for the July Board.**	**AMBER**
APR 2018	**TB085/18 Monthly Mortality Report**	**MD May 2018**	The outcomes of Dr Chris McManus' review of all pneumonia mortality from September 2017 to March 2018 to be circulated along with the proposed changes in the clinical process, in the next 4-6 weeks.	**Report going to Mortality Operational Group (MOG) in May.**	**AMBER**
APR 2018	**TB087/18 Monthly Safe Staffing Report**	**DoN May 2018**	Outcome of review of hours worked by registered and non-registered staff on HealthRoster to be brought to the May Board.	**Review continues to identify hours worked that are not captured centrally. DoN to update Board when full impact identified.**	**AMBER**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 2 May 2018

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
APR 2018	**TB089/18 Charitable Funds Committee**	**DoF JULY 2018**	Fundraising and/or Volunteer Manager Business Case and evaluation to be brought to the July Board, post approval at Executive Team Meeting (ETM).	**Future agenda item.**	**AMBER**
APR 2018	**TB091/18 Integrated Performance Report**	**DoF MAY 2018**	A draft version of the new report format will be circulated for the Executive Team Meeting and brought to May's Private Board initially before going to the Public Board, as confidence in this key report as a trustworthy source is a necessity.	**This is being updated in light of recommendations from the CEO.**	**AMBER**
APR 2018	**TB095/18 Board Development Programme**	**Chair MAY 2018**	Opinion of NHSI to be sought on options presented and response brought to the May Board.	**Chair to update at Board**	**AMBER**
APR 2018	**TB096/18 Draft Annual Governance Statement**	**ICoSec MAY 2018**	To be revised to include feedback from Mazars and brought to the May Board.	**This is being continuously updated but final Draft to Audit Committee and Board due 23 May**	**AMBER**

NHS Southport and Ormskirk Hospital NHS Trust

Public Board Matters Arising Action List as at 2 May 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

COMPLETED ACTIONS

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
DEC 2017	**Quality & Safety AAAs Highlight Report-Follow Up Appointments**	COO Jan 2018	Overdue Follow Up Appointments. Diabetic eye screening appointments have been impacted by the failure of a service provider arrangement with Aintree Hospital. High risks patients were to be consulted by the end of January and all patients by the end of March	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. Update: unexpected TUPE issues have impacted on the Diabetic Eye Screening service and consideration for the future is required. Patient care is unaffected. Update: Staffing issues will be resolved from April 18. Aintree provided bank staff to support screening service. 24.04.18: Issues now picked up monitored monthly through Q&S.	**BLUE**

NHS
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Public Board Matters Arising Action List as at 2 May 2018

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
FEB 2018	**TB037/18 Exec Ward Visits – Stroke Rehabilitation Ward**	COO April 2018	Stroke rehabilitation area/bed was being used as an escalation for emergency admission preventing right care at the right time for stroke patients. This should be reviewed and The COO to update via the Emergency Care Performance Report.	2 beds ring-fenced for Stroke patients but due bed pressure they had to be used for escalation, starting again on 26th March. **24.04.18: Escalation beds have now been de-escalated on 23.04.18 and 1 bed ring-fenced for Stroke patients with the 2nd bed to ring-fenced by the end of the month**.	**BLUE**
APR 2018	**TB094/18 Trust's Compliance with Provider Licence**	ICoSec MAY 2018	Self-certification of non-compliance with Provider Licence Condition FT4 relating to governance to be updated to show non-compliance with action plan on how to be and brought back to the Board in May.	**On May Board agenda**	**BLUE**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2nd May 2018

Agenda Item	TB108/18	Report Title	Chief Executive's Report
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Silas Nicholls, Chief Executive		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Key Messages and Recommendations

This, my first report to the Board, focuses on the following:

1. Board appointments
2. Freedom to Speak Up
3. Financial Performance
4. Urgent Care
5. Care Quality
6. Sterile services clean up
7. NHS ambassadors
8. Media Briefing

Recommendation

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

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

- ✓ **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…..)*

- ✓ Annual Business Plan Priority
- ✓ Best Practice
- ✓ Linked to a Key Risk on BAF / Risk Register Ref No.: ___ALL_____
- ✓ Other List (Rationale) _____

✓ Service Change ✓ Statutory requirement

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

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

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

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

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

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

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

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

For Information: Literally, to inform the Board

Care Quality

CHIEF EXECUTIVE'S REPORT TO PUBLIC BOARD – 2 May 2018

This is my first report to Board following my arrival as Chief Executive on 3 April. I have already had the opportunity to meet many staff and partners, and I look forward to getting to know many more over the coming weeks and months.

I know it has been an uncertain and sometimes bewildering time for staff over the past couple of years with no permanent leadership at the top of the organisation.

However, I'm here for the long-haul. This is an organisation with a great future ahead of it and one I am now proud to lead. I also know that, from what I've seen and the great people I've met, I can rely on their support to make that future happen.

Board appointments

Juliette Cosgrove will join the Trust on 7 May as Director of Nursing, Midwifery and Therapies. She succeeds Sheila Lloyd who left in March for a director's post at The Clatterbridge Cancer Centre NHS Foundation Trust in Wirral.

She has more than 30 years' nursing experience, most recently as Assistant Director of Quality and Safety at Calderdale and Huddersfield NHS Foundation Trust in West Yorkshire where she led on quality, governance and improvement.

Juliette has also held other senior nursing posts including deputy chief nurse at Leeds Teaching Hospital NHS Trust and head of nursing quality at the former Yorkshire and Humber NHS Strategic Health Authority.

I am also pleased to welcome **Dr David Bricknell** and **Mr Gurpreet Singh** as non-executive directors of the Trust. They will formally join the Board in June.

A solicitor by profession, Dr Bricknell was Group Legal Advisor and Company Secretary at Pilkington plc, and is a former non-executive director at the Liverpool Heart and Chest Hospital NHS Foundation Trust. He holds a PhD in strategic decision-making.

Mr Singh is a former Trust surgeon and has more than 25 years' experience in general urology. He has been an executive member for The British Association of Urological Surgeons where he helped write the curriculum for functional and neuro-urology.

Freedom to Speak Up

Trust Chaplain, the Rev Martin Abram has been appointed Freedom to Speak Up guardian, continuing the role he acted into since the autumn.

This is an important post that underpins our response to the National Guardian's Office report on speaking up at the Trust published in November.

Martin is there to support staff who want to raise a concern in confidence but don't feel they can have that conversation with their manager. He will also continue as chaplain but with backfill support to ensure this equally important service continues unaffected.

Financial performance

The Trust hit its revised financial forecast for 2017/18 of a deficit of £29.1m However, the final position was £33.6m due to the impact of Expert Determination on contract disputes and sanctions for contract performance.

A bright spot was agency spend which achieved the target of £7.2m. A significant contribution to this success was the introduction of a medical bank and compliance with framework agency rates, and recruiting temporary medical staff on longer term contracts, has helped keep costs down.

Urgent care

Performance against the four-hour standard to discharge, transfer or admit 95% of patients from A&E remains a challenge (79.33% in March), particularly given inpatient pressures and high occupancy of beds at Southport hospital. Attendances at Southport saw an increase of 3.6% with a 7.3% rise (238) in seriously ill patients.

Taking the pressure off A&E, improving the experience of care for patients, and creating a better environment is a priority for the Trust. My aim over the next 12 weeks is to "cool down" A&E and among the initiatives which will help us do this are:

- The successful craning in of an eight-bay Clinical Decision Unit next to Southport A&E on 25th March
- Additional staffing, more bays in the existing A&E, and upgrades to the main waiting area, disabled toilets and X-ray waiting room
- An improved ambulance arrival area to better expedite handovers
- A new, dedicated discharge and transfer lounge in what is now the Salus Centre next to Medical Records
- Ring-fencing assessment beds and capacity in the Emergency Assessment Unit, Ambulatory Care Unit, Surgical Assessment Unit, Observation ward and for hyper-acute stroke patients

The opening of a surgical assessment service at Southport has been postponed until later in the year to fit better with the sequencing of the other changes.

Care quality

- Cases of C. difficile infection attributed to the Trust in 2017/18 were 14, less than half the maximum set by NHS England. One case of MRSA bacteraemia was recorded in August

- Mortality remains a concern. Summary Hospital Level Mortality is a measure used to compare the actual number of patients that have died either in hospital or within 30 days of discharge against the expected number of deaths based on national figures. The Trust is ranked 106th out of 136 English NHS trusts. Reducing mortality is a core priority and the Trust is focussed on it through a reducing avoidable mortality project

- Referrals, first appointments and day case/elective patients all rose in March but overall remain lower than 2017

- 181 bed days were lost to delayed transfers of care in February (latest figures). 94 bed days were due to patient/family choice; 9 to waits for assessment; 25 waits for a place in a nursing home; 10 to public funding; 35 to waits for further non-acute NHS care; and 8 due to waits for community equipment/adaptations

Sterile Services clean up

Praph Chohan, Decontamination Manager, and Deputy Chief Operating Officer Jenny Farley gave a presentation at Aintree hospital in December to take on sterile services work from there. They heard in April they were successful with three other bidders.

Sterile Services were also subject to an unannounced audit in March of the Trust's ISO 13485 certification, sampling records to ascertain staff followed the procedures. They passed with flying colours with no findings or non-conformities reported on the audit.

Two paper-free clinical systems go live

Two big changes to reduce clinical paperwork went live in April: the successful launch of electronic referrals and the online ordering and delivery (OrderComms) of pathology and radiology tests.

Many GP first outpatient referrals can now only be made using the NHS e-referral system. Over time other services will be transferred too. The Trust is the first trust to be rolling out paper-free locally with others following later in the year.

OrderComms went live at Ormskirk with more than 1,000 tests requested in the first five days. The service will be rolled out to Southport staff in due course.

NHS ambassadors

Events were held at both hospitals to encourage staff to volunteer as a NHS career ambassador. They will act as a role model to young people, offering the chance to find out as much as possible about jobs and professions in the NHS, particularly the role they play in providing excellent patient care.

Media briefing

There was limited proactive external communications from the Trust in April due to purdah ahead of the local government elections.

An anonymous staff member raised concerns about the "privatisation" of the Trust car parks with the Champion weekly newspapers. This was prompted by the Trust tendering for parking control and payments solution. We made clear parking would remain owned and managed by the Trust as would the setting of parking fees.

ALERT ADVISE ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	Quality & Safety Committee
MEETING DATE:	23rd April 2018
LEAD:	Mrs Julie Gorry, Non-Executive Director & Chair of QSC

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

- Concerns were raised at the Mortality Operational Group Meeting (MOG), held on 9th April 2018, regarding outlying patients. A working group will review the clinical and organisational processes for the management of outliers and report to MOG.
- The CBUs are investigating how to prevent a delay of PICC lines being place and improve PICC line provision. Any concerns will be escalated to the Quality & Safety Committee.
- There has been a delay in setting up the Hyper-Acute Stroke Service at Aintree. A meeting with executives and senior managers, which was due to take place with Aintree at the end of March was cancelled. This will be rearranged urgently.

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 number of medication errors reported has increased in the month of March. It is possible that this is because of increased reporting, which is being encouraged or potential harm. However, due to ensure safety a deep dive has been requested and will be reported to the Clinical & Effectiveness Committee.
- There has been a 16% reduction in the number of complaints the Trust received April 2017 – March 2018.
- At year end (March 2018), 21 C-Diff cases have been identified against a target of 36. The Infection, Prevention and Control Team continue to monitor and inform through mandatory training. The target for 2018/19 as set by NHSI is to have no more than 35 cases.

ASSURE

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

- The Infection, Prevention and Control Team reported that 81% of staff were vaccinated against Influenza during the 2017 flu period. Planning has now started in preparation for the next flu season.
- Duty of Candour information leaflet is now on the Trust Website along with the “Saying Sorry” staff leaflet.
- During April 2017 – March 2018, there were 56 cardiac arrests. This is significantly below the Trust target of 96. The number of patients surviving a cardiac arrest as reported in Q3 was twice the number predicted. It was noted that overall there is an improved performance across the CBUs.
- Over-due Patient Follow-Up’s. Work is ongoing to address the backlog within specialties, supported by an action plan and weekly operational meetings. A progress report will be presented to Quality & Safety Committee on a monthly basis.
-

New Risk identified at the meeting	None.
Review of the Risk Register (Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)	

NHS
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Board of Directors
2nd May 2018

Agenda Item	TB111/18	Report Title	Quality Improvement Plan Progress Update
Executive Lead	Gill Murphy, Acting Director Nursing, Midwifery and Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information		☐ To Note ☐ To Receive

Key Messages and Recommendations

This report is to update the board on progress made to date in the delivery of actions related to the CQC recommendations following receipt of the CQC Inspection report March 2018.

There are:

54 MUST do actions
5 MUST do actions migrated from the 2016 action plan
37 SHOULD do actions
2 SHOULD do actions migrated from the 2016 action plan

There is a risk identified in the delivery of the 2 should do actions from 2016:

- PDR rates in maternity
- Cross departmental working to support clinics where children attend

The CQC inspection report following the unannounced visit to A&E on 7th March has to date not been received.

Detailed plans and actions implemented to give assurance on the delivery of 3 MUST do actions, (Fit and Proper Person, Duty of Candour and Trust-wide Governance Systems) was submitted to the CQC on 16th April 2018.

The executive leads continue to support teams in the delivery of this action plan.

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

- ☐ **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…..)*

☐ Annual Business Plan Priority
☐ Best Practice

X Linked to a Key Risk on BAF / Risk Register Ref No.: 1362

☐ Other List (Rationale) _____
☐ Service Change

X Statutory requirement

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

X Compliance	X Quality
☐ Equality	X Risk
☐ Finance	☐ Workforce
☐ Legal	

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

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

The board are asked to take assurance from this report that there are systems, processes and escalation plans in place, when required, to deliver the CQC recommendations.

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE

1. PURPOSE OF REPORT

This paper provides the Board of Directors with an update on progress against actions identified in the Trust's formal response to the CQC inspections in 2017 and 2018. It provides an update as of w/c 23rd April 2018

2. BACKGROUND

The CQC visited the Trust for an unannounced Core Services inspection between 20th – 23rd November, the North West Spinal Injuries Unit was also inspected 27th and 28th November 2017, and an announced Well-Led inspection was undertaken between 5th -7th December 2017. The inspection report was published on 13th March 2018.

In addition, on 7th March 2018 the CQC visited the Trust in response to a query regarding patients being cared for in the back of ambulances. The report following this visit has not yet been received

In line with the requirements of the CQC the Trust submitted a formal response to the CQC which set out the actions being taken to deliver the improvement required.

3. DETAILS/PROGRESS

Of the 98 actions in the improvement plan

- **54** - Regulatory Must Do Actions
- **37** - Should Do Actions
- **7** - Measures carried over from 2016 (to ensure sustained improvement)

Generic themes for 2017 Regulatory Must Do Actions are:

- Access & Flow (4)
- Clinical Care (4)
- Environment (6)
- Equipment (5)
- Governance (8)
- IPC (5)
- Medicines (6)
- Leadership / Strategy (1)
- Records / Documentation (11)
- Training / Appraisals (3)
- Patient Experience / Engagement (1)

Outstanding actions from the 2016 CQC inspection have now been migrated into the new Improvement Plan and any actions identified following the unannounced inspection of A&E in March 2018 and future visits will also be incorporated into the Improvement Plan.

Of the 54 Regulatory Must Do Actions 53 are currently rated green based on current review and progress. A breakdown is provided below:

Completed	1
In progress - on track to achieve target date and outcomes	53
In progress – some risks to delivery or outcomes identified	
In progress – significant risks to delivery or outcomes identified	

Of the 37 Should do actions, 35 are rated green and 2 rated Amber.

Completed	
In progress - on track to achieve target date and outcomes	35
In progress – some risks to delivery or outcomes identified	2
In progress – significant risks to delivery or outcomes identified	

The 2 amber ratings relate to 2016 actions :

- PDR rates in maternity (currently 74.3%)
- Cross departmental working to support clinics where children attend

4. CONCLUSION

The Trust are identifying that 54 Must do actions are on track or completed, 35 should do actions are on track with risks to delivery in 2.

5. RECOMMENDATIONS

It is recommended that the Board of Directors notes the progress and risks identified in this report

Jo Simpson
Assistant Director of Quality

Southport and Ormskirk Hospital NHS Trust

Board of Directors

2nd May 2018

Agenda Item	**TB112/18**	**Report Title**	**Draft Quality Improvement Strategy**
Executive Lead	Gill Murphy, Acting Director of Nursing, Midwifery & Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	✓ To Note ☐ To Receive	

Key Messages and Recommendations

This strategy has been further developed since previous discussion at board in October 2017

The 5 quality priorities:

- Preventing harm
- Reducing mortality
- Safer staffing at all times
- Developing the Experience of Care
- Delivering care For You

have all been reviewed to align to the quality improvement plan. The required outcomes have been identified and timescales agreed to support the organisation to deliver safe high quality care through a journey of continual quality improvement and learning.

With the appointment of a new Chief Executive 1st April and Director of Nursing 7th May there is an opportunity to review this strategy, support the overall direction and approach and to approve further development with the new leadership team to ensure alignment with key priorities and messages for staff and stakeholders 'Safe and Calm'.

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

X 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
X SO4 Deliver high quality, well-performing services
X SO5 Ensure staff feel valued in a culture of open and honest communication
X SO6 Establish a stable, compassionate leadership team

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

☐ Annual Business Plan Priority

X Best Practice

☐ Linked to a Key Risk on BAF / Risk Register Ref No.: _____
☐ Other List (Rationale) _____
☐ Service Change
☐ Statutory requirement

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

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

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

The board is asked to note this strategy and support further development once reviewed by the new leadership team.

Previously Presented at:

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

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

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

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

Information: Literally, to inform the Board

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

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Quality Improvement Strategy

2018 - 2021

1. Introduction

This Quality Improvement Strategy sets out our firm commitment to improving the quality of care for our patients and how we will make this a reality in terms of equipping our staff with the skills and tools to deliver high quality services, safe at all times.

For the third year running we have been assessed as “requires improvement” as part of the Care Quality Commissions Chief Inspector of Hospitals inspection programme and whilst we have made some improvements we fully recognise that we have a long way to go in some areas and this is a journey of continuous improvement that we, along with our staff are on.

This Quality Improvement Strategy has been developed within that context and reflects the journey of improvement. Our aim is to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

This document follows on from the Quality Improvement Strategy 2016-19 which was reviewed during 2017 and aims to improve standards of care for our patients and addresses 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.
Local people and patients will have confidence that our local services are safe and high quality in the future.

2. What are we aiming to accomplish?

Our vision for quality is to “Deliver High Quality Services. For You. With You. ” and the Quality Improvement Strategy sets out the direction and how we will achieve this for staff, volunteers, and Board members to ensure that we deliver our vision.

This strategy will ultimately drive the organisation to deliver safe high quality of care through a journey of continual quality improvement and learning. The Board is committed to ensuring that elements of the Quality Improvement Strategy are delivered at pace and the most urgent priorities are (a) to reduce harm and mortality by improved clinical processes and behaviours (b) substantially improve the urgent and emergency patient flow and (c) address urgently the safety short-comings in our quality of care, at Trust and specialty level and ensure this is sustainable.

Patients, carers and their families will have trust and confidence in our services when they see that their issues are being addressed in a timely manner and care and safety of patients across the organisation is our first priority. Therefore the focus of the first year of the strategy will be on delivering consistent standards or care in the three areas highlighted above. In addition our patient experience strategy (Developing the Experience of Care) which was developed in 2017 identified that patients, carers and their families wanted us to get the basics right and to enable them to have trust and confidence in their care and the staff caring for them.

In response to the Robert Francis report the Trust has introduced an open and transparent culture with families and patients when things go wrong by implementing the Duty of Candour and supporting our staff by implementing Freedom to Speak Up. These are fundamental to developing a learning culture and being able to change the way we provide care from lessons learned.

We also recognise that in order to accomplish our quality improvements the leadership of the organisation is central to setting the values and beliefs of the Trusts culture. The Chief Executive, the Board and Directors have a vital role to play in building a safety culture that is open and fair. 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.

Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the strategy will deliver an improved outcome at future CQC inspections. We will agree realistic but challenging timescales to deliver any Must Do and Should Do actions following receipt and recommendations from our regulators. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation, the Board has set the ambition to be rated “Good” by 2020.

The objectives and commitments set out in this strategy will be reviewed regularly and update actions to maintain progress.

The Quality improvement priorities are:

- Preventing harm
- Reducing mortality
- Safer staffing
- Developing the experience of care
- Delivering care for you

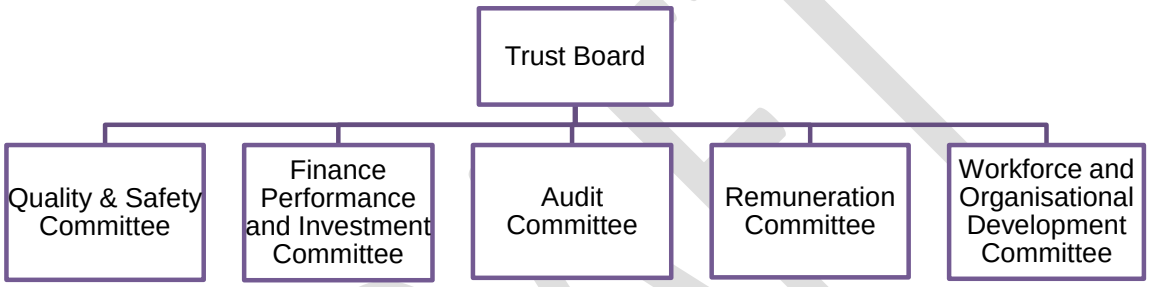
3. Governance and assurance

The Board is committed to ensuring that the Quality Improvement Strategy is delivered, working with our staff and with support of partner organisations, the Board is confident that the Strategy will deliver improved outcomes for all, as well as promoting a culture which embraces continuous improvement in everything we do.

The Board will apply leadership and support, focus and rigour to ensure the delivery of the plan. The Board will also start work to create the conditions that allow staff to do their job well by removing obstacles and barriers to success and managing risks to delivery. A core facet of the plan is the engagement of frontline staff in the improvement journey and alignment to the Quality Improvement Strategy. This will ensure the impact of the improvements is understood and take advantage of the

expertise and knowledge of staff as well as patients to ensure the plan is delivered. It will also start to signal a common purpose and priority for the organisation that is owned by everyone from the board to frontline staff.

The Strategy will be monitored through our corporate governance structure, reporting to the Board via the Quality & Safety Committee. The Quality & Safety Committee, chaired by a Non Executive Director 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.

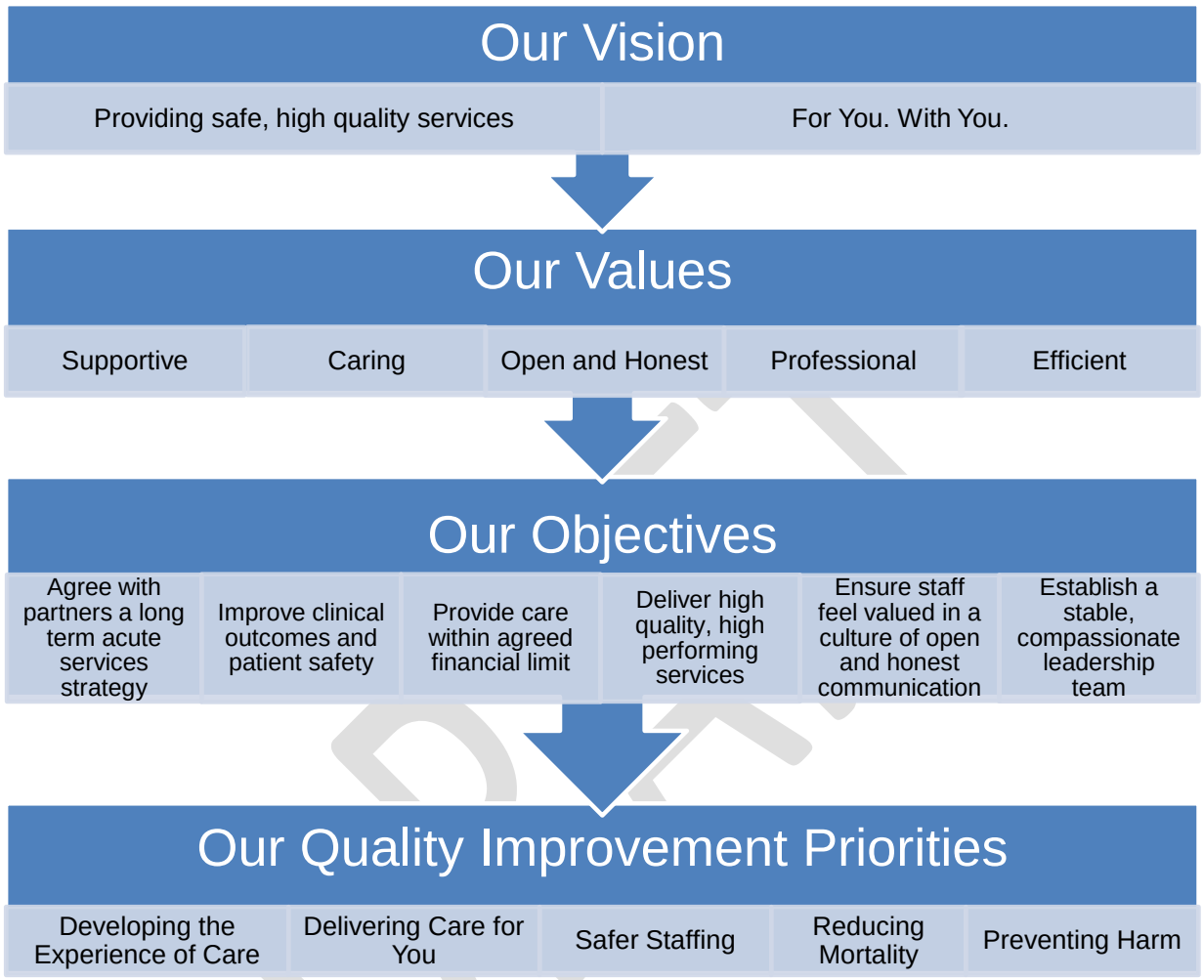


In strengthening our governance we will focus more on outcomes and ensuring consistency, so that every patient, every day, should expect to experience the same high standard of care irrespective of which service they are being cared for. The assurance will be provided through the use of appropriate measures, audit and service reviews involving patients carers and our staff.

4. Vision and Values

We are committed to ensuring that quality drives everything we do. It underpins our vision, values, objective and our improvement priorities.

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 improvement priorities.



5. Definition of Quality

High-quality, person-centred care for all, now and into the future is the single shared view of quality across the NHS (Shared commitment to quality from the National Quality Board, Five Year Forward View). The NHS Five Year Forward View confirms a national commitment to high-quality, person-centred care for all and describes the changes that are needed to deliver a sustainable health and care system. Our approach to quality aligns to this view as we strive to deliver improvements in the quality of our clinical services for the people of Southport and Ormskirk.

It is our aim to deliver a long term acute services strategy which will improve clinical outcomes and patient safety within agreed financial limits and as such as we organised our strategy around five our quality improvement priorities:

- Preventing harm
- Reducing mortality
- Safer staffing at all times
- Developing the experience of care
- Delivering care for you

These five improvement priorities ensure we focus on making improvements in areas that have the greatest benefit and continue to deliver improvements that areas that we have already started to make a difference in.

We believe that by being successful in these five improvement priorities we will see better outcomes for our patients and our staff will feel valued in a culture of open and honest communication.

Each year through the Quality Account, we will report on our performance and progress in each of these five improvement areas and will identify further improvement priorities.

6. Developing a culture of continuous improvement

We are committed to improving quality and recognise that in order to be successful we need to work together and in partnership with all stakeholders including patients, carers, families and other local providers to ensure that we are open and collaborate internally and externally and are committed to learning and improvement. As we drive forward on our transformational journey , the strategy will be regularly reviewed by both the Executive Team and the Quality and Safety Committee.

Strong and stable leadership is key to the development of an improved culture and we know we have some good leaders with the experience, capacity, capability and integrity to ensure that our improvement priorities can be delivered. However we know that we have had high levels of

unplanned turnover and vacancies across a range of areas within the Trust and as a result we need to ensure that staff understand their role and contribution to achieving the Trusts objectives.

Our aim is to create a culture of continuous improvement and learning which is both patient centred and safety-focused. To do this, we must create the conditions where we:

- listen to and include the views of our staff and key stakeholders
- fully embed the Trust Values in everything that we do in order to ensure the working environment is conducive to enable continual improvement and innovation
- actively engage with and enable staff to lead and deliver measurable change for improvement
- focus on human factors - how we deliver care as teams
- are open and honest with people when things go wrong

We must also ensure that improvement is seen and understood to be everyone's business by:

- expecting all teams and staff to be involved in improvement and innovation as part of their everyday business
- local teams regularly discussing lessons learned, innovation and improvement

One of the key features of an organisation that has a successful safety culture is that its workforce is capable of delivering improvement. All staff must respond well to change and embrace new initiatives, be open to new ideas and encourage forward thinking. Staff must feel valued and supported to deliver their roles, they must have confidence that their views are heard and can shape future service direction.

7. Quality Improvement Priorities

The five quality improvement priorities each have an Executive Sponsor who will work with the Clinical Lead to ensure delivery of the improvements.

Preventing Harm
Joint Executive Sponsor: Director of Nursing / Medical Director

To reduce harm, prevent errors, improve documentation and deliver consistently safe care

Reducing mortality
Executive Sponsor: Medical Director

To reduce mortality ratio to 100 or less by reducing risk and avoidable harm to our patients by developing a culture of learning and continuous improvement

Safer Staffing
Joint Executive Sponsor: Director of Nursing / Medical Director

To have the right staff, with the right skills, in the right place at the right time.

Developing the experience of care
Executive Sponsor: Director of Nursing

To put patients at the heart of everything we do, delivering timely access to services, treatment and care that is compassionate, dignified and respectful wherever it is provided.

Delivering Care for You
Executive Sponsor: Chief Executive

To deliver clinically sustainable high quality services which are designed to reflect the needs of our local population and are based on the very best models of care and evidence based pathways

7.1 Improvement Priority 1 - Preventing Harm

We are committed to providing safe, high quality services and harm-free care. We strive to ensure that our patients are cared for in surroundings which are safe and clean, delivered by caring and competent staff. When patient safety incidents do occur, we are committed to managing them in an open and transparent manner, in accordance with the Duty of Candour, and ensuring we learn and continuously improve care as a result.

Preventing Harm
Joint Executive Sponsor: Director of Nursing / Medical Director

To reduce harm, prevent errors, improve documentation and deliver consistently safe care

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.

Preventing Harm		
Action	Outcome	Completion
Launch Ward Accreditation system (Q2 18/19)	Getting the basics right and delivering great care with all wards accredited as 'good'	June 2019
Implement a Trust wide approach to support safe discharge	Implementation of Safer Patient Flow Bundle across all areas 100% compliance	November 2018
Safe transfers of care by implementing a Trust wide approach to improve staff and patient handover between care areas and organisations.	Reduction in delayed discharges by 5%.	September 2018
Reduce serious incidents in pressure ulcers (3s and 4s), inpatient falls and medication errors	Improvement against the 95% threshold of patients receive harm free care as measured by	March 2019

	the Safety Thermometer	
Zero preventable Trust attributed healthcare associated infections	Improvements in ward based practice of infection control and zero MRSA infections and below trajectory for c-difficile and E.coli.	October 2018
Zero Never Events	Culture of learning from incidents increased and zero never events.	April 2019

7.2 Improvement Priority 2 - Reducing Mortality

Whilst many patients experience excellent care in the months or years leading up to their death this is not uniform and some patients experience poor quality as a result of multiple contributory factors. In recognition of this National Guidance on Learning from Deaths was developed in 2017. This Trust has strong clinical leadership and enthusiastic staff who are eager to become an exemplar organisation which can learn from mistakes and understand the causes of avoidable mortality. We have developed a comprehensive programme to improve mortality so that our patients and public can be confident that care is safer based on a culture of openness, continual learning and improvement.

Reducing mortality
Executive Sponsor: Medical Director

To reduce mortality ratio to 100 or less by reducing risk and avoidable harm to our patients by developing a culture of learning and continuous improvement

Reducing Mortality		
Action	Outcome	Completion
Implement evidence based care pathways which reduce mortality	Delivery of best practice pathways for sepsis, AKI, pneumonia, frailty	January 2019
Ensure there is real time escalation and communication to support the deteriorating patient	Improving the recognition and management of the deteriorating patient	September 2018
Develop a learning culture which systematically uses learning from deaths, never event and serious untoward incidents to continuously improve safety and reduce harm	Reduce risk and avoidable deaths which are identified thought SJRs of deaths	September 2018
Implement advanced care planning (End of Life Care) which will ensure patients receive high quality care in their chosen setting and have an alternative	Patients die in their place of choice	April 2019

to hospital admission		
Implement workforce changes which improve safety (staffing levels and senior assessment) and prioritise training and development required to reduce mortality	Staffing and skill mix reflect patient acuity	March 2019
Provide real time, accessible and validated information on mortality from Board to Ward	Governance and reporting systems in place which identify trends, benchmarks and future opportunities for improvement	September 2019

7.3 Improvement Priority 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

Safer Staffing
Joint Executive Sponsor: Director of Nursing / Medical Director

To have the right staff, with the right skills, in the right place at the right time.

Safer Staffing		
Action	Outcome	Completion
Deliver safe sustainable staffing by linking staffing and skill mix with patient acuity and dependency	Harm Free Care Outcomes	March 2019
Develop a workforce strategy focusing on recruitment and retention	Reduction in the use of temporary Staffing	December 2018
Improve fill rates and reduce the use of temporary staffing	Further reduction in agency staff costs	December 2018
Freedom to speak up and responding to staff concerns	Deliver NGO action plan	Last date for actions December 2019

7.4 Improvement Priority 4 - Developing the experience of care

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. This priority links into the implementation plan of the Developing the Experience of Care Strategy approved by the Board in 2017.

Developing the experience of care
Executive Sponsor: Director of Nursing

To put patients at the heart of everything we do, delivering timely access to services, treatment and care that is compassionate, dignified and respectful wherever it is provided.

Developing the Experience of Care		
Action	**Outcome**	**Completion**
Pledge 1 – Develop and implement systems and processes to involve carers and families in decision making.	Implement a Carers and Families Charter across the Trust to encourage partnership between carers, families and Trust Staff.	April 2019
Pledge 2 – Access to information is easy and relevant for patients, carers , families and professionals	All patients and relatives will have access to a relevant standardised list of Trust information leaflets in all adult in-patient areas.	September 2018
Pledge 3- We will ' get the basics right when caring for all '	All patients will have a recognised pain assessment score recorded, and this will be regularly audited. All adult in-patients will be able to access a hospital comfort pack if required. We will ensure that all patients will have access to at least one pillow and blankets to maintain	March 2019 December 2018 April 2018

	warmth and comfort. 90% of all applicable patients will have their meals served on a red tray to highlight need for assistance with nutritional and fluid intake. There will be an increased number of dining companion volunteers to support nutritional and fluid intake.	December 2018 April 2019
Pledge 4 - Improve staff involvement and awareness of their impact on patient, carer and family experience.	All new NHSP staff will receive information regarding the Trust values and behaviours.	September 2018
Pledge 5 – Improve discharge process and facilitate better links into community support	A leaflet supporting 'Combating Loneliness' will be available to patients, families and carers. The success of this leaflet will be measured be recording the 'source of referral' as contact is made with third sector organisations.	August 2018
Pledge 6 – Respond to complaints and concerns in a timely manner	We will support the 60 day target for complaint responses, there will be an increase in the number of opportunities for staff to complete complaints training within the organisation.	December 2018
Pledge 7 – Increase the profile of patient , carer and family experience, collecting upon and acting upon feedback and opinion in a more robust manner.	Improve the response rate of patients that would recommend the Trust – Friends and Family Test (FFT) by 10% year on year Reduce the number of complaints by 5% year on year	March 2021
Pledge 8 – Develop systems and processes to capture patient's and family's memories to share and cherish for the future.	A garden area will be developed at Southport DGH to use as an area of remembrance and reflection.	August 2018

7.5 Improvement Priority 5 - Delivering Care for You

Delivering Care for You
Executive Sponsor: Chief Executive

To deliver clinically sustainable high quality services which are designed to reflect the needs of our local population and are based on the very best models of care and evidence based pathways
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Like many healthcare providers the Trust faces significant challenges in providing high quality services which are sustainable in the future. The Trust and its stakeholders have therefore committed to developing a transformation strategy which provides a coherent and clinically sustainable plan for the future of hospital and related community services in Southport and Ormskirk. In particular it is clear from discussions with local clinicians and our staff that a significant amount of effort should be dedicated to improving patient flow and the provision of services for the frail elderly population. The transformation strategy has 3 stages:

Stage 1	**Implementing changes to service models and pathways which can be made without the need to re-configure services. These changes should begin immediately to improve operational performance, clinical sustainability and quality**
Stage 2	Optimising the configuration of services across the Southport and Ormskirk hospital sites
Stage 3	Developing strategic partnerships and networks within Cheshire and Merseyside and Lancashire which will enable delivery of local accessible services by bringing the workforce into larger networks

The clinical teams have led the design of the significant quality improvements to address short comings in the current pathways of care. The outcome expected is better patient flow, better outcomes and experience. The Sefton Transformation Board is leading this important process for the Trust. The Trust has commenced delivery of service developments and changes in Stage 1 and 2 which will improve sustainability and through this the safety and quality of care. We will use the experience of our patients and carers to inform these service developments in line with Pledge 7 of our Developing the Experience of Care Strategy.

Delivering Care for You		
Action	Outcome	Completion
Improving Flow – Improving flow for acute medical patients through Southport Hospital supported by a coherent Urgent Care strategy agreed and owned by commissioners and providers across Southport & Formby, South Sefton and West Lancashire	• Increase simple discharges (ALOS 0 and 1 days from 49%* in 2016/17 to 54% and sustain. National benchmark average is 54%* and regional peer group is 54%*. (**Dr Foster*) • Improvement of the 4 hr performance. The trajectory is 90% and sustain. • Decrease medical outliers from average of 9.6 per day to 8.6 (10% reduction). • Increase the number of patients who are admitted directly to a stroke ward from 49.5% to 75% by end of quarter one and to 90% • Average length of stay for stroke patients is reduced from 18.7* days in 2016/17 to 15.6* days (Benchmark of all acute non-specialist Trusts). (**Dr Foster*)	May 2018 June 2018 June 2018 September 2018 December 2018
Emergency Surgery - Improving emergency surgery facilities in Southport counter-balanced by modernising practice and increased usage of Ormskirk for day case surgery	• Greater stability in a consultant led 7 day, 24 hour emergency bleeding service. • Increase in short stay ALOS (O,1 and 2 days) for emergency surgical patients in line with best practice. Trust is currently 9.4 days against all acute non specialist trusts rate of 7.4	April 2018 August 2018

	days (*Dr Foster*). • Zero day surgery cancellations. 12 pcm average in 2016/17. 20% reduction would give target of 10 pcm. • Day case activity % increase from 87.6% to 90%. National average 82.9%. (*NHSE MAR return*)	August 2018 August 2018
Developing an over-arching plan for the implementation of the Frail Elderly Pathway, agreed and owned by commissioners and providers across Southport & Formby, South Sefton and West Lancashire	• Sign off clinical model and the costs to deliver by system wide leaders. • Reduction in levels of service demand and need in those over 65 • Length of stay, long term conditions, without dementia in those over 65 • Emergency re-admissions 30 and 90 day • All frail elderly patients admitted to specialist geriatrics ward and discharged alive: median length of stay in the SGW (a) before and (b) after medically fit for discharge • Percentage of those admitted to or transferred into a specialist geriatrics ward who are newly discharged to long term residential care • Less patients with a ALOS of 21 days and longer	May 2018 August 2018 August 2018 October 2018 March 2019 September 2018

8. Key Enablers for Delivering the Quality Improvement Strategy

8.1 Communication & Engagement

We recognise the need to increase staff involvement in our quality improvement priorities. An engaged workforce is one where staff are valued, listened to and provided with the tools, resources and skills to do meaningful work. The culture of an engaged organisation will facilitate and encourage participation and front line ownership by staff in the creative design, delivery and improvement of services and says thank you for a job well done. Linking back to our Trust values, we expect all our staff to put quality and safety at the heart of everything 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 and this will be overseen by the Assistant Director of Quality.

8.2 Improvement Methodology

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. To address this, the Trust will:-

- Develop an organisational development plan
- Deliver quality improvement courses to build improvement skills in managers and frontline staff
- Commission the Advancing Quality Alliance to work with staff on improvement methodology and to enable the planning, implementation and measurement of sustainable change
- Strengthen specialised skills across the Trust in lean methods and tools and rapid improvement methods
- Implement a leadership programme
- Increase the number of staff trained in Root Cause Analysis methodology and the impact of human factors

8.3 Evaluation Measurements

In August 2013, the Don Berwick review report into improving patient safety across the NHS was published. One of the recommendations in this report related to the use of information, including transparency and integration of information. With the support of our Business Intelligence Department

we will use specialist measurement for improvement to develop a Quality Improvement Dashboard to allow us to track progress against our aims.

Robust outcome metrics will be set for each priority and action to identify progress and success in achieving this improvement Strategy. The metrics we will use will be meaningful to both staff and patients. Measurement will be used to demonstrate the impact of change and then continued as on-going performance measures following the implementation of successful change.

8.4 Implementation Plan

The delivery of our strategy will be through programme management approach. The programme is designed to contribute to our aim to deliver high quality services, safe at all times. This will focus our work as we move forward. We intend to tackle our proposed projects by using appropriate quality improvement methods on a project by project basis through the development of a Programme Management Office. Subject matter experts will work with improvement experts to test and implement changes on the front line of care. If successful, systems will be redesigned from the bottom up using small tests of change.

The Quality & Safety Committee will oversee the delivery of this strategy. A timeline setting out when each of the projects will be started and delivered by will be attached to this strategy. Each project as it starts will have a project initiation document that includes clear aims, measures and delivery outcomes to this committee for approval and monitoring.

Southport and Ormskirk Hospital NHS Trust

Board of Directors
2nd May 2018

Agenda Item	**TB113/18**	**Report Title**	**Monthly Mortality Report**
Executive Lead	Dr Jugnu Mahajan, Interim Medical Director		
Lead Officer	Dr Chris Goddard, Assistant Medical Director of Patient Safety Mike Lightfoot, Head of Information Rachel Flood-Jones, Project Delivery Manager		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information		✓ To Note ☐ To Receive

Key Messages and Recommendations

The relationship between mortality data reporting, the Structured Judgement Review, Learning from Deaths and the Reducing Avoidable Mortality (RAM) Project is outlined in the Mortality Monthly Report for April 2018.

While the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) remain as outliers and are above expected level, the data for November 2017 shows a month on month improvement in all five diagnostics with the exception of stroke.

The Mortality Dashboard has been developed in three sections to provide a high level overview of key indicators, a more detailed analysis of a broader range of indicators and the 'Learning from Deaths' Dashboard, which is reportable quarterly. Appendix 1 is the Mortality Dashboard for April 2018.

The second 'Learning from Deaths' report to the Trust (in accordance with the requirements of NHS England) looks at data and findings for quarter three. An update is also provided on the Structured Judgement Review across the Trust.

As previously reported, the RAM Project has begun and details of the activity currently underway for the 'Care Pathway' work stream have been included for information.

Finally, for the purposes of effective governance, a new timetable is proposed for mortality reporting. The process will ensure that the mortality report is responsive to scrutiny, analysis and contribution throughout the reporting cycle.

The Board of Directors is asked to note the progress to date.

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

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…..)*

☐ Annual Business Plan Priority
☐ Best Practice
☐ Linked to a Key Risk on BAF / Risk Register Ref No.: _____
☐ Other List (Rationale) _____
☐ Service Change
☐ Statutory requirement

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

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

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

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

Previously Presented at:

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

Monthly Mortality Report
April 2018

1.0 Executive Summary

Section		Summary
2.0	**Strategic Context**	The relationship between mortality data reporting, the Structured Judgement Review, Learning from Deaths and the Reducing Avoidable Mortality (RAM) Project is outlined.
3.0	**Reporting Timetable (Governance)**	For the purposes of effective governance, a new timetable is proposed for mortality reporting. The process will ensure that the mortality report is responsive to scrutiny, analysis and contribution throughout the reporting cycle.
4.0	**Measuring Mortality**	**Mortality Ratios** While the Summary Hospital-level Mortality Indicator SHMI and Hospital Standardised Mortality Ratio HSMR remain as outliers and are above expected level, the data for November 2017 shows a month on month improvement in all five diagnostics with the exception of stroke. **Mortality Dashboard** The Mortality Dashboard (Appendix 1) has been developed in three sections to provide a high level overview of key indicators, a more detailed analysis of a broader range of indicators and the 'Learning from Deaths' dashboard which is reportable quarterly.
5.0	**Learning from Deaths Report, Quarter Three**	The second 'Learning from Deaths' report to the Trust (in accordance with the requirements of NHS England) looks at data and findings for quarter three. An update is also given on the roll out of the Structured Judgement Review across the Trust.
6.0	**Reducing Avoidable Mortality Project**	Details of the activity currently underway for the 'Care Pathway' work stream have been included for information.
Appendices		
1	**New Mortality Dashboard**	The summary pages for the Mortality Dashboard are provided from the Mortality Dashboard report for April.

2.0 Strategic Context

Mortality is a core priority for the Trust which is now focused through the Reducing Avoidable Mortality Project (RAM) which incorporates a number of work streams and subsumes the work

previously undertaken by the Deteriorating Patient Project, with the overriding aim of reducing avoidable mortality by April 2019. The project will drive improvements in safety and quality in collaboration with the Advancing Quality Alliance (AQuA) and the North West Innovation Agency.

The Trust will continue to embed 'Learning from Deaths' national guidance[1] through a 'Learning Culture' (driven by a dedicated RAM project work stream). The Trust's 'Learning from Deaths' Policy is now available on the Trust website, alongside guidance for patients, families and carers on mortality and bereavement.

The Royal College of Physician's Structured Judgement Review Method is also being rolled out across the Trust with a universal 'go live' date of 31st August 2018. The learnings from which will be triangulated with mortality reporting and the milestones of the RAM Project, all of which will be fed back through the governance structure.

3.0 Reporting Timetable

For the purposes of governance and scrutiny, the timetable for mortality reporting will be as follows:

- The Mortality dashboard will be taken to the Mortality Operational Group (MOG) for analysis and comment.
- After the MOG, the monthly Mortality Report will be written and presented to the Quality and Safety Committee (QSC) along with an Alert, Advise and Assure (AAA) Highlight Report.
- The Mortality Report will be further updated as required after the QSC and submitted, again with a AAA Highlight Report to the Trust Board,
- A final version of the report will be submitted to the Southport Improvement Board.

4.0 Measuring Mortality

4.1 Mortality Ratios

4.1.1 Summary Hospital-level Mortality Indicator (SHMI):

The latest available reportable period for SHMI is for July 2016 to June 2017 for which the Trust was reported to be at a ratio of 117.39. The next available figure will be published this month and will be reported to the Board in May.

4.1.2 Hospital Standardised Mortality Ratio (HSMR):

HSMR applies to in-hospital mortality (excluding palliative care). It includes around 55-60% of deaths.

The latest available data from Dr Foster for November 2017 shows the Trust's rolling 12 month position at 113.2 and in-month position at 90.1; significantly below the mean. This has improved month on month, with the Trust's rolling 12 month position in October at 114.87 and in-month position at 90.57 which was further improvement on September 2017 with the Trust's rolling 12 month position at 120.17 and the in-month position was 105.92.

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

4.1.3 Disease-Specific Mortality:

Pneumonia rolling 12 month SMR to November 2017 which fell for a third consecutive month to 125.2, down from August when it was 134.82. Dr Chris McManus, Consultant in Respiratory Medicine reviewed all cases of pneumonia for diagnostic accuracy for six months from September 2017 to March 2018. This activity is to be recommenced in the near future.

Acute Bronchitis rolling 12 month SMR to November 2017 was 114.6 a great improvement on October 2017 which was 139.67, up from 137.55 in the previous period.

Stroke rolling 12 month SMR to November 2017 was 133.7 which continued the trend of marginal increases since a low of 120.21 in May 2017. The general trend of the last 18 months however shows an overall increase.

The Sentinel Stroke National Audit Programme (SSNAP) is currently reporting a ratio of 100 for the Trust; their calculations take into account specific indicators of poor stroke outcome (for example stroke severity).

Septicemia (Except in Labour) rolling 12 month SMR to November 2017 was down to 89.4 from 91.56 in September, holding the ratio below the target of 100. This has been the result of a downward trajectory since a high of 120 in December 2016. Raised awareness of septicaemia in A&E, ensuring the appropriate treatment is to have contributed to this improvement. The Sepsis Pathway Standard Operating Procedure has been signed off at the Clinical Effectiveness Committee.

Urinary Tract Infection rolling 12 month SMR to November 2017 was 118.5 from 121.73 in September 2017. This is currently on a downward trajectory following a high of 156.14 in the year to July 2017. This indicator was last below 100 in May 2016.

4.1.4 Crude Mortality:

The latest position is for February 2018 was 39.3, an improvement on January when it had risen to 48.9. In November the rate had been 21, at which time a significant increase had been predicted over the winter months, as crude mortality is particularly demonstrative of seasonal variation.

4.2 Mortality Dashboard

The Mortality Dashboard (Appendix 1) has been developed in three sections to provide a high level overview of key indicators, a more detailed analysis of a broader range of indicators and the 'Learning from Deaths' dashboard which is reportable quarterly.

The dashboard consists of more than 60 indicators grouped into key areas including Nationally Reported Indicators, Mortality Reviews, In Hospital Deaths, Post Discharge Deaths and Clinical Coding. The purpose is to provide analysis and assurance that all aspects of a patient's journey and care is included which could have an effect on the Trust's mortality performance, in addition, statistical process control (SPC) methodology is used to determine control limits and report on relative performance for each indicator. Where available, the most up-to-date information is used for each section.

The Mortality Dashboard for the reporting month of April 2018 (Appendix 1) covers The latest available reportable period for SHMI is for July 2016 to June 2017 and HSMR for November 2017 and is therefore is pertinent to the narrative above.

5.0 Learning from Deaths Report – Quarter Three

5.1 Background

5.1.1 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.

5.1.2 This is the second quarterly learning from deaths report to the Board of Directors. Data is presented from Quarter 3.

5.1.3 It has been identified through Clinical Audit that one patient had had two review forms, one completed by ITU and a second by their parent speciality. This duplication is shown in Table 2 as two 'possibly avoidable' deaths, however in reality this was one patient reported twice. In Quarter 3 there was therefore one 'possibly avoidable' and two 'systems error' deaths reported, giving a 0.5% proportion of avoidable deaths over the period.

5.1.4 Once duplications were removed it was confirmed that 186/201 (93%) of deaths have undergone a consultant review.

5.1.5 The potentially avoidable death has triggered a coronial inquest, a review of the trusts procedure for identifying, escalating and managing acute kidney injury (AKI) and the development of a simplified, accessible tool for the initial management of AKI to complement the trusts policy.

5.1.6 Widespread issues with the supplier of Vitalpac and Medway (System C) has delayed the implementation of both the 'Order Comms' and 'AKI Module' developments. Resolution of these issues and continued rollout will allow the implementation of safer systems of AKI alerting.

5.1.7 The Trust is transitioning to the Structured Judgement Review methodology developed by the Royal College of Physicians. There are 7 trust departments that require training. This training was due to complete by the end of April 2018, but due to annual leave of departmental mortality leads, staff availability for training and experience gathered of delivering the training; this target must be re-evaluated. It is now anticipated that this will take until June 2018.

5.1.8 The trust continues to review a high proportion of deaths. The new system is anticipated to bring greater depth to the process. The two systems will run in parallel until a full transition to SJR is achieved.

5.2 Quarter Three Data

Total Deaths and Number Reviewed			
	Number of Deaths	**Number of Deaths Patients with Learning Disabilities**	**Number of Reviews Completed**
October 2017	63	1	53 (84%)
November 2017	53	0	64 (121%)
December 2017	85	1	80 (94%)

Mortality Review Outcomes			
	October 2017	**November 2017**	**December 2017**
Not preventable death due to terminal illness or condition upon arrival at hospital	17	20	23
Not preventable death and occurred despite the health team taking preventative measures	36	40	54
Not preventable death BUT medical error or system issue was present	0	2	0
Possibly preventable death resulting from medical error or system issue	0	2	0
Likely preventable death resulting from medical error or system issue	0	0	0
No Review Outcome Documented	0	0	3
Total	**53**	**64**	**80**

5.2.1 Two unpreventable deaths with ‘system errors’ have been reported, again in November. One has initiated work on access to upper GI endoscopy while the other highlights the need for improved access to frailty reviews, consultant physicians and future care planning.

5.3 Structured Judgement Review (SJR)

5.3.1 The recommended method of reviewing case notes for the purpose of finding problems and excellence in care. Main function is to crystallise the ‘general feeling’ from a case note review into an objective, defensible ‘judgement’. This is done phases of care: The first 24 hours, ongoing care, procedural care, perioperative care, end of life care and overall. The judgements allow the giving of a score for each phase and overall.

5.3.2 The greater contextual information will allow for deeper learning and greater understanding of the issues.

5.3.3 Training to allow local training was provided in November 2017 to Dr Paddy McDonald and Dr Chris Goddard.

5.3.4 Training materials from the RCP to actually deliver this were received via e-mail on the 20th of December 2017. Until this point, the actual method of local training required and thus logistical and resource requirements were unknown.

5.3.5 Training in SJR methodology is based around the actual making of structured judgements. This requires face to face training and actual practice on simulated case notes. The training requires an absolute minimum of 2 hours to complete.

5.3.6 Performing this training has identified guidance required and potential flaws which must be dealt with to make the system effective. Problems include where issues with operative procedures are recorded and prompts to review certain data sets not currently reviewed as a matter of course. These resources are required for new reviewers.

5.3.7 The current mortality process is governed by the Clinical Audit Department; this is transferring to the risk department with the development of Datix IQ. We are the first trust in the country to deploy this mortality package and we are developing this with Datix.

5.3.8 This has required the development and clinical testing of a bespoke screening tool, which is now ready for use.

5.3.9 Training in this tool for the junior doctors is required and will be undertaken by the risk department.

5.3.10 The ability to collate recorded SJRs for analysis and learning has been a challenge. Via the AQUA meeting of 26/3/18 we have taken the decision to categorise SJR reviews in order to allow this. Minor amendments to the system are required in order to facilitate.

5.3.11 Recording of SJR reviews on the Datix system are on hold until issues regarding data back up and data protection have been resolved. Fortnightly calls are to be held between IT, Information Governance, the Risk Team and Datix to expedite a resolution as soon as possible. If the issues are not resolved by the end of April, it has been agreed that the Trust use the free version of DATIX for an interim period.

5.4 Mortality Operational Group

5.4.1 The sub-committee of the Quality and Safety Committee will receive and govern the categories identified by SJR and the phases of care breakdown for the trust. This will be triangulated by the committee with risk, simulation, pharmacy and educational data.

5.4.2 The first meeting of this group was cancelled due to administration problems which have been rectified.

5.4.3 The first meeting proper took place on 9th April 2018.

5.5 Next Steps

The Structured Judgement Review rollout will continue, all planned care departments will be using this by the end of April 2018. AED and general medicine will be trained following this. It is anticipated training will be complete by June.

- Train junior doctors on screening tool and begin screening.
- Add categories to Datix SJR and begin screening.
- Circulate guidance to reviewers to ensure quality and consistency

6.0 Reducing Avoidable Mortality

As detailed in last month's report, the Reducing Avoidable Mortality Project is underway to improve the mortality ratios for the trust through quality improvement activity.

Project Objectives	1. CARE PATHWAYS: To develop robust clinical processes for high risk conditions by June 2018
	2. COMMUNICATION: Drive the implementation of a robust Communications Hub and ICT Infrastructure through the SAAT Project in place for both sites by May 2018
	3. LEARNING CULTURE: Implement and embed a learning culture with regard to learning from deaths across the organisation by September 2018
	4 . FUTURE CARE PLANNING: Implement care planning for those patients identified as approaching end of life (GSF) that encourages appropriate levels or intervention and enables communication with the patient and their families by April 2019
	5. INFORMATION: Produce one version of reporting on mortality by October 2018 that provides clear and consistent information to inform different groups of leaders and clinicians
	6. WORKFORCE: Establish the proposed workforce model to deliver agreed clinical outcomes which will include a tangible 24/7 Outreach Team by September 2018

A full detailed breakdown for all six work streams for the project will be included in the May report. The following pages give an update on activity currently underway for the first work stream, 'Care Pathways'.

PROJECT PLAN

Reducing Avoidable Mortality

Project Initiation Document

Southport & Ormskirk Hospital Trust

Key	
Red	Activity has not yet commenced / is behind schedule
Amber	Activity has commenced / activity is still required
Green	Project is on track / required activity has been undertaken

Planned Project Start Date	12th February 2018
Project End Date	1st April 2019

			Planned		Actual		
Task No	**Description of task (if you have completed your objectives tab. These will automatically be brought over in the highlighted cells. This should allow you to put in tasks relevant to completing the objective shown)**	**Person responsible**	**Start date**	**End date**	**Start date**	**End date**	**Status RAG**
1	**CARE PATHWAYS: To develop robust clinical processes for high risk conditions which support clinical staff to provide safe, reliable care and produce evidence to assure quality of delivery, by June 2018**						
1.1	**SEPSIS PATHWAY: A change in the proforma for sepsis is required. (The new Sepsis Pathway and SOP have been signed off by the Clinical Effectiveness Committee, March 2018. A revision to the process; requiring two blood samples to now be taken has neccessitated a change to the paperwork).**						
	New paperwork awaiting printing	Head of Quality Standards	April 2018	April 2018			A
	Roll out and education of pathway by Critical Care Outreach	Critical Care Outreach Clinical Nurse Specialist Lead	May 2018	June 2018			R
	Sepsis awareness activity to be reinstated once paperwork is in place.	ADM Patient Safety	May 2018	August 2018			R
	A plan for sepsis awareness activity to be designed	ADM Patient Safety & Project Delivery Manager	May 2018	May 2018			R
	Development of a pre-hospital Sepsis Pathway with Southport and Formby CCG and West Lancs CCG is ongoing.	ADM Patient Safety	April 2018	30th June 2018			A
1.2	**AKI PATHWAY: The revised AKI Pathway requires review and approval from the Clinical Effectiveness Committee**						
	Henry Gibson to advise on changes to V3 ahead of approval and sign off at the Clinical Effectiveness Committee.	AKI Lead	March 2018	March 2018	May 2018		A
	Clarification of new Clinical Lead for AKI required	AKI Lead	April 2018	April 2018			A
1.3	**IV FLUID THERAPY POLICY: An Implementation Meeting was set for 10/04/18 at which the roll out plan for the revised policy, including confirmation of training and education for doctors and nurses is to be decided. New drug charts require reprinting.**						
	Update required from Laura Gibson on the outputs of the IV Fluid Implementation Meeting	Project Delivery Manager	April 2018	August 2018			R
	New drug charts awaiting printing	Specialist Pharmacist	April 2018	August 2018			R
	Does the IV Fluid Therapy pathway link into AKI & Sepsis Pathway - (All 3 to be audited together)	Specialist Pharmacist / AMD Patient Safety	April 2018	August 2018			R
	Education roll out will be discussed at the next IV Fluids Project Group - Launch now timetabled for August 2018	Specialist Pharmacist	August 2018	October 2018			A

Task No	Description of task (if you have completed your objectives tab. These will automatically be brought over in the highlighted cells. This should allow you to put in tasks relevant to completing the objective shown)	Person responsible	Start date	End date	Start date	End date	Status RAG
1	**CARE PATHWAYS:** **To develop robust clinical processes for high risk conditions which support clinical staff to provide safe, reliable care and produce evidence to assure quality of delivery, by August 2018**						
1.4	**PNEUMONIA:** **A six month review of patient coding for pneumonia improved accuracy (2017/18). This has resulted in HSMR for pneumonia reducing to within confidence intervals. Further work is required to continue improvement.**						
	Names for two new Respiratory nurse specialists to be confirmed and invited to relevant project group meetings and meeting with AQuA (30th May)	Critical Care Outreach Clinical Nurse Specialist Lead / Project Support Officer / Project Delivery Manager	April 2018	April 2018			R
	Coding reviews to be reinstated to avoid misdiagnosis	ADM Patient Safety & Project Delivery Manager / Consultant in Respiratory Medicine	April 2018	April 2019			R
	External Review to take place for Pneumonia.	ADM Patient Safety & Project Delivery Manager	May 2018	June 2018			A
	Once the External Review report has been published this will provide out baseline data and the AQuA to advise on how to advance practice. (Resp. Nurse Specialists to be invited).	Project Delivery Manager	May 2018	August 2018			R
	After AQuA recommendations ,process to be confirmed as to how can we get chest x-rays quicker for patients presenting with chest infections (flow chart to be produced - pneumonia is an x-ray diagnosis not a clinical diagnosis).	Critical Care Outreach Clinical Nurse Specialist Lead / AMD Patient Care	July 2018	December 2018			R
1.5	**UPPER GI BLEED:** **Kevin Thomas and Mike Robersts leading the work to investigate intermediate and long term options for 24 hour emergency endoscopy cover.**						
	There is not currently a formal pathway for this other than an informal arrangement with Aintree - further investigation into the most suitable arrangement required	Associate Medical Director / Consultant Gastroenterologist	March 2018	August 2018			A
	Refer to 7DS Project and the Upper GI Bleed Working Group.	Associate Medical Director / Consultant Gastroenterologist	April 2018	April 2019			A
1.6	**SYSTEM C:** **An upgrade to VITALPAC 3.5 is required**						
	Upgrade our Live VitalPAC to version 3.5 is planned for the end of June, (inhouse testing and clinical input would required ahead of this to ensureversion 3.5 is running correctly and is clinically safe).	Vitalpac Business Change, Improvement & Development Manager	18th April 2018	30th June 2018			A
1.7	**NATIONAL EARLY WARNING SCORE (NEWS):** **What are the steps required to ensure that the Trust upgrade to NEWS2 ahead of April 2019?**						
	Upgrade our Live VitalPAC to version 3.5 is planned for the end of June, (inhouse testing and clinical input would required ahead of this to ensureversion 3.5 is running correctly and is clinically safe).	Vitalpac Business Change, Improvement & Development Manager	18th April 2018	30th June 2018			A
	Move to Vitalpac 3.6 required ahead of April 2019 so that the transition to NEWS2 can be made. NEWS2 must be in A&E by April 2019 in order to secure Sepsis CQUIN.	Vitalpac Business Change, Improvement & Development Manager	January 2019	April 2019			R

Task No	Description of task (if you have completed your objectives tab. These will automatically be brought over in the highlighted cells. This should allow you to put in tasks relevant to completing the objective shown)	Person responsible	Start date	End date	Start date	End date	Status RAG
1	**CARE PATHWAYS:** **To develop robust clinical processes for high risk conditions which support clinical staff to provide safe, reliable care and produce evidence to assure quality of delivery, by August 2018**						
1.8	**ACCESS TO DIAGNOSTIC IMAGING:** **Weekend on-site radiology (CT Reporting and Ultrasound) provision is available for emergency procedures but is only available by negotiation for planned elective care. A strategy will be formulated to ensure this service continues and is robust."**						
	Refer to 7DS Project - 7 day on-site for both emergency and planned procedures	Project Delivery Manager / ADO Specialist Services / Radiology Department Manager	April 2018	April 2019			R
1.9	**MORTALITY RELATED PROCESSES TO BE PRIORITISED & MODIFIED ACCORDING TO LEVEL OF IMPROVEMENT REQUIRED** **Focus on diagnostic pathway, ie Sepsis, AKI, Pneumonia, Bronchitis or Stroke to be prioritised according to the requirement for improvement**						
	The Mortality Operational Group to decide the priority of focus by diagnostic pathway (ie Sepsis, AKI, Pneumonia, Bronchitis or Stroke) according to mortality rates. (If signal SMR signals issues then Screening tool - Screening tool to area of greatest risk)	ADM Patient Safety	April 2018	April 2019			A
1.10	**TIMELY EMERGENCY SURGERY:** **Timely surgery will be improved by the implementation of the Surgical Assessment Unit (SAU) which comes under the scope of the Safe At All Times Project.**						
	Safe at All Times has become 'Business as Usual' within the CBUs	KPMG	April 2018	April 2018			G
	The opening of a surgical assessment service (SAU) has been delayed from May until later in the year to fit in better with the sequencing of the planned changes.	AMD for Planned Care / Head of Nursing for Planned Care	May 2018	July 2018	Yet to be confirmed	Yet to be confirmed	A
	Identification of further work is required to ensure all acute admissions areas can provide post-operative care for minor non-elective procedures. The question to be asked of matrons as to why post-operative patients cannot go back to ward of origin. Education required of new process if agreed in order to move this forward.	ADM Patient Safety & Project Delivery Manager	May 2018	October 2018			R
1.11	**EARLY RECOGNITION OF ACKNOWLEDGEMENT LIKELY TO DIE:** **A meeting has been organised with Dr Karen Groves 17/04/18 regarding the design and roll out of enhanced training to acute specialities for specialist palliative care reviews.**						
	Transform (Palliative Care) to link in with Outreach to identify process for Early Recognition of Ackn. To Die	Consultant in Palliative Care / ADM Patient Safety / Critical Care Outreach Clinical Nurse Specialist Lead	April 2018	August 2018			A
	Design of enhanced training required - update required from Chris Goddard to SE/ RFJ	ADM Patient Safety	April 2018	August 2018			R
	Enhanced training to be designed and signed off	Consultant in Palliative Care / ADM Patient Safety / Critical Care Outreach Clinical Nurse Specialist Lead	May 2018	May 2018			R
	Roll out training required by Transform Team	Consultant in Palliative Care	August 2018	January 2019			R

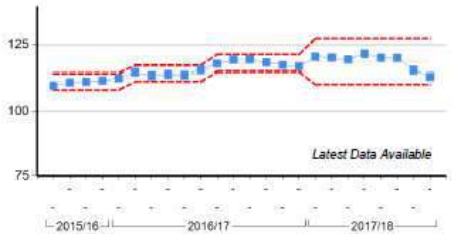
Appendix 1

Southport & Ormskirk NHS Trust Mortality Dashboard April 2018

Southport & Ormskirk Hospital NHS
NHS Trust

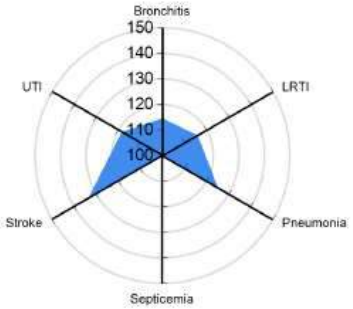
Dr Foster National Mortality Statistics

Rolling 12 Month HSMR

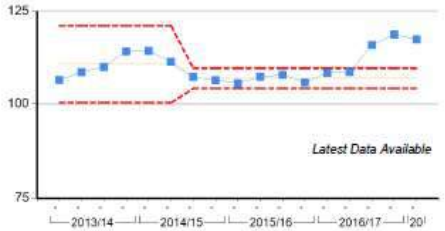


UCL and LCL are reset when 6 consecutive periods are above or belowthe mean.

Local HSMR November 2017/18



SHMI



UCL and LCL are reset when 6 consecutive periods are above or belowthe mean.

Trust Mortality Statistics

In Hospital Deaths

YTD Deaths of Patients with Learning Difficulties: 6

0.71% ▼

YTD Deaths of Patients with GSF Alert: 430

50.5% ▲

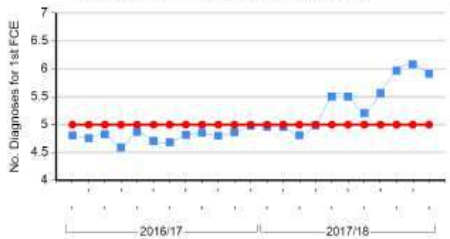
Deaths Post Discharge

Avg Spell LOS whilst admitted: **13.2**

Avg Days to death post discharge: **14.3**

YTD Deaths of Patients with GSF Alert: 361 **64.1%** ▲

Depth of Coding - (compared to national average)



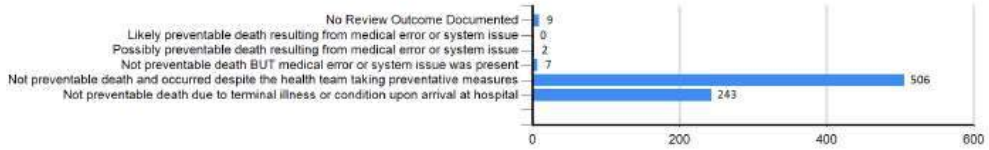
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

Primary Diagnosis Name	This Month	
Pneumonitis due to food and vomit	11	▲
Lobar pneumonia, unspecified	10	▼
Pneumonia, unspecified	7	▼
Sepsis, unspecified	5	▼
Acute renal failure, unspecified	4	▼

Mortality Reviews

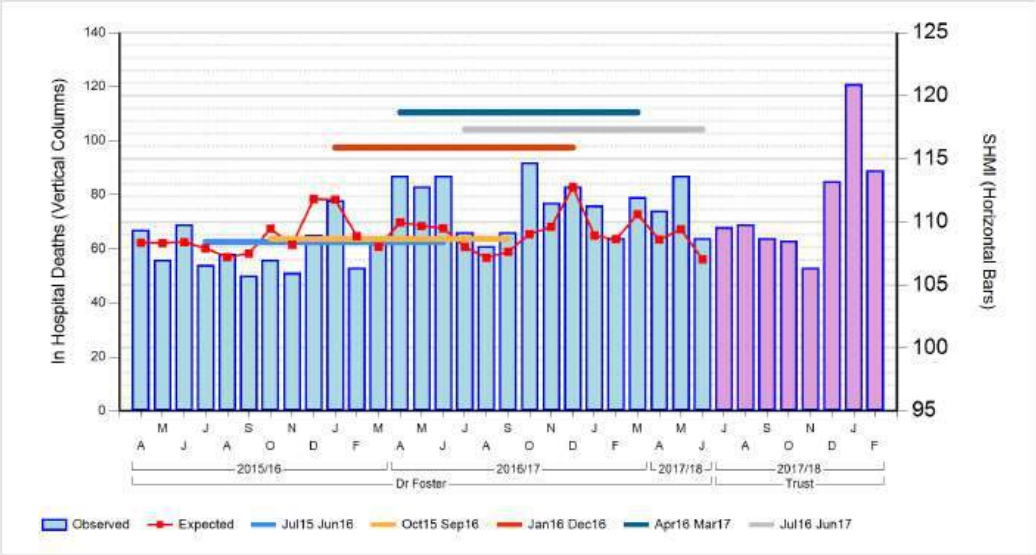
	2016/17	2017/18										
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Reviews Completed		66	123	72	53	77	71	53	64	80	108	
Reviews %	0.0%	83.5%	132.3%	107.5%	77.9%	111.6%	110.9%	84.1%	120.8%	94.1%	89.3%	0.0%

Mortality Review Outcomes - Last 12 Months



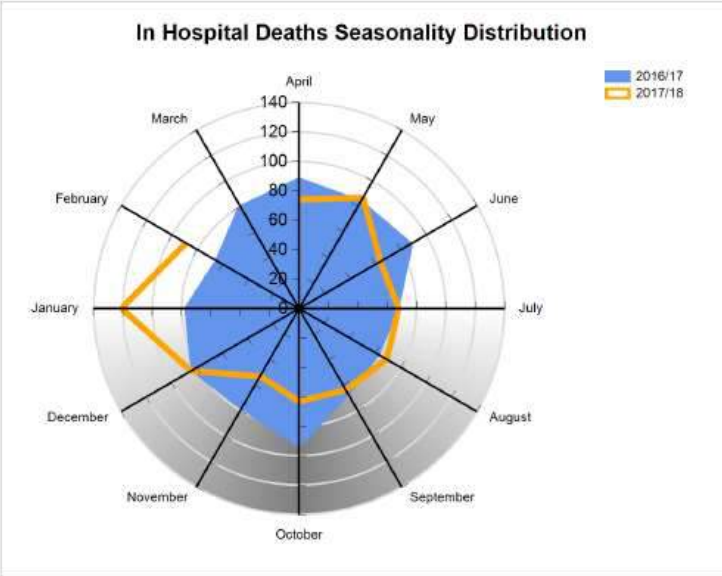
SHMI Breakdown

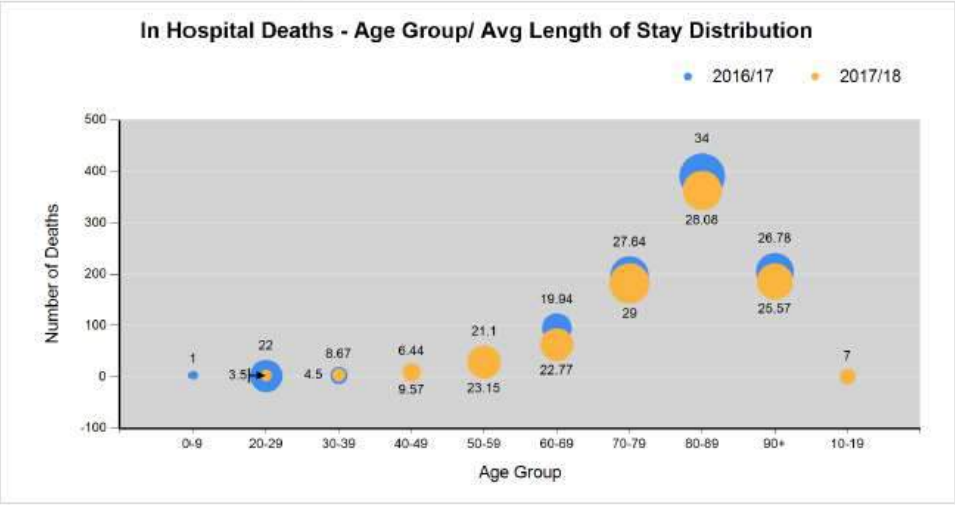
Southport & Ormskirk Hospital NHS



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

The horizontal coloured bars are the reported SHMI for the 12 month period they cover, this is updated every quarter from Dr Foster.

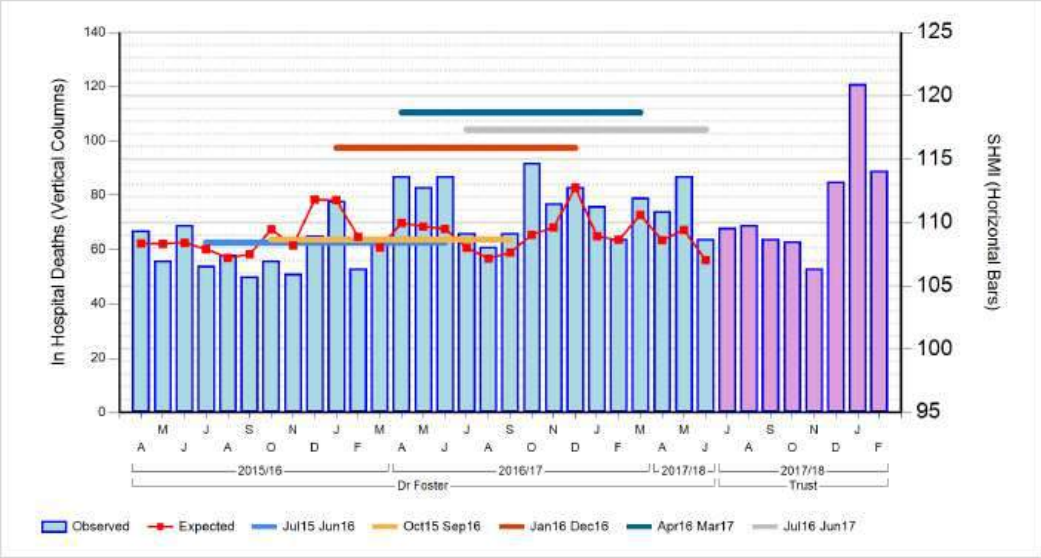




The above chart shows the distribution of in-hospital deaths by age group in 2016/17 compared to 2017/18. The relative size of the bubble represents the average length of stay of the spell.

SHMI Breakdown

Southport & Ormskirk Hospital NHS



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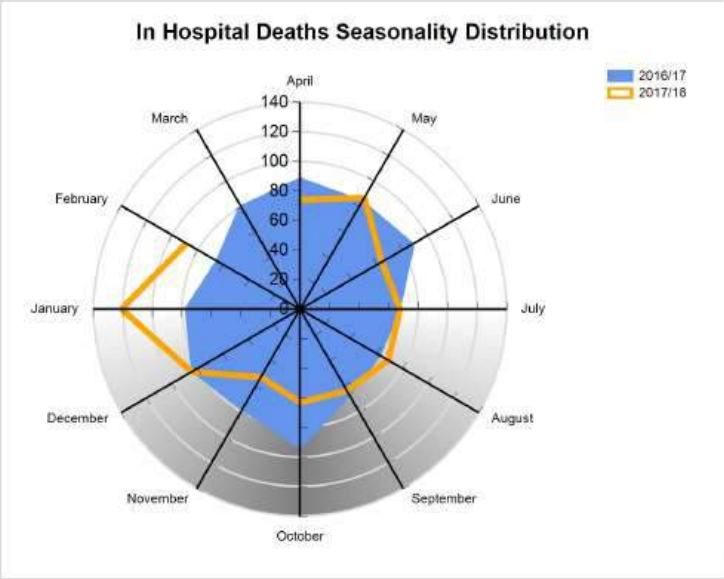

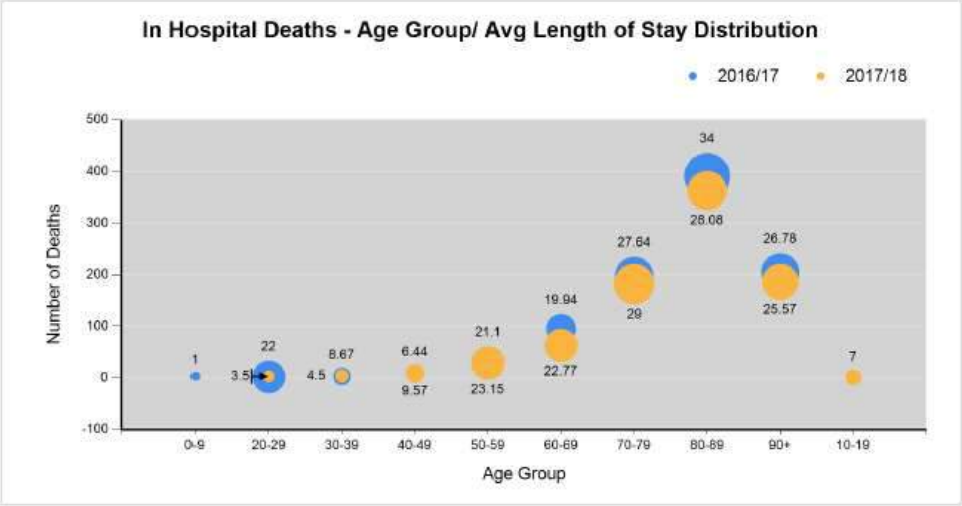

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ALERT ADVISE ASSURE (AAA) HIGHLIGHT REPORT

Committee/Group Meeting date:	Workforce Committee Meeting 19.04.2018
Lead:	Ged Clarke

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Medical Education
HEENW are due to visit the Trust on 21.06.18 and the University of Liverpool due to visit 25.04.18. Whilst progress has been made to evidence improvements in medical education, this is not translating in to the trainee experience due to continuing service pressures and rota gaps impacting on their ability to attend training and access supervision.

Staff Survey
The staff survey results are disappointing and a real concerted effort and plan to address culture and employee experience needed as soon as possible.

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)

NGO
The NGO Action Plan is on track. There was some discussion regarding the format of the Action plan which was suggested by NHSi.

ASSURE

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

Apprenticeships

The Trust has 42 registered apprentices across band 2-7 and across various roles. The Trust has until March 2021 to demonstrate how it will achieve the annual public sector target of 67 registrations per year to report to the Department of Health.
The first Apprenticeship Steering Group was held in April 2018 and will agree the objectives of a new Apprenticeship Strategy for the Trust.

E&D Lead
Has been appointed and attended the meeting. Karen Chazen was welcomed.

New Risk identified at the meeting	None

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Board of Directors

2nd May 2018

Agenda Item	**TB115/18**	**Report Title**	**Monthly Safer Staffing Report**
Executive Lead	Gill Murphy Acting Director of Nursing Midwifery & Therapies		
Lead Officer	Carol Fowler Assistant Director of Nursing - Workforce		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		✓ To Note ☐ To Receive

Key Messages and Recommendations

This monthly safe staffing report has reflected the guidance within the following:
National Quality Board (NQB) guidance November 2013/updated July 2016
Care Quality Commission
NHSI Safe staffing for adult inpatients in acute care December 2016
NICE 2014 – safe staffing for nursing in adult inpatient wards in acute hospitals

This report presents the safer staffing position for the month March 2018 and confirms compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff.

The Trust Board is advised that the Trust continues to comply with the requirements to upload and publish the aggregated monthly average registered nursing and non-registered nursing staff data for inpatient ward areas. These can be viewed via the following hyperlink address on the Trust's web-page

http://www.southportandormskirk.nhs.uk/safe-staffing.asp

The data reported is summarised as follows:

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 March 2018 against the accepted national level of 90%:

- **Trust overall 84.59%**
- 77.52% Registered Nurses (RN) on days
- 78.79% Registered Nurses on nights
- 93.82% Care staff on days
- 100.52% Care staff on nights

- **Trust vacancy:**
- 9.93% (109.72wte) Registered Nurse vacancies at band 5 and above
- 9.74% (29.07 wte) Healthcare assistant vacancies band 2 and above.

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

	Funded WTE	Contracted WTE
Registered	859.16	761.94
Non-registered	377.04	340.33
Total	1236.20	1102.27

Whilst completing a 'deep dive' into safe staffing in A&E, it emerged that not all hours worked by registered and non-registered staff are captured on the electronic roster system. This suggested that we are potentially under reporting the percentage fill rate, as this monthly data is pulled from the electronic roster. A full review of available data and utilisation of the safer nursing care tool/e-roster is ongoing to better understand the reporting against all inpatient wards areas. The aim is to assure on trust safe staffing reporting and utilisation going forward.

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

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…..)*

☐ Annual Business Plan Priority
✓ Best Practice
✓ Linked to a Key Risk on BAF / Risk Register Ref No.: 1368
☐ Other List (Rationale) _____
☐ Service Change
☐ Statutory requirement

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

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

Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
To note this report	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds ☐ Finance Performance & Investment Committee	☐ **Quality & Safety Committee** ☐ Remuneration & Nominations Committee ☐ Workforce Committee

1. Aim of the Report

1.1 To inform the Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England NQB and Care Quality Commission.

2. Background

The National Quality Board updated its guidance for provider Trusts in 2016, which set out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive nursing and midwifery staffing levels. Trust Boards are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.
This report presents the safer staffing position for the month March 2018 and confirms compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff.

2.1 Overall Fill Rates

The March 2018 submission indicates a trust fill rate for registered nurses on days 77.52 %, non –registered nurses days 93.82%. Fill rate of registered nurses nights 78.79% and 100.52% for Non-registered nurse's 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.

Whilst completing a 'deep dive' into safe staffing in A&E, it emerged that not all hours worked by registered and non-registered staff are captured on the electronic roster system. This suggested that we are potentially under reporting the percentage fill rate, as this monthly data is pulled from the electronic roster. A full review of available data and utilisation of the safer nursing care tool/e-roster is ongoing to better understand the reporting against all inpatient wards areas. The aim is to assure on trust safe staffing reporting and utilisation going forward. This issue is seen as a potential risk and has been added to the risk register.

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 9.93% Registered nurse Vacancies (109.72WTE) and 9.74% non-registered nurse vacancies (29.07WTE) at the end of March 2018 across the Clinical Business Units.

Nurse staffing reports as a high risk on the Trust Risk Register and is reviewed monthly.
In terms of midwifery staff and children's services all Registered posts are filled.

Recruiting and retaining the nursing and midwifery workforce continues to be an area of increased focus.

In terms of strategic context with nursing staffing, the future supply of registered adult nurses remains the primary concern for the Trust's Director of Nursing.
Ageing nursing and care assistant workforces continues to be a risk locally to the Trust and will feature within the nurse workforce planning meeting on 24th April 2018.

Apprenticeship Levy:

The first Apprenticeship Steering Group was held on the 12th April 2018. The group will meet on a monthly basis for the first 12 months to monitor the Levy spend and track registrations. Momentum has built within nursing with the x10 Healthcare level 3 apprenticeships registered (April) and x12 Assistant Practitioner level 5 apprenticeships registered.

3.1 The Recruitment of Bank staff via NHSP

Recruitment of bank Health Care Assistants (HCA) 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.

March 2018 recruitment:
Registered nurses - 10 new starters, 3 of which have worked shifts (30%)
Nonregistered nurses –12 new starters, 0 of which have worked shifts.

NHSP are currently open to advert to recruit paramedic colleagues and ANP's considering flexible working opportunities within Southport AED department.

4. Student Nurse Recruitment Update

March 19th 2018 was the last Trust local recruitment event for adult nursing, with 12 nurses recruited. The challenge is on to try and retain these people and also secure others that were not able to attend the event.

The ability to recruit sufficient numbers of registered nurses in order to meet safer staffing requirements remains a recorded risk until staffing levels stabilise more.

On-going Recruitment of Registered Nursing Staff

The acting Director of Nursing and Midwifery has commissioned the Nursing Board on 25th April to focus on nurse workforce planning.
This will align to the support work streams on recruitment, retention and roster management with NHSI.

The next North of England Nursing Workforce Group will take place on 1st May 2018 with agenda items covering The Health and Care Workforce Strategy for England to 2027 and Age profile/impact of nursing workforce in the North. The assistant Director of Nursing – workforce will be in attendance.

The Trusts PR/Communication team are supporting a local recruitment campaign including 'Post-code drops' and widespread local advertisement through local media and public transport.

The Trust has representation on the Cheshire and Merseyside Director of Nursing workforce recruitment and retention collaborative program and continues to have representation at the meetings.

5. Staffing Related Reported Incidents

43 staffing related incidents were reported in March 2018 of which 24 highlighted insufficient nurses/midwives. The highest number of insufficient nurses were reported on G Ward in Ormskirk, who reported 5 incidents, of which 4 occurred between 26 – 28th March and raised concerns about the number of registered nurses on duty in comparison to the number of Urology and Gynecology patients on the ward. They had been impacted by the movement of staff from G Ward to ACU in SDGH. These moves were risk assessed and supported through the safe staffing escalation meetings. In addition, Ward 14A reported 4 incidents of insufficient nurse numbers in March 2018, 3 of which were on the 20th March and as a result of moving staff to ward 14B, again these moves were supported through the safe staffing huddles.
Ward 9B (FESS) reported 2 incidents in March 2018 and raised concerns about an inability to provide full 1-2-1 care for a patient on a DoLs.

Incidents are not directly correlated to nurse staffing numbers alone.
Incidents appear to be attributable to short term nurse sickness and opening of escalation areas leaving areas challenged at times in accommodating the acuity and flow of patients.
The trusts escalated bed base during March 2018 reflected an average of 22.8 additional beds occupied, which further impacts on staffing capacity and capability.

Senior Nurses continue to contribute to additional temporary cover across the Trust to assure safe staffing is reviewed and supported against patient flow challenges.

Ward leaders clinical shifts remain in place across planned and urgent care business groups with minimal supervisory shifts. The placement of senior matrons into clinical shifts to help boost direct care giving hours continues whilst providing ongoing managerial support. Matron clinical hours are not currently captured on either HealthRoster or the Unify data and will form part of the review described above. The re-deployment of nursing staff across hospital sites continues to be a requirement within the escalation and management of safe staffing daily supported by enhanced pay rates and utilisation of flexible workers via NHSP and agency.

6. Inpatients experiencing moderate harm or above in March 2018

2 grade 3 hospital acquired pressure ulcers were reported in March 2018, both on Short Stay Unit. There was one incident of a patient being delayed 32 days for a biopsy, and one incident of a delay for medical review of a patient on ward 14A.

These incidents are investigated as part of the investigation process within the trust.

7. NHS Improvement (NHSI) Safer Staffing Guidance

NHSI visited Southport site as agreed on 12th/13th March 2018 to commence their workforce review. Further visits are planned over the next few months. A teleconference was convened on 13th April 2018 with video conference arranged for 27th April 2018 to discuss nursing workforce productivity with an aim to deliver efficiency and productivity saving through optimisation of e-rostering tool. The main interdependencies of this work are safer staffing and workforce improvement opportunities.

Summary

The report has presented information on staffing headcount fill rates on inpatient wards for the month of March 2018 and provided an update regarding on-going nursing and midwifery workforce recruitment activities to address vacancies.

Bi-annual nurse staffing reviews are underway reportable to board in June 2018.

The consultation on the Health and Care Workforce Strategy for England to 2027 is now closed and the Strategy for the health service is due to be published in July 2018.

The Board is asked to note the Trust monthly safe staffing report. To recognise and thank the significant effort that is being made by many registered and non-registered nursing staff, which includes many working outside their 'normal' area of specialty to help care for patients, in sometimes very challenging circumstances.

The format and content of the Monthly Safer Staffing report is being updated with the support of NHSI in order to strengthen the report and clearly meet the recommendations within the NQB, NICE.

Carol Fowler
Assistant Director of Nursing - Workforce

Southport and Ormskirk Hospital NHS Trust

Board of Directors

2nd May 2018

Agenda Item	**TB116/18**	**Report Title**	Medical Education Update Report
Executive Lead	Dr Jugnu Mahajan, Interim Medical Director		
Lead Officer	Mr Sanjeev Sharma, Director of Medical Education		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information		☐ To Note ☐ To Receive

Key Messages and Recommendations

To note that the Trust will undergo inspections from the University of Liverpool, 25th April, 2018, and by Health Education England (NW), 21st June, 2018, in relation to our provision of undergraduate and postgraduate medical education.

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

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…..)*

☐ Annual Business Plan Priority
☐ Best Practice
✓ Linked to a Key Risk on BAF / Risk Register Ref No.: 1549
☐ Other List (Rationale) _____
☐ Service Change
☐ Statutory requirement

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

☐ Compliance	✓ Quality
☐ Equality	✓ Risk
☐ Finance	✓ Workforce

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

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

The Board are advised that the Director of Medical Education will provide an update as to the outcome of the Quality Assurance visit by the University of Liverpool in his May 2018 report.

Previously Presented at:

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

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

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

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

Information: Literally, to inform the Board

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

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

MEDICAL EDUCATION REPORT

For Trust Board – April 2018

INTRODUCTION

Following on from the last report submitted to the Trust Board on 8th March 2018, the Medical Education Department submitted the completed Action Plan to HEE NW.

HEE NW have provided their response to the Action Plan on 23rd April, 2018. They have stated:

"It is obvious from the action plan that much work has been carried out in relation to our previously stated concerns and there are a number of positive initiatives. However, some of the timelines are confusing and some actions have been closed without relevant supporting evidence."

HEE NW have requested a Trust update by 25th May, 2018. The DME and Medical Education Manager are working to provide the additional information required . The full inspection visit will be carried out by HEE NW as planned on 21st June, 2018.

MEDICAL EDUCATION UPDATE Period March – May 2018

The following is an update from the Medical Education department for the period March, 2018 – May 2018:

1. The Quality Assurance visit from the Institute of Clinical Services, School of Medicine is scheduled for 25th April, 2018. The University of Liverpool has received the required pre-visit report in accordance with their deadline of 29th March, 2018, together with a comprehensive portfolio of supportive evidence. The Director of Medical Education (DoME) will provide an update to the Board on the outcomes of the visit on 2nd May, 2018.

2. Restructuring of the medical education administrative team is now underway with the initial consultation meeting having taken place with the team on 10th April, 2018. This is in line with the agreed structure **Appendix 1.**

3. The interviews for Undergraduate Year 4 Lead and the Postgraduate Clinical Tutor are scheduled for 27th April, 2018, and recruitment is underway for the new Clinical Education Lead roles (x2).

4. The Trust has approved the funding for the IT Software system – Bookwise Elements – which will support the development of robust quality assurance management processes in medical education.

5. The Grand Round will be reintroduced on a weekly basis from 8th June, 2018. A full programme is currently being compiled for publication at the beginning of May. This forum will provide continued professional development to medical staff and is a step towards becoming a learning organisation.

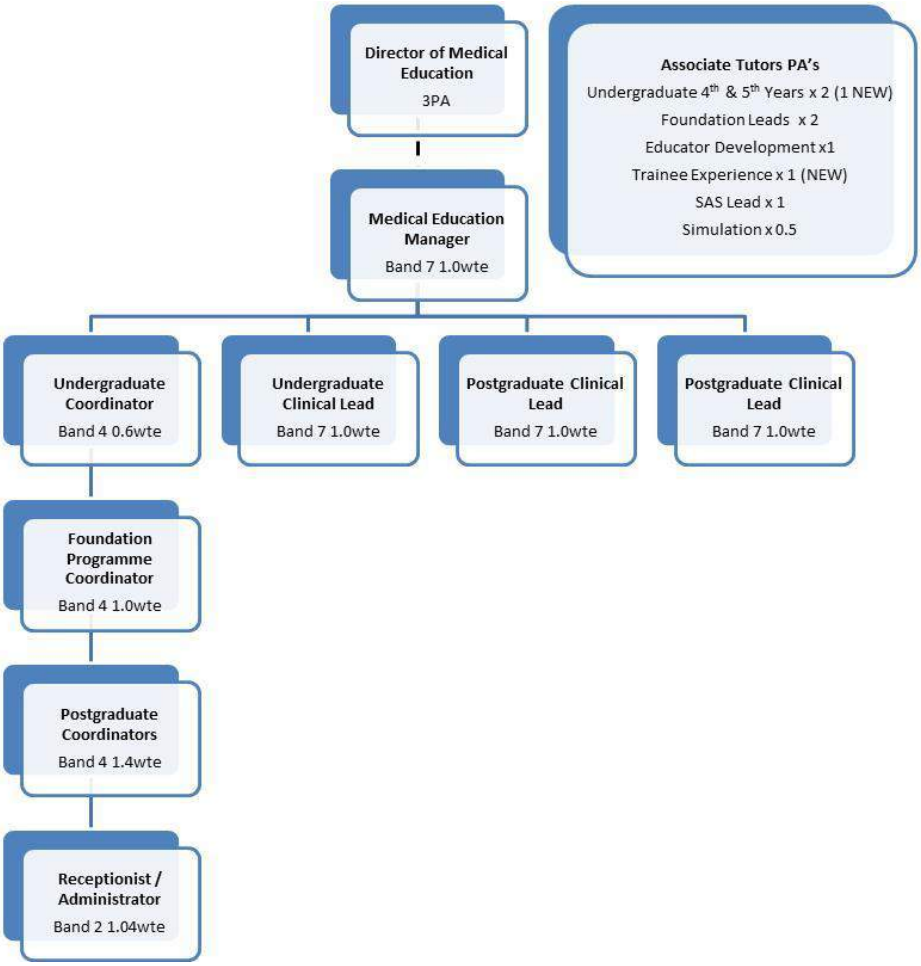
CONCLUSION

Significant progress continues to be made to improve the consistency and quality of medical education in the Trust.

RECOMMENDATION

The Board is requested to note the content of the report.

Appendix 1


Director of Medical Education
3PA
Associate Tutors PA's
Undergraduate 4th & 5th Years x 2 (1 NEW)
Foundation Leads x 2
Educator Development x1
Trainee Experience x 1 (NEW)
SAS Lead x 1
Simulation x 0.5
Medical Education Manager
Band 7 1.0wte
Undergraduate Coordinator
Band 4 0.6wte
Undergraduate Clinical Lead
Band 7 1.0wte
Postgraduate Clinical Lead
Band 7 1.0wte
Postgraduate Clinical Lead
Band 7 1.0wte
Foundation Programme Coordinator
Band 4 1.0wte
Postgraduate Coordinators
Band 4 1.4wte
Receptionist / Administrator
Band 2 1.04wte

Southport and Ormskirk Hospital NHS Trust

Board of Directors

2nd May 2018

Agenda Item (Ref):	**TB117/18**	**Report Title:**	**Guardian of Safe Working Report to Board 24/01/18 - 22/04/18**
Executive Lead	Dr Jugnu Mahajan, I**nterim Medical Director**		
Lead Officer	Dr Ruth Chapman, Guardian of Safe Working		

Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive

Key Messages of this Report & Recommendations:

There have been no episodes of Double Bleep Carrying in Paediatrics since 23.01.18

Despite an almost fully staffed trainee 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. A Briefing paper to address staffing across Medical wards was presented on 30th April.

Inadequate staffing in Medicine during Bank Holidays is now being addressed.

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

Exception Reports are reducing compared with the previous quarter.

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

NHS
Southport and Ormskirk Hospital
NHS Trust

THE GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT 23rd January – 22nd April 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 Hours, Pattern and Service Support Exception reports generated by trainees and I disseminate an anonymised overview to the Assistant Medical Directors, Clinical Directors and trainees on a monthly basis. Education Exception Reports are monitored by Director of Medical Education and he will report on these to Board.

1. E-EXCEPTION REPORT TRAINING

Education department have arranged more user friendly Exception Report training as part of February induction and an extended time slot for GOSW. Feedback from trainees was predominantly positive.

2. EXCEPTION REPORT OVERVIEW (23rd January – 22nd April 2018)

	26/07-19/10/17	20/10/17 -22/01/18	23/01-22/04/18	
Exception Reports ERs	19	95	73	
Completed ERs	17/19	65/95	38/65*	
Trainees	9	15	14	
Episodes	27	103	102	
Review Interview Held	9/9	95/95	55/65*	
A&E	0	0	0	
Medicine	15	88	65	
Surgery	2	3	2	
Orthopaedics	2	2	2	
Anaesthetics	0	0	0	
Ophthalmology	0	0	0	
Paediatrics	0	2	6	
Obs & Gynae	0	0	0	

*8 reports added within last week and therefore not overdue

See Appendix A for Exception Report Breakdown

Each Assistant Medical Director and Clinical Director receives a monthly overview report.

Meetings with clinical supervisors are occurring in a more timely manner in the last 4 weeks. Only 4 trainees are 4 weeks overdue their review meeting.

However 59 Exception Reports have not been completed. There was a delay in setting up the Payment Procedure. (See 4. Payment) and therefore many have not been signed off as completed by trainees. Of concern is the increased number of Service Support ER submitted because the majority of these indicate instances when either shifts are unfilled or Consultants or other Senior Doctors have been unable to provide sufficient support due to their own excessive workloads.

Payment rather than Time Off In Lieu (TOIL) is still necessary for most Exception Reports. Many of the TOIL hours initially agreed in Medicine have not been taken and have now been converted to payment.

Action: Due to Winter Pressures, Trainees are still being given payment but GOSW to monitor Clinical situation and revert to TOIL as soon as possible

3. MEDICINE

Deputy Medical Director, GOSW, Assistant Medical Director and Clinical Director for Medicine have drawn up a staffing template for all Medical Wards. The Interim EMD presented a briefing paper at the Executive Team Meeting on the 30th April. Following consultation with trainees, additional phlebotomy capacity was calculated and an increase in phlebotomy hours, particularly at the weekends has been agreed. Employment of additional staff is now required.

4. PAYMENT AND FINES

Developing forms for Payment as a result of Exception Reports and identifying appropriate nationally agreed payment rates for trainees of different grades has taken longer than anticipated. Trainees were emailed the appropriate forms and supporting information on 10th April. Backdated claims need to be submitted by 30th April. The costs will be presented in the August GOSW Report.

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

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

5. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

Coverage of Surgical shifts has been much better since the OSM escalates any week ahead uncovered shifts to the EMD. (See 10.2 Trainee Concerns). A similar procedure needs to be embedded in other departments. Medicine had uncovered shifts in March following the departure of a CT doctor. Paediatrics has 2 vacancies again resulting in unfilled shifts. Paediatric Consultants continue to act down to support trainees.

Employment of 5 Trust doctors at FY1 level for 6 months has improved the rota gaps situation. The GOSW strongly supports the extension of their contracts once clinical competencies are signed off.

Discussions continue around breaks, payment and rates.

Action: ***GOSW, Interim EMD and HR to formalise a SOP for In-house Locum arrangements by June 2018***

6. DOCTORS NOT ON THE NEW CONTRACT

Medical Staffing identified the 10 doctors not on 2016 contract following February 2018. No concerns about safe working from non-trainee doctors have been escalated to the GOSW.

Action: ***Medical HR will identify any doctors not on 2016 contract and GOSW will continue to monitor these trainees***

7. DOUBLE/TRIPLE BLEEP CARRYING

This practice has patient safety implications as well as causing significant stress to any trainees involved. In Paediatrics there have been no episodes of Double Bleep carrying reported since 23.01.18. Unfilled shifts in Medicine have resulted in 1 doctor covering 2 doctors' on call duties although not actually carrying 2 Bleeps (See 5. Rota Compliance and In-house Locum Arrangements).

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

8. VACANCIES (as of 18th April 2018)

See Appendix B

9. MIAA REPORT

The Mersey Internal Audit Agency Report on Junior Doctors Contracts was positively rated as Significant Assurance. Some weaknesses in the design and operation of controls which could impair the achievement of the objectives of the system, function or process were identified. However, either their impact would be minimal or they would be unlikely to occur. They did highlight the delay in Exception Reports being submitted and reviewed. Although it is understandable that during periods of high intensity workload, clinical work must be prioritised, this is also when timely intervention would have most impact.

ACTION ***GOSW to write a SOP for the exception reporting dealing with exception reporting for safety issues and processing overtime payments resulting from exception reports by June 2018***
ACTION ***DME to write a SOP for the exception reporting dealing with exception reporting for training issues by June 2108***
ACTION ***GOSW to write Terms of Reference for Trainee Doctors Forum by June 2018***

10. TRAINEE CONCERNS

The Trainee Doctor Forum continues to meet monthly. Trainee attendance remains low, but trainee representatives raise concerns forwarded to them. Clinical pressures are still 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. Employment of Physician Associates should allow greater attendance in the future.

Trainees continue to email their concerns to the GOSW. Datix Reports involving trainees are sent to GOSW and relevant ones are discussed at TDF.

10.1 Medicine

Trainees in Medicine continue to report excessive workloads. This continues to impact on some trainees ability to attend training opportunities. It is hoped that employment of more Medical and Non-Medical staff will improve this situation longer term.

In order to ensure trainees meet 2016 rota guidelines, there are insufficient trainees to adequately staff Bank Holidays. Only 3 trainees covered all Medical patients opposed to 7 during the same period at weekends. As soon as this was brought to the GOSW's attention it was escalated to the interim EMD. Interim EMD immediately asked for Bank Holiday templates to be the same as week end Templates and locum staff to be employed to cover the forthcoming Bank Holidays.

ACTION*: Monitor employment of more staff and effect on excessive workloads*
ACTION*: DME and AMD to look 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*
ACTION *EMD and GOSW to monitor Bank holiday staffing*

10.2 Surgery

Unfilled on call shifts have been minimal this quarter. The OSM for surgery informs the EMD of any unfilled shifts a week in advance and then an up lift on locum pay is agreed with finance. However on occasions the same shift has been refilled 4 times because locums have taken shifts elsewhere citing the reason as higher pay at other hospitals.

ACTION*: EMD and GOSW to monitor situation*

10.3 Paediatrics

See previous information on double bleep carrying. There are 2 vacancies in Paediatrics since the April rotation. This is already causing issues around covering rota gaps which require Consultants to step down. Employment of Advanced Nurse Practioners should ease this situation. Further Advanced Nurse Practioners are in training.

Trainees have reported senior support for Neonatal Life Support during first shifts is in place.

10.4 Facilities

Longstanding concerns have been raised by trainees about inadequate mess facilities and poor IT. A review of space and accommodation usage is underway and new mess facilities should be considered following this. Poor wifi means that trainees are sometimes having to use their own phones for clinical tasks which looks unprofessional. IT systems upgrade would be necessary.

Charging doctors for room usage post night shift was commenced without consultation. EMD and GOSW ensured this was suspended and a new system introduced ensuring entitled trainees had free room use but prompt key return occurs.

ACTION *GOSW to monitor re-siting of mess facilities*
ACTION IT to upgrade wifi
ACTION *GOSW to monitor accommodation concerns*

11. ADDITIONAL GOSW CONCERNS

Unfortunately this section is unchanged. Very poor morale across trainees, particularly in Medicine, is a significant cause of concern. 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.

A Medical Engagement survey is running at present.

Action: *A Trainee Doctor Concerns Committee which meets monthly has been set up.*
Action: EMD will use Medical Survey results to further target resources to areas identified.

12. DOCTORS IN DIFFICULTIES

Both trainees continue to be 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. There were no significant issues with February induction.

14. LOCAL INDUCTION

This is being followed up by the Medical Education Department and Assistant Medical Directors and will be resolved by the next intake.

15. GOSW ROLE

GOSW work load is improving but of 1 PA/week is still inadequate at present. Administration support of 4 hours/week has been in place for the last quarter. This has reduced the GOSW additional hours on a monthly basis and by August I would expect 1 PA to be sufficient.

Action: ***EMD to review extra hours on a monthly basis.***

Dr Ruth Chapman
Guardian of Safe Working
22nd April 2018

Appendix A

EXCEPTION REPORT OVERVIEW (24th January – 22nd April 2018)

Exception Reports

73 by 14 trainees
65* Medicine
2 Surgery
6* Paediatrics
38/65 Completed on system*
102 Episodes

***- 8 added not overdue review 5 Medicine and 3 Paediatrics**

Exception Episodes

Medicine

92 Episodes (* 5 not overdue review)
73* Extra Hours Episodes (includes x 8 Breaks missed)
6 Training Episodes
13 Service Support

Extra Hours

39/68 Episodes Completed*
55/66 Episode interviews have taken place*
25/66 Episode Interviews within 7 days*
16/55 Awaiting trainee sign off
41.50 Extra hours worked
0.00 hours TOIL agreed
41.50 hours Overtime pay agreed
14 Episodes overdue
0-76 days overdue

Training

3/6 Episodes Completed
4/6 Episode interviews have taken place
2/6 Episode Interviews within 7 days
2/4 Awaiting trainee sign off
2 Episodes overdue
0-16 days overdue

Service Support

7/13 Episodes Completed
10/13 Episode interviews have taken place
0/13 Episode Interviews within 7 days
3/10 Awaiting trainee sign off
3 Episodes overdue
0-31 days overdue

Surgery

4 Episodes
4 Service Support

Service Support

0/4 Episodes Completed

4/4 Episode interviews have taken place
2/4 Episode Interviews within 7 days
0/2 Awaiting trainee sign off
0 Episodes overdue

Paediatrics

7 Episodes
3 Extra Hours (1 not overdue review)
3 Service Support (1 not overdue review)
1 ?Not an Exception (added 4 days ago and not reviewed yet)

Extra hours

1/3 Episodes completed (1 not overdue)
2/2 Episode interviews have taken place (1not overdue)
2/2 Episode Interviews within 7 days (1 not overdue)
1/2 Awaiting trainee sign off
2.50 Extra hours worked
0.00 hours TOIL agreed
2.50 hours Overtime pay agreed
0.00 No TOIL or Payment
0 Episodes overdue

Service Support

0/3 Episodes Completed (1 not overdue)
2/2 Episode interviews have taken place
2/2 Episode Interviews within 7 days
2/2 Awaiting trainee sign off
0 Episodes overdue

Not an Exception

1 Episode not yet reviewed (not overdue)

Appendix B

VACANCIES AS OF 11 APRIL 2018

AED

Consultant	0 vacancies in 11 posts
SAS	0 vacancies in 8 posts
ST3	0 vacancies in 2 posts
FY2 – ST2	2 vacancies in 8 posts
Clinical fellow	6 vacancies in 6 posts
FY1	1 vacancy in 2 posts

Anaesthetics

Consultant	3 vacancies in 20 posts (1 locum in post)
SAS	1 vacancy in 32 posts
ST3	2 vacancies in 4 posts (1 locum in post)
FY2 – ST2	1 vacancy in 8 posts

Dermatology

Consultant	0 vacancies in 2 posts
SAS	2 vacancies in 6 posts
ST3	2 vacancies in 3 posts

GP Practice

FY2 – ST2	1 vacancy in 9 posts

Haematology

SAS	0 vacancies in 1 post

MFU Medical Staff

Consultant	0 vacancies in 2 posts
ST3	0 vacancies in 4 posts

Medicine

Consultant	2 vacancies in 20 posts (2 locums in post) 2 vacancies in 11 person rota (2 locums in post)
SAS	1 vacancy in 5 posts (1 locum in post)
ST3 and above	1 vacancy in 10 posts
FY2 – ST2	1 vacancy in 16 posts (1 locum in post)
FY1	0 vacancies in 16 posts

Obstetrics and Gynaecology

Consultant	0 vacancies in 13 posts
SAS	2 vacancies in 7 posts (2 locums in post)
ST3	1 vacancy in 7 posts
FY2 – ST2	0 vacancies in 8 posts

Ophthalmology

Consultant	1.4 vacancies in 3 posts
SAS	0 vacancies in 5.7 posts
ST1-7	0 vacancies in 1 posts

Orthopaedics

Consultant	0 vacancies in 7 posts
SAS	1 vacancy in 7 posts (1 locum in post)
ST3	1 vacancy in 1 posts
FY2 – ST2	5 vacancies in 8 (3 locums in post)
FY1	2 vacancies in 3 posts (2 locums in post)

Paediatrics A&E

Consultant	0 vacancies in 2 posts
SAS	0 vacancies in 11 posts
ST3	0 vacancies in 4 posts
FY2 – ST2	1 vacancies in 2 posts (1 locum in post)

Paediatrics

Consultant	0 vacancies in 6 posts
SAS	0 vacancies in 5 posts
ST3	0 vacancies in 4 posts
FY2 – ST2	2 vacancies in 9 posts 2 in 8 person rota
FY1	0 vacancies in 1 post

Psychiatry

FY2	1 vacancy in 2 posts
FY1	0 vacancies in 2 posts

Sexual Health

Consultant	0 vacancies in 2 posts
SAS	0 vacancies in 2 posts

Spinal Injuries

Consultant	0 vacancies in 3 posts
SAS	0 vacancies in 3 posts

ST3	0 vacancies in 2 posts
FY2 – ST2	0 vacancies in 2 posts

General Surgery

Consultant	0 vacancies in 7 posts
SAS	2 vacancies in 6 posts
ST3	1 vacancies in 5 posts
FY2 – ST2	3 vacancies in 9 posts
FY1*	0 vacancies in 8 posts

FY1 1 in 8 on call rota comprises FY1 in surgery, orthopaedics and psychiatry

Urology

Consultant	0 vacancies in 4 posts
SAS	0 vacancies in 3 posts
ST3	0 vacancies in 1 post
FY2 – ST2	0 vacancies in 2 posts
FY1	0 vacancies in 1 post

NB Long term Locums are not easily identifiable on Health Roster so may not all be identified.

Southport and Ormskirk Hospital NHS Trust

GOSW February 18 Trust Board Report Action Log

Matters Arising Action Log

May, 2018

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. Education department have arranged more user friendly Exception Report training as part of induction and an extended time slot for GOSW**	GOSW	Aug-18	Aug-18	**Feedback from February Induction was positive**	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	**Exception Review meetings are occurring in a more timely manner. Sign off by trainees has been delayed because Payment system needed development. This is now in place.**	AMBER
GOSW Nov Trust Board Report	Nov-17	**Payment System for Exception Reports and Fines**	**GOSW, HR and Finance to organise a suitable system. GOSW to present Exception and Fine costs at the May Board**	Fianance, GOSW	Dec-18	Aug-18	**System set up in January was inadequate - new procedure in place from 10.04.18. No payments made as yet**	AMBER
GOSW Nov Trust Board Report	Nov-17	**Rota Compliance and In-house Locum Arrangements policy**	**GOSW, Interim EMD and HR to agree in-house locum arrangements and write a policy. EMD to formalise a SOP**	GOSW/EMD	Dec-18	Jun-18	**Discussions aound breaks, rates and payments are ongoing**	AMBER
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	ongoing	**10 Doctors identified last week. All on standard pre- 2016 contracts**	BLUE
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. Any concerns about safe working from non-trainee doctors will be investigated by GOSW	GOSW	Ongoing	ongoing	**All doctors not on 2016 contract emailed - no issues raised. Medical HR will identify doctors not on 2106 contract after each changeover and GOSW will contact them by email**	BLUE
GOSW Nov Trust Board Report	Nov-17	**Double/Triple Bleep Carrying**	GOSW has and will continue to forward all instances of double bleep carrying to EMD.	EMD/GOSW	Nov-18	ongoing	**All episodes of Double Bleep carrying reported to GOSW. All escalated to EMD**	AMBER
GOSW Nov Trust Board Report	Nov-17	**Doctors in Difficulties**	Monitoring and support have been given. GOSW, EMD and DME to monitor situation.	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. GOSW to check whether there were any issues for new starters in February	EMD/HR	Jan-18	Ongoing	**No issues with new trainees start in Feb 18. GOSW will continue to monitor until after Aug 18**	GREEN
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. HR, DME and GOSW to consider possible solutions.	DME/EMD/G OSW	Jun-18	Jun-18	**DME and AMDS are working to resolve local induction before next intake**	BLUE
GOSW Nov Trust Board Report	Nov-17	**GOSW Admin support**	HR to provide 4 hours a week admin support. Medical Staffing to organise administrative support.	HR	Nov-17	Feb-18	**Excellent admin support in place since late Jan 2018 - training ongoing**	GREEN
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 to review extra hours on a monthly basis.	EMD/Finance	Feb-18	Aug-18	**Significant reduction in Extra hours in February and March. Once Admin support training completed 1 PA/**	GREEN
GOSW Nov Trust Board Report	Feb-18	**Exception Report Overview**	GOSW to monitor Clinical situation and revert to TOIL as the default as soon as possible.	GOSW/EMD	Aug-18	Aug-18	**TOIL still the necessary default at present due to Clinical Pressures**	AMBER
GOSW Nov Trust Board Report	Feb-18	**ADDITIONAL GOSW CONCERNS**	Trainee Doctor Concern Committee which meets monthly will implement changes to improve trainee experience	GOSW/HR	Feb-18	Ongoing	**Awaiting results of Site Use Assessment with regard to finding alternative space to replace the inadequate Mess used presently. Still problems with trainees taking leave**	RED

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Owner	Original Deadline	Forecast Completion	Status Outcomes	Status
GOSW Nov Trust Board Report	Feb-18	**Medicine Workload**	EMD and AMD for medicine to determine safe medical staffing levels for each ward following the principles of safe nurse staffing. EMD and AMD to conduct a Clinical Activity review to ensure safe medical staffing on wards is a priority.	EMD/AMD Medicine/GOSW	Aug-18	Aug-18	**Medicine Ward Staffing Template generated by AMD & CD in Medicine,DMD and GOSW with trainee input. E**	**AMBER**
GOSW Nov Trust Board Report	Feb-18	**Medicine training opportunities**	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	DME/AMD	Aug-18	Aug-18	**DME to feedback to Board**	**BLUE**
GOSW Feb Trust Board Report	Feb-18	Surgery unfilled shifts	EMD and GOSW to monitor situation	EMD/GOSW	Ongoing	Ongoing	**Considerable reduction in unfilled shifts**	**GREEN**
GOSW Feb Trust Board Report	Feb-18	Paediatrics training opportunities	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.	DME/CD	Ongoing	Ongoing	**DME to feedback to Board**	**BLUE**
GOSW Feb Trust Board Report	Feb-18	Paediatrics NLS support	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	GOSW	Apr-18	Apr-18	**Trainees feedback good support in place for first shifts until confident with NLS**	**BLUE**

ALERT ADVISE ASSURE (AAA) HIGHLIGHT REPORT

Committee/Group Meeting date:	Finance, Performance & Investment Committee 23 April 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 latest draft 2018/19 Operational Plan forecasts a net deficit of £28.8M after allowing for the delivery of a £7.0M Cost Improvement Plan. (CIP schemes to the value of £3.1M have been identified to date.)
- The Trust's 2017/18 deficit is £29.2M before the application of penalties/ sanctions and the Expert Determination assessment, which increases the deficit for 2017/18 to £33.6M.
- As a consequence of the Expert Determination decision there is an ongoing discussion about the methodology for charging CCGs for patients who are admitted to assessment/clinical decision units rather than inpatient beds.

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)

- KPMG has been appointed to look at the Trust's systems and processes that surround the Cost Improvement Programme and advise on ways of improving the delivery of targeted savings.
- Achievement of the 62 day cancer waiting time targets has been affected by delayed access to diagnostic services. It is anticipated that the Trust will be back on target by June.
- Enhancements to the Patient Flow Improvement Programme mean that the Trust is now scheduled to hit the 90% 4 hour access target in September.

ASSURE

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

- Over the last month the Trust has ceased the acceptance of paper outpatient referrals. It has also implemented an electronic Order Comms system for ordering pathology and radiology tests at Ormskirk. Whilst each change has had some teething problems, both initiatives are working effectively.
- One of the CQC's key recommendations to the Trust was the need to convert Room 8 at Ormskirk Hospital into an additional delivery room. This work has been successfully undertaken.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

Southport and Ormskirk Hospital NHS Trust

ALERT ADVISE ASSURE (AAA)
HIGHLIGHT REPORT

Committee/Group:	Audit Committee
Meeting date:	11 April 2018
Lead:	Ged Clarke, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

This meeting was concerned to receive a number of end of year reports and to sign off on behalf of the Board a number of annual compliance documents and Annual Plans. These include:

- Internal Audit Annual Plan - 2018/19
- Anti-Fraud Annual Plan-2018-19
- Security Management - Annual Work Plan 2018-19
-

The Committee also reviewed and/or approved a number of key documents and Corporate Registers:

- Standing Orders, SFIs and Scheme of Reservation & Delegation
- Board of Directors Register of Declared Interests
- Register of Gifts and Hospitality
- Annual Governance Statement
- Audit Committee Annual Report
- Freedom to Speak Up Annual Report
- Compliance with Provider Licence
-

Some documents were approved whilst others received recommendations for improvement from the Committee

ADVISE

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

The Committee's advice to the Board is:

- It was pleased with progress being made with the BAF but recommends continuous improvement
- That the Board review the Annual Governance Statement and make recommendations accordingly; the same goes for Compliance with Provider Licence

ASSURE	
(Detail here any areas of assurance that the committee has received)	
• The Committee has again been informed that Executive Directors are giving attention to their individual risks as set out in the BAF and that this has been enhanced by placing the BAF on Datix, the Trust's Risk Management System. • The Board can be assured that a Tool for the Committee to assess its performance and effectiveness was adopted and will be used.	
New Risk identified at the meeting ? (If identified please add to risk register)	**None**
Review of the Risk Register (Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)	

Southport and Ormskirk Hospital NHS Trust

Board of Directors

2nd May 2018

Agenda Item	**TB12018**	**Report Title**	**Emergency Care Performance Report – 4 Hour Access Performance Review**
Executive Lead	Therese Patten Chief Operating Officer		
Lead Officer	Therese Patten Chief Operating Officer		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note X To Receive	

Key Messages and Recommendations

The Trust continues to struggle to deliver against the 4 hour access target

The Committee is asked to note:

- In March overall performance deteriorated by 1%
- The Performance of the Walk In Centre has dropped by 2% since January affecting Trust overall position
- There was a marked increase in attendances in March
- 12 hour breaches rose compared to February to six
- The Patient Flow Programme has been reset to take all patient off the corridor by the end of June

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

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
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…..)*

☐ Annual Business Plan Priority
☐ Best Practice
☐ **X** Linked to a Key Risk on BAF / Risk Register Ref No.: _____
☐ Other List (Rationale) _____
☐ Service Change
☐ Statutory requirement

Impact *(is there an impact arising from the report on the following?)*	
X Compliance ☐ Equality ☐ Finance ☐ Legal	**X** Quality ☐ Risk ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds ☐ Finance Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

4 HOUR ACCESS, REVIEW OF PERFORMANCE MARCH 2018

1 EXECUTIVE SUMMARY

The report reflects the key elements which impact on the delivery of the 4 hour access target for March 2018. It should be noted that that the data is a reflection of the Southport site unless clearly stated otherwise, there may also, as appropriate, be reference to the Walk In Centre as both it and Paediatric ED at the Ormskirk site make up the total position for the Trust.

Pressures in the system continued throughout March and the overall 4 hour position (including Walk In Centre and Ormskirk Paediatrics) compared to February deteriorated by around1% from 80.9% - 79.2%. Ormskirk achieved 98.2% a deterioration from 98.7% in February. Southport site achieved 52.9% a deterioration from 56.6% in February and the Walk In Centre has deteriorated since January with breaches doubled compared to February and increased 8 fold since January overall a reduction by almost 2%.

Month	WIC Attendances	Breaches	Performance
Jan-18	3658	17	99.5%
Feb-18	3114	50	98.4%
Mar-18	3473	94	97.3%

For the Southport site attendances were up on the previous month and the number of ambulance handovers over 30 minutes increased by comparison to February although this is the 1st time it is being reported. Lack of beds available in a timely manner was the main cause of breaches and disappointingly the number of 12 hour breaches increased to 6 this month. Sickness increased during the Easter week but our Mersey partners reported the same issue. Admissions also increased but conversion rates remained at circa 32% for both February and March.

Despite single figures in terms of daily surgical elective admissions (most of which is now carried out at the Ormskirk site) outliers and escalated areas did not decrease with SAU permanently bedded and more often than not Ambulatory Care. At peaks during the month patients outlied into Coronary Care beds and HDU beds in order to try to relieve some of the pressure from the ED and to avoid 12 hour breaches. The Cancer Centre was also escalated into above agreed guidelines on some occasions.

SAFER commenced on a few select wards and the data appears to demonstrate an increase in discharges during certain points of the day compared to February and previous months. The focus will move from those wards to other wards so it is anticipated it should continue to improve. LoS is not the most accurate measure but has increased as has the number of patients who have been in hospital for between 7 and 20 days and 20 days plus. This is despite twice daily meetings with our partners to expedite delays. There continues to be pressures with capacity in the community, and it is recognised that without support from a dedicated discharge team ward staff struggle to release the capacity to complete the often complex and time consuming paper work for discharge to places other than the patient's home.

2 KEY PERFORMANCE ELEMENTS

4 Hour Access Performance

There continues to be a downward trend in performance with March dropping just below 80%. The additional unit being built for A&E arrived and is due for completion mid-April which will give additional capacity in the department.

The tables below are a summary of the overall performance between April 2017 and March 2018 combing all sites figures. Easter fell at the end of March and the Trust in line with the Mersey region experienced a spike in sickness amongst staff which in addition to annual leave and bank holidays meant that staffing levels were low across all disciplines in all clinical areas.

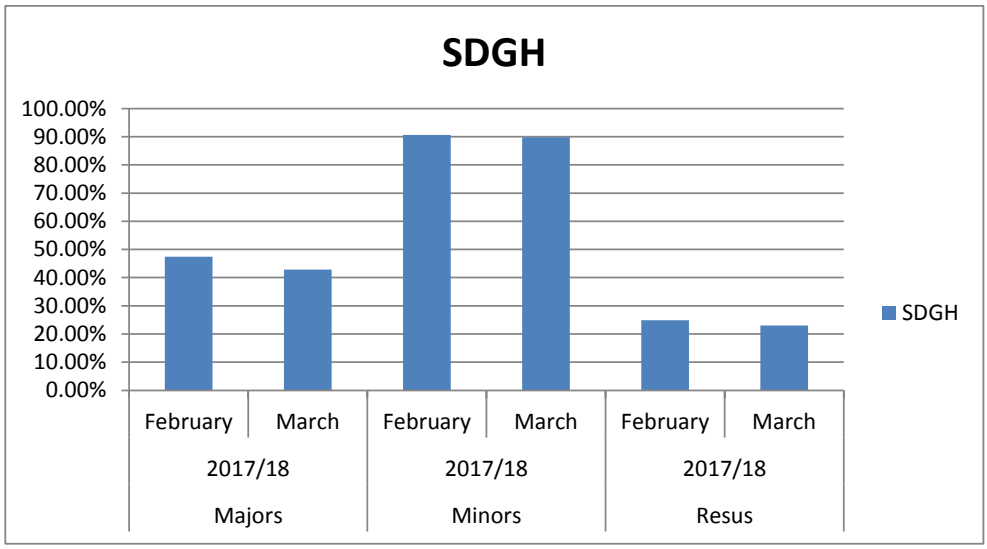
Table 1a Performance April 2017/March 2018

April	May	June	July	August	September	October	November	December	January	February	March
91.20%	89.40%	90.30%	88.30%	88.40%	85.70%	85.50%	80.70%	80.30%	80.90%	80.90%	79.00%

Crude Attendances for all 3 contributors to the Access Target and the figures are below indicating an increase in attendances in all of the service sites.

Row Labels	ODGH	SDGH	WLHP
2017/18			
February	2118	3844	3167
March	2599	4311	3542
Grand Total	4717	8155	6709

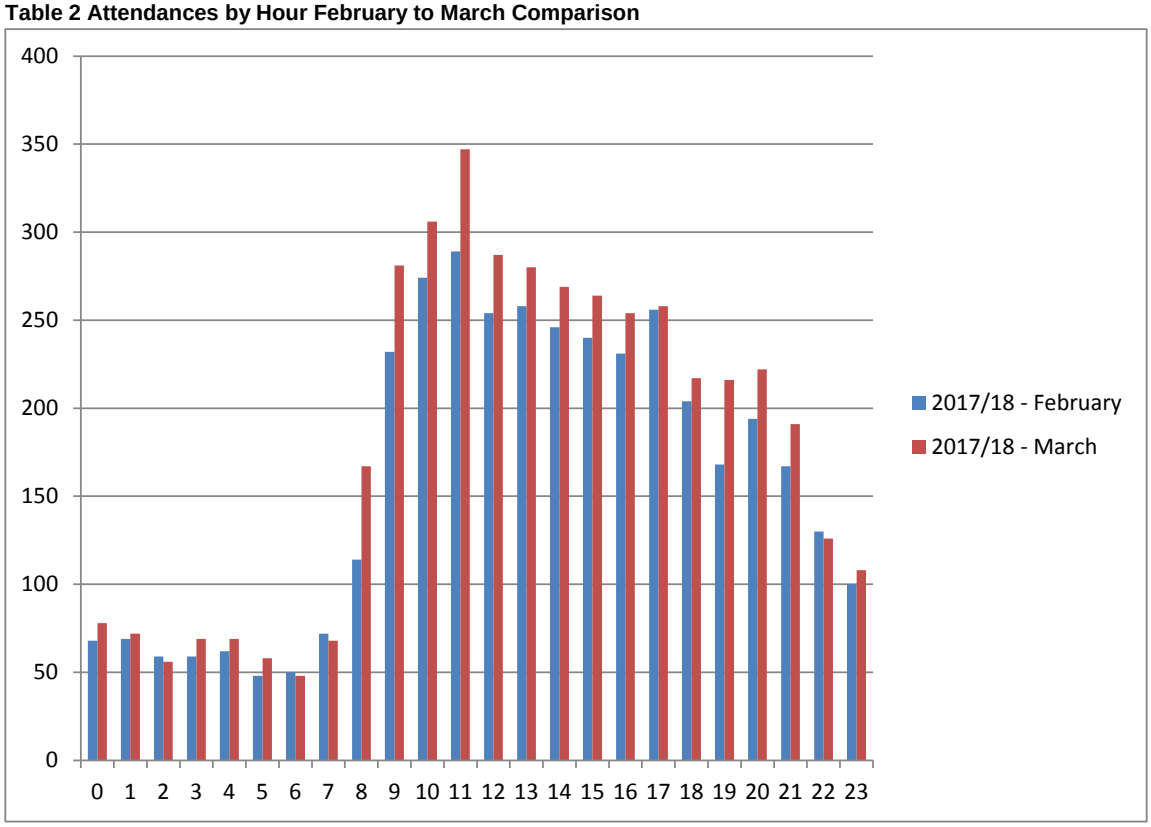
Table 1b Performance February – March Southport Site



Attendances by Hour of Day

March saw a significant peak in attendances per hour compared to February, throughout most of the 24 hour period. Easter fell in March and is a traditionally busy period with many community support services, including GP services, reduced due to annual leave. It was an extremely difficult month for the ED teams as a number of their Trust Grade medical teams had completed their contracts and were moving on leaving the department with a depleted medical resource which was difficult to support.

Table 2 Attendances by Hour February to March Comparison

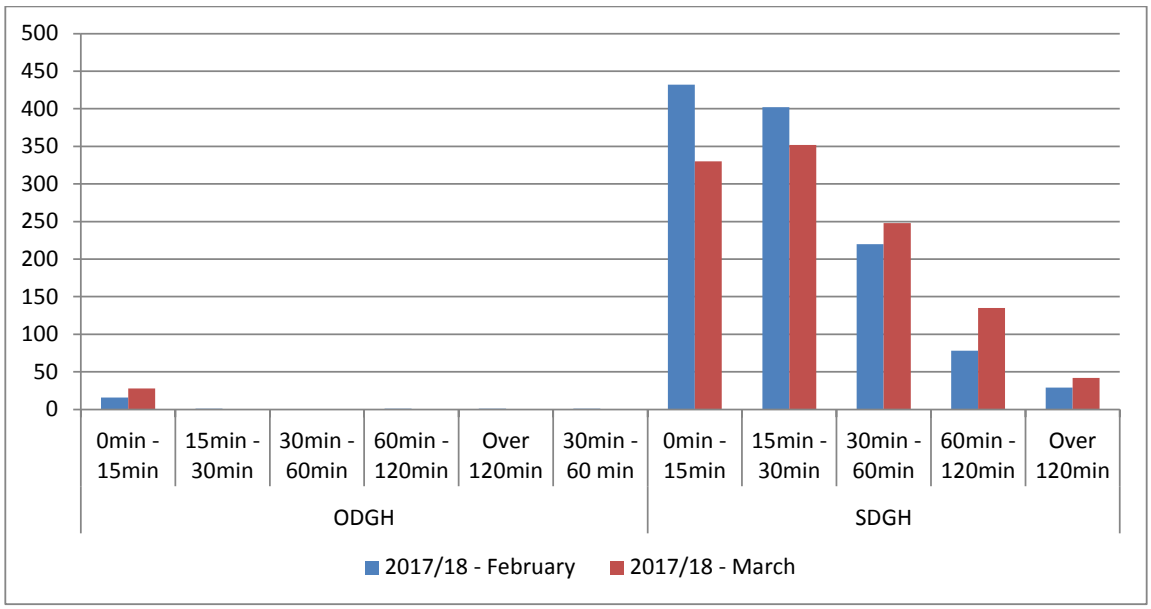


Ambulance Handovers

Not previously included, this March report contains details on Ambulance Handover times. The data below shows the performance compared to February. The number of patients waiting 0-30 minutes has improved compared to the previous month but deteriorated in the 30 minutes to 2 hours and over period. This is often a reflection of the over-crowded department and the inability to take handover due to all the corridors having patients on them either on trolleys or on beds.

There is to be in internal RIE (Rapid Improvement Event) within the department during the month of April which will focus on improving the bottlenecks within its control and part of that will include the ambulance handover processes with our NWAS partners.

Table 3 Ambulance Handover Times



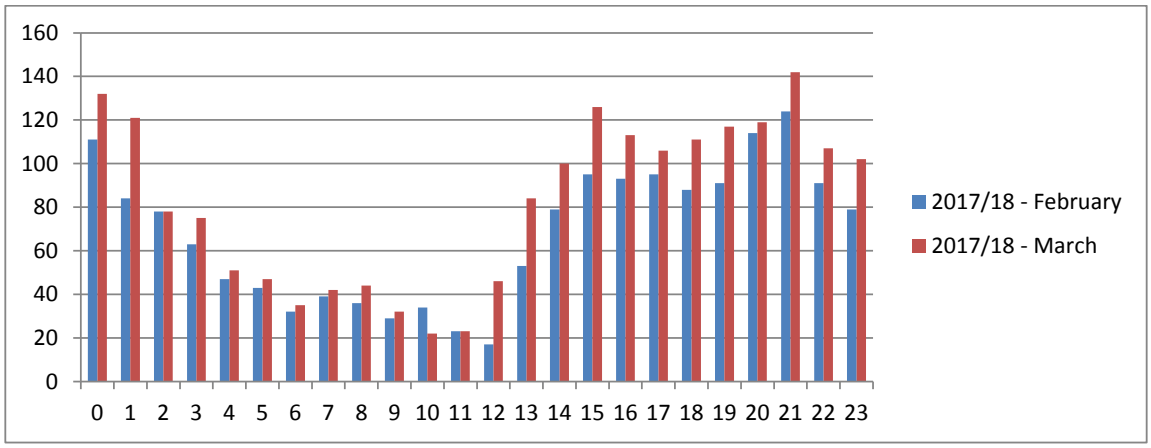
Breaches February – March Comparison

The majority of the breach reasons remain due to the lack of beds available in a timely manner, which also impacts on the ability to assess patients in the department as it remains over crowded.

The performance for Minors plateaued at just below 90%. Work has begun focusing on the reason for these breaches and in trying to ensure minimum achievement of 95%. Many of the breaches fall out of hours when the department is full, and the medical teams are prioritising sick patients and creating flow. Minors will often have Majors patients' waiting in that dedicated area to be treated.

Plans are being drawn up as part of the patient flow work programme to avoid unnecessary breaches particularly those which breach just over 4 hours and the non-admitted breaches. A mini Rapid Improvement Event is planned for mid-April to focus on the actions that are within control of the department to identify areas for improvement.

Table 4 Breach Comparison February to March

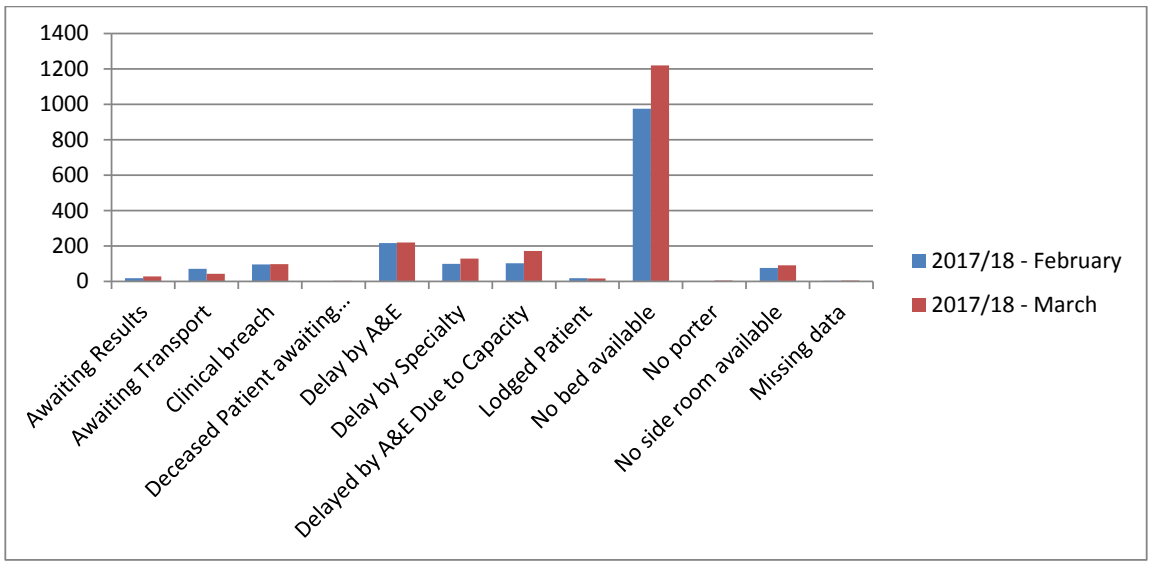


Breach Reasons

As to be expected given the deterioration in performance, the number of breaches also rose in March by comparison to February. The Department remains overcrowded and there were significant challenges this month with filling the rota in ED with both middle grades and juniors as many of our doctors left. Although consultants' stepped down and agency and bank were maximised where possible there were still gaps which compounded the ability to see patient in a timely manner.

Despite also maximising Ormskirk and all escalation areas being opened throughout the month including the assessment areas, creating flow continued to be challenging.

Table 5 Reason for breaches

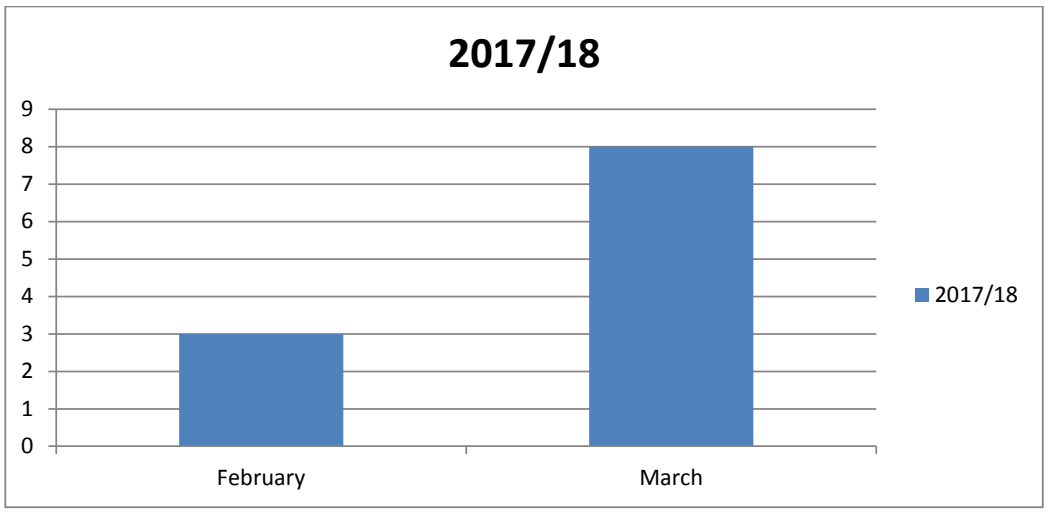


12 hour breaches February - March

The number of 12 hour breaches crept up over March by comparison to Februray, the vast majority of them happened over the weekends. During the weekends the 1st and often 2nd on call are onsite supporting the bed managers managing flow. Despite having this additional support and a medical discharge team on site part of the day for both days, plus the Integrated Dischage Teams supporting the expedition of "complex" delays, weekend discharges are considerbally less than required to manage admissions.

At the time of the breaches the Trust was esclated to full capacity and followed that protocol which includes boarding patients where safe to do so. Ambulatory areas for elective and non elective remained beded down for most of the entire month. Note the table shows eight breaches as two were mental health breaches.

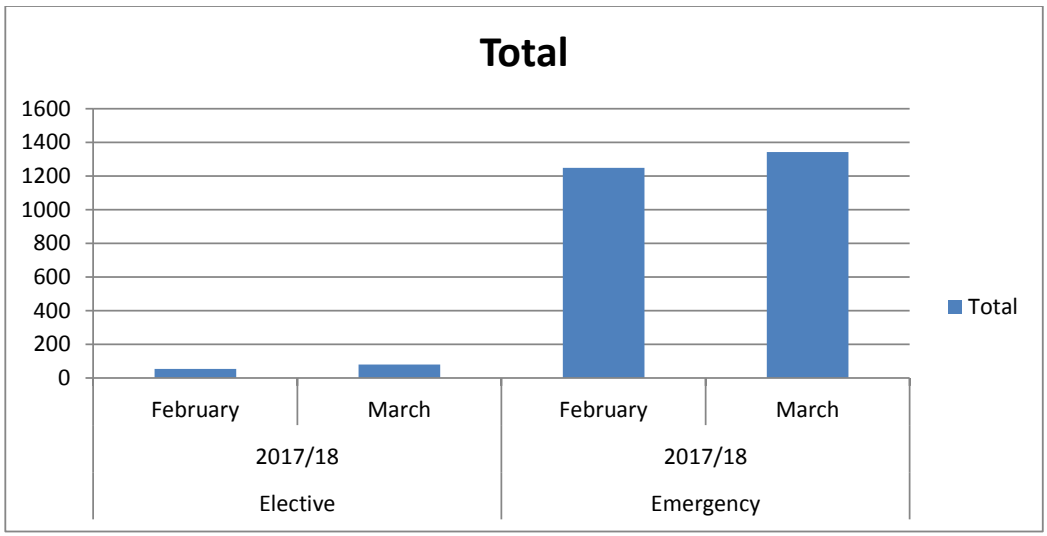
Table 6 12 hour breaches February - March



Admissions

Whilst February saw a slight decrease in emergency admissions by just over 200, March by contrast saw an increase by nearly 100 patients in comparison. This correlates with the attendance increase. The number of elective patients improved as concerted efforts were made not to cancel elective care and to maximise elective activity through the Ormskirk site.

Table 7 Admission Trends

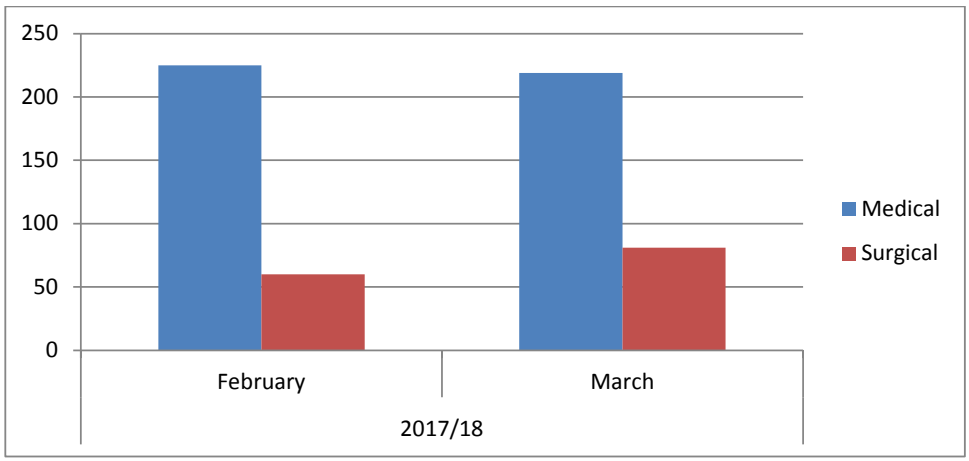


Outliers

Outliers continue to be relied upon in order to manage flow resulting in patients not in the right specialty beds. There is now a significant programme of work being led by the mortality group to better manage outliers. Progress is reported into Quality and Safety Committee.

Escalated areas continue to be significant at times up to 10% of the total bed base and averaging daily around 7%; a reflection of the continuous pressure the Trust is under.

Table 8 Outliers Medical and Surgical Specialties

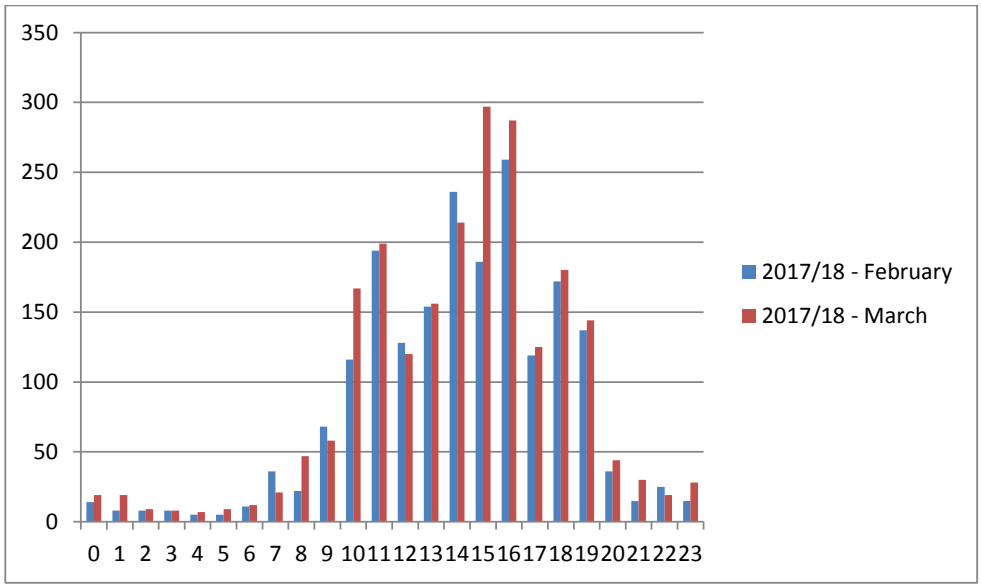


Hourly Discharges

Daily discharges, as per previous months' continue to trend late afternoon and early evening, too late for the admissions and part of the cause for the overcrowded ED, which in turn impacts on breaches. Although the time of day of discharges follows the same trends, there were significant improvements in the number of patients discharged from early afternoon onwards which may be the result of additional support to implement the role of SAFER as planned.

There was no substantial discharge lounge in place in March but there are plans in place to open the Salas area as permanent place and estates work is to complete before the end of May. A temporary discharge lounge area was identified (Theatre 5) and was available most of the time but subject to staffing and no surgical operations. As previously noted data recording is not contemporaneous and relies heavily on the ward clerks who are a limited resource. The longer term solution of an electronic flow system within our current Medway system continues to be reviewed.

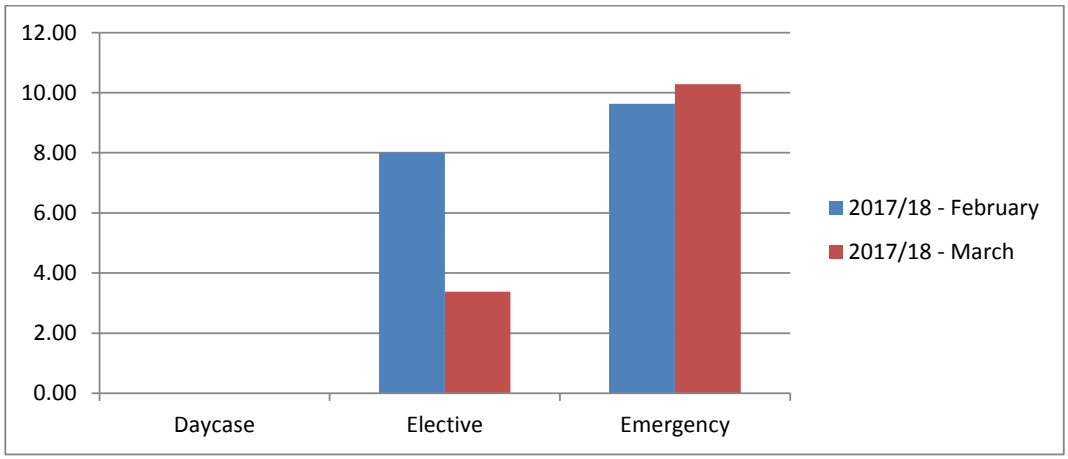
Table 9 Hourly Discharges



Length of stay

The data continues to show an increase length of stay although not the most robust of measures due to the potential of one or two patients' excessive length of stay potential distorting the figures. (as was the case for the apparent hike to 8 days in February -an elective cardiology patient's excess length of stay).

Table 8 Length of Stay Elective & Emergency

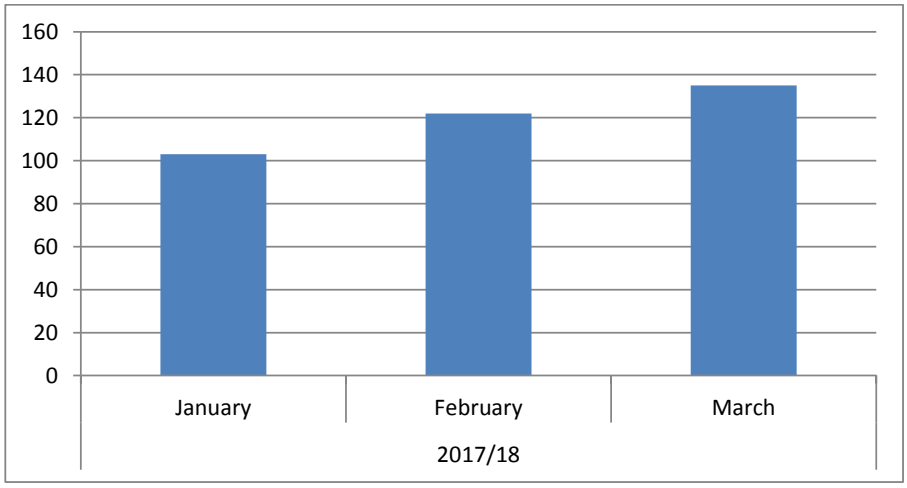


Super Stranded Patient Southport Site 21 days plus

There was a slight increase in numbers of patients' who are reportable as super stranded compared to February all be it that February was a shorter month. January is included as a comparison and it demonstrates that number of patients continues to rise despite the twice daily meetings introduced in February to better manage all delays.

The Trust continues to work with our CCGs and Local Authorities to improve the delays and funding for 6 months was agreed to support recruiting to a permanent integrated discharge team, however, it would not be possible to recruit to 6 month posts so negotiations continue to agree a more sustainable solution. Meanwhile there continues to be twice daily meetings with the Trust and its partners agreeing every delay and actions and responsibilities to ensure that there is improved management of system delays.

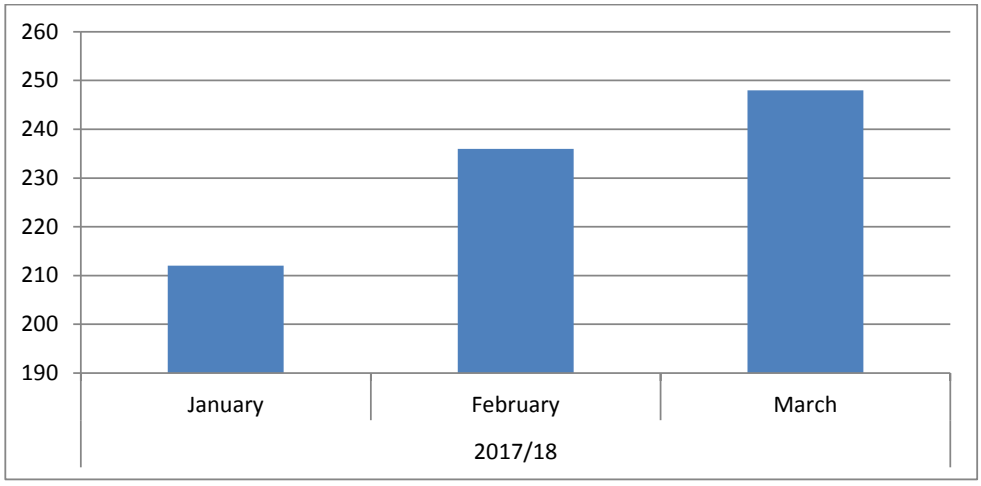
Table 9a Super Stranded Patients



Stranded Patients 7 - 20 days

The Stranded Patient figures are a component of the super stranded patients so the same patients may be counted in both figures. Like the super stranded the number of delays continues to increase despite best efforts to manage them on a daily basis. There continues to be issues with our re-ablement capacity in the Sefton area and overall getting Health Assessments completed by our partners. Our work on SAFER has demonstrated an improvement in discharges, however despite these changes there has not been a significant impact on delays.

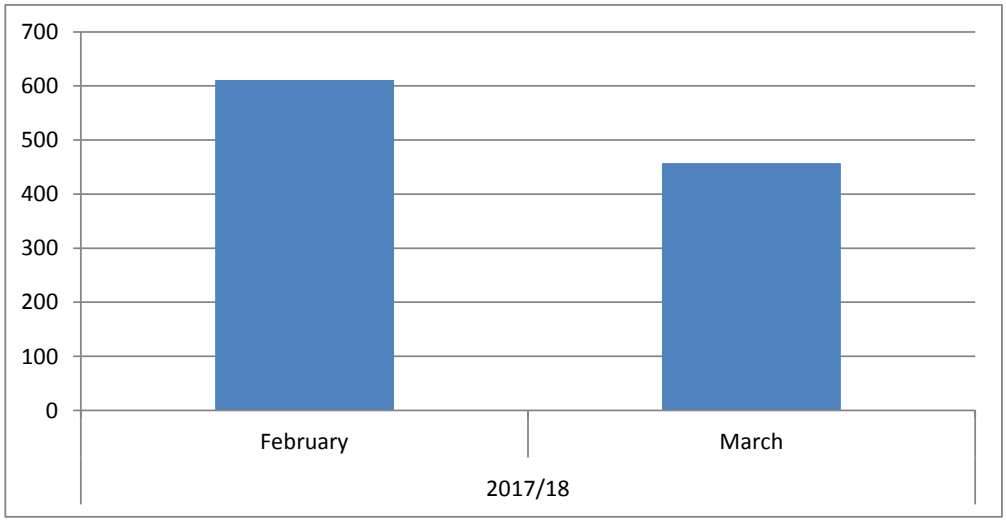
Table 9b Stranded Patients



Medically Optimised for Discharge (MOfD) Patients

MOfD increased in February despite dropping in January but using the measure of bed days post MOfD the number has dropped in March. The Trust is working on a more sustainable process of ensuring that there is single version of the numbers.

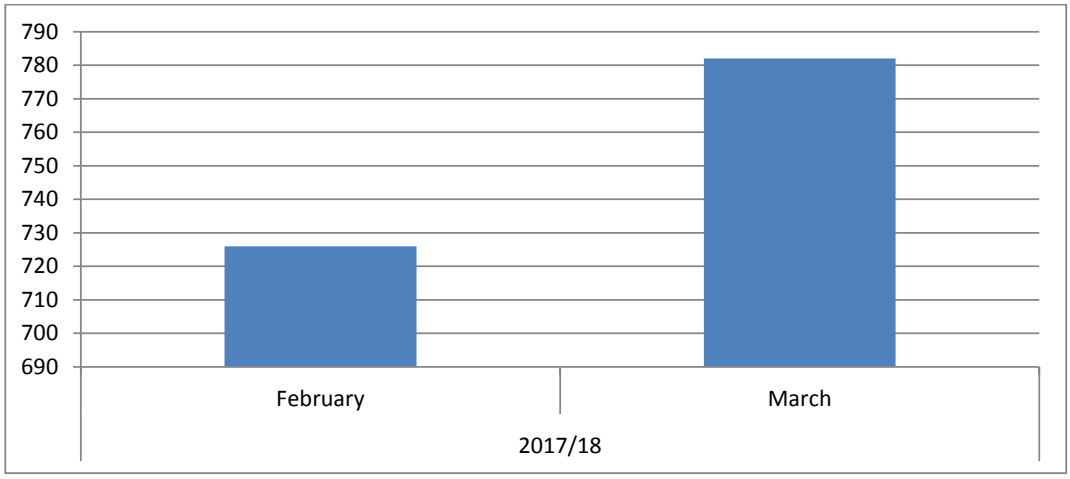
Table 10 February – March Comparison



Delayed Transfers of Care (DToCs)

The DToC figures in the graph below are not yet confirmed with our commissioners. Agreed figures would not be available for reporting until May. So based on these preliminary figures DToC's continue to demonstrate an increasing trend. The actions noted above will support better control and monitoring and ensure a more accurate reflection of the number of patients delayed waiting care

Table 11 DToC February – March



3 IMPROVEMENT ACTIONS

The Patient Flow Improvement Board continues to meet and focus on the actions required for improvement in performance and there is effective clinical engagement and leadership supported by the senior management team.

On 17 April the Trust submitted an A&E performance trajectory for the year 1018/19 as below:

The incoming CEO has asked the COO to refocus the work to ensure no patients are waiting on the corridor. A timescale of three months has been set to achieve this. The team are currently working with EY partners to 'reset' the programme; while many of the actions are in train to deliver on this outcome there will need to be a reprioritisation of the work programme. It is essential that additional medical bed escalation capacity is secured to provide the headroom to concurrently move patients off the corridor and to ring fence assessment areas. A number of options are currently being investigated to deliver this. The programme below describes the work, this will be finalised and dates confirmed by 20 April ready for a launch in to the organisation the following week.

Southport and Ormskirk Hospital NHS
NHS Trust

Reprioritised - Patient Flow Improvement Programme & mobilisation (dates to be confirmed)

Draft for Discussion – dates to be confirmed

High Impact Changes	Workstream	EY support	WK1	WK2	WK3	WK4	WK5	WK6
Open Medical bedded Capacity	Operational	✓ .	Agree clinical criteria	Model number of beds required	Staffing	Operational procedures	Mobilise system partners	Proposed 'Super Week' to reset use of existing and enhanced bed capacity to improve patient flow and reduce 12 hour breaches and corridor waits (Date to be confirmed – End of May / Beginning of June)
Discharge and transfer lounge	Operational		Confirm location (interim and SALUS)	Clinical criteria & ops protocol	Go live		Prepare for SALUS centre use	
Site management	Flow	✓ .		MADE	Intensive site management support			
Ring fenced assessment capacity – EAU, ACU, SAU, Obs	Assessment	✓ .	Agree clinical criteria for each unit	Staffing model	Operational procedures			
Mobilise CDU	Assessment	✓ .	Agree clinical criteria for each unit	Staffing model	Operational procedures			
Senior RAT-ting/triage	ED		Identify role of each	Understand impact of senior RAT-ting	Go live	Embed an escalation RAT model in Triage	Mobilise revised RAT model	
Specialty IPS response	ED	✓ .	Agree response times	Go live	Audit	Sustain		
ED coordination	ED	✓ .	Finalise Training package	Initiate training package (1:1 learning, See observe; do learn)				
ED medical workforce	ED	✓ .	Model workforce requirements	Understand shortfall and limitations – actual vs budget	Present recommendation			
Escalation policy and procedures	Flow	✓ .	Review current escalation policies	Redraft	Present back for ratification	Education with team	Go live	
Bed Right Sizing	Overall		Agree Scope & Finalise deliverables	Perform analytics		Outputs validation	Confirm changes / Prepare plan to adjust bed base	
Phase 3 – New build	ED		Build work commence					

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Board of Directors
2nd May 2018

Agenda Item	**TB120/18**	**Report Title**	**Integrated Performance Report**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Michael Lightfoot, Head of Information		
Action Required *(Definitions below)*	☐ To Approve ☒ To Assure ☐ For Information	☐ To Note ☐ To Receive	

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 2018/19)*

- ☐ **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…..)*

- ☐ Annual Business Plan Priority
- ☐ Best Practice
- ☐ Linked to a Key Risk on BAF / Risk Register Ref No.: _____
- ☐ Other List (Rationale) _____
- ☐ Service Change
- ☒ Statutory requirement

Impact *(is there an impact arising from the report on the following?)*	
☐ Compliance ☐ Equality ☐ Finance ☐ Legal	☐ Quality ☐ Risk ☐ Workforce
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Policy ☐ Service Change ☐ Strategy
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Charitable Funds ☐ Finance Performance & Investment Committee	☐ Quality & Safety Committee ☐ Remuneration & Nominations Committee ☐ Workforce Committee

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

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

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

Information: Literally, to inform the Board

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

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

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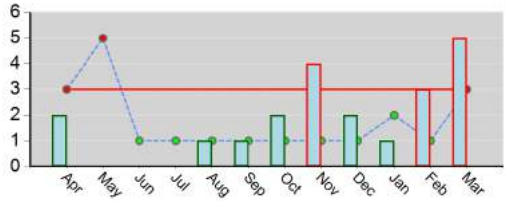
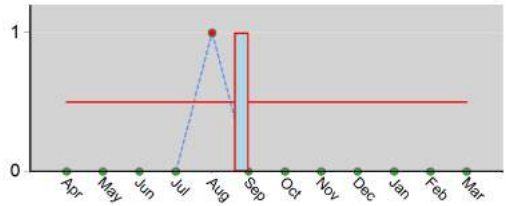
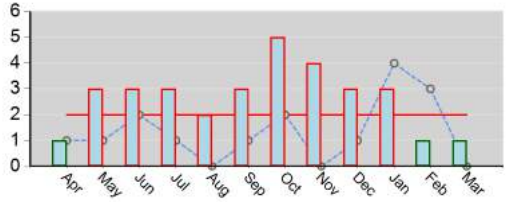
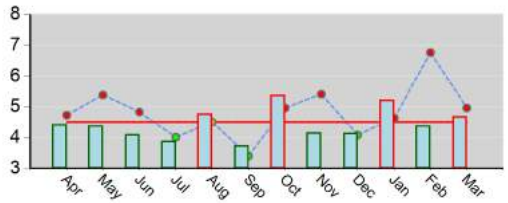
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
C-Diff	Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 36 for the year. Good performance is fewer than 36 for the year. Line = Last Financial Year Bar = This Financial Year	5 cases of C diff in the Trust in March. RCAs have been completed on 2 of the March cases and no lapses in care have been identified; RCAs are pending on the remaining 3. The Trust Target is to have no more than 3 cases per month, or 36 per year. In 2017/18 the Trust had a total of 21 cases which is 15 below trajectory. In the beginning part of the year we had so few cases there wasn't sufficient to go through the appeals process, however 6 now have been appealed and of these 5 were upheld and found no lapses in care. Following the RCAs held on 13/4/18 we now have a further 6 cases eligible for appeal. The target for 2018/19 as set by NHSI is to have more than 35 cases.	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 MRSA bacteraemia in March; the last case was in August 2017.	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	There was 1 hospital acquired E coli bacteraemia identified in the Trust in March out of a total of 25 cases (24 community acquired cases). This patient has been reviewed by the Consultant Microbiologist and the patient's Consultant. The likely source of the infection was metastatic cancer; no lapses in care have been identified.	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	A total of 66 falls were reported through DATIX in March'18. 60 (91%) Urgent Care, 6 (9%) Planned Care. 42(64%) of falls were reported as no harm, 24 (36%%) were reported as low harm. There were no reported falls at Level 3 or above. The revised falls risk assessment tool is now embedded into a risk assessment booklet. This will be commenced in A+E as part of the new nursing documentation which is due to 'go live' on 30th April'18. The Trust Falls Group membership has been reviewed and the terms of reference revised. The Lancashire care Community Falls Team have now engaged with group going forward to support collaborative working.	Quality & Safety Committee	

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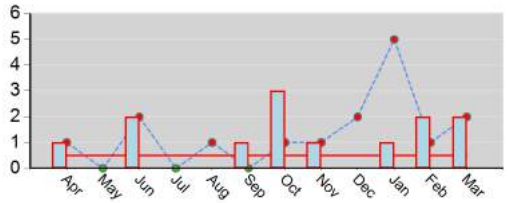
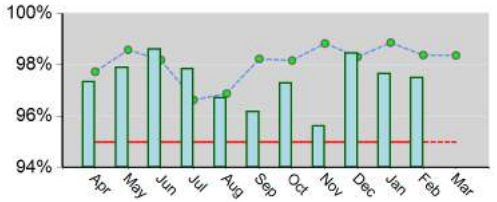
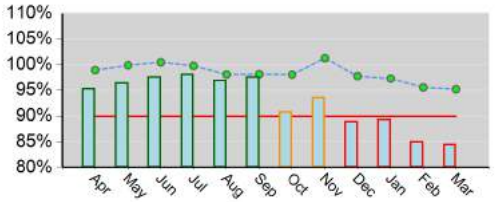
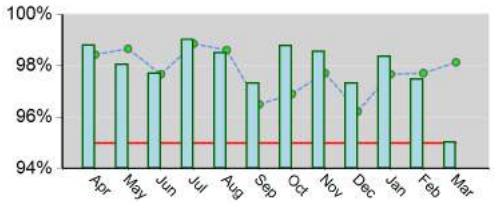
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Hospital Pressure Sores	Number of reported Trust acquired pressure sores graded between 3 and 4. Threshold: 0. Collaborative goal: Elimination of grade 3 and 4 pressure ulcers plus 25% reduction overall. Line = Last Financial Year Bar = This Financial Year	There were 2 Grade 3 Pressure ulcers in March, both on SSU. Both of these pressure sores are awaiting review/investigation.	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	Currently awaiting the March data release.	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 is undergoing a deep dive to provide assurance against the utilisation and reporting from Trust systems. 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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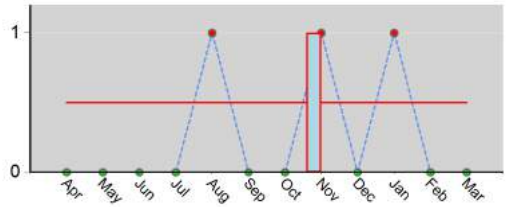
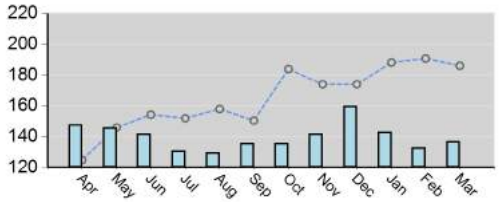
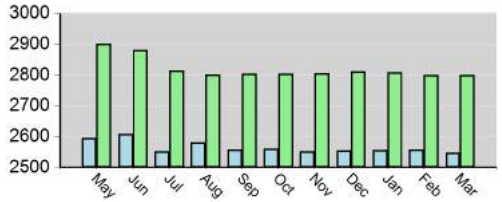
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death. Line = Last Financial Year Bar = This Financial Year	There were no Never Events reported for March.	Quality & Safety Committee	
Nursing vacancies	Number of nursing vacancies in month. Line = Last Financial Year Bar = This Financial Year	There were 137 Nursing Vacancies in March, 4 higher than the 133 reported in February. The 137 vacancies in March 2018 is considerably lower than the vacancies of 186 reported in March 2017.	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 level of vacancies remains consistent with previous months.	Finance, Performance & Investment Committee	

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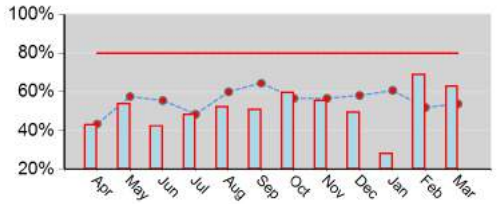
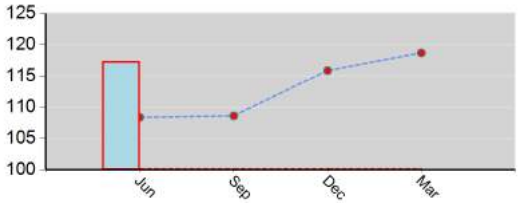
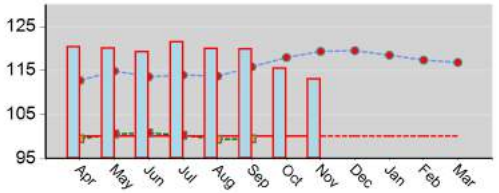
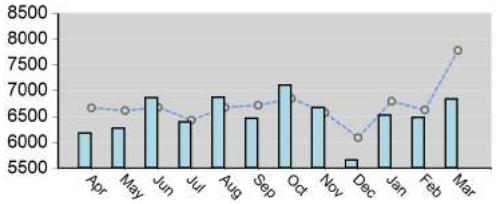
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Stroke 90% ward stay	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Previously reported performance may change as a result of validation. Line = Last Financial Year Bar = This Financial Year	Bed pressures across the Southport site and wider non-elective pressures impact our ability to achieve this standard. System-wide work Commissioners and wider urgent care work with Ernst & Young should deliver improvements in all areas.	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 117.4, remains high and outside expected limits, but has reduced from the previous quarter level of 118.7. This is following the implementation of a comprehensive action plan, managed and monitored by the Mortality Operational Group (MOG) which reports to the Trust Board through Quality & Safety Committee. Work of the Reducing Avoidable Mortality Project is progressing and looking at Primary & Secondary drivers. An external review is due to start at end of May 2018.	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 113.2, 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 Group (MOG) which reports to the Trust Board through Quality & Safety Committee. Work of the Reducing Avoidable Mortality Project is progressing and looking at Primary & Secondary drivers. An external review is due to start at end of May 2018.	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 Trust has seen an increase in referrals in March'18 of 358 taking us up to 6859. This is considerable lower than March 2017 (7785).	Finance, Performance & Investment Committee	

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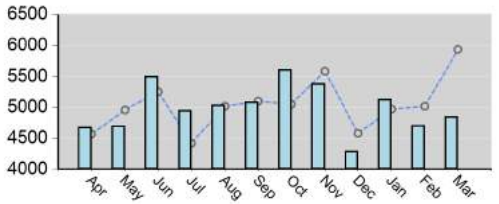
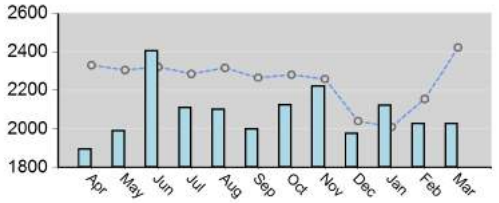
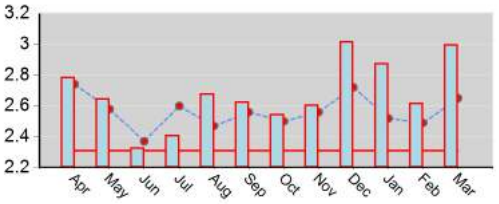
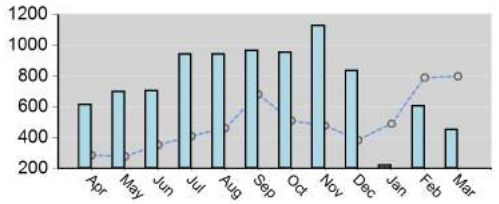
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
First Appointments	The number of patients seen in a first appointment including where the patient is seen in an outpatient clinic and has a procedure undertaken. Line = Last Financial Year Bar = This Financial Year	The Trust has seen an increase of 144 First Appointments in March'18 from February '18 with 4856 patients seen. This is around 1000 lower than March 2017.	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	The Trust has maintained its position from Feb'18 with March'18 also recorded at 2033 patients treated. This is considerably lower than March 2017 (2423).	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	The overall length of stay for March saw the highest reported figure to date. With an ageing population, the reliance on community partners to support onward transfers from hospital with funding applications, best interest meetings, placements, packages of care, and equipment remains high. Despite the ongoing work of the Acute in relation to discharge lanes and board rounds, increase seen in stranded and LOS. Additional planned system wide response is planned as above.	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	The number of bed days post MOFD remains significant. Daily ward/ board rounds are key to ensuring that any avoidable delays are addressed or escalated, with timely actions from partners to support next steps. twice weekly MOFD and LOS meetings are being held with community partners and social services. Trust developing SAFER but delays due to staffing. review has been undertaken and relaunched in April. System leaders MADE review is planned for April. business case for IDPT ongoing. current acute DPT remain in seconded posts to support delivery of SAFER and the continued support of board rounds.	Finance, Performance & Investment Committee	

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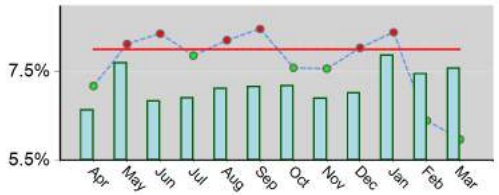
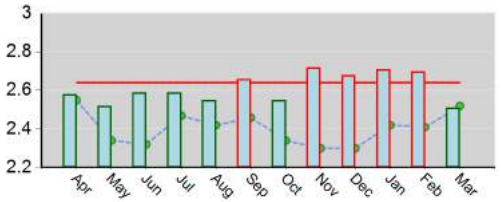
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better. Line = Last Financial Year Bar = This Financial Year	The DNA Rate for the Trust is 7.6% which is below target.	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	The New:Fu Rate for the Trust is 2.51 which is now achieving following 4 months breaching the 2.6 target.	Finance, Performance & Investment Committee	

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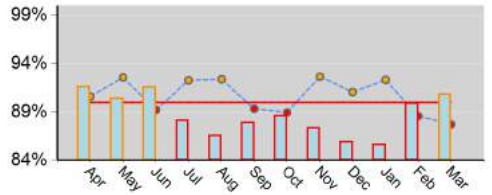
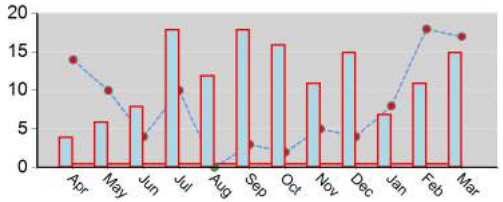
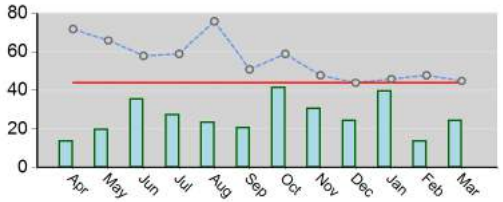
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Friends and Family Test	Friends and Family Test. The proportion of patients that would recommend the Trust to their friends and family. Threshold: 94%, Fail: 90%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	The percentage of patients that would recommend the Trust to Friends & Family rose to its highest monthly position since June 2017 with 90.9% recommending the Trust. This is against a Trust response rate of 5.6% which is 2% higher than February. For February CBU recommending percentages are Specialist 91.7%, Planned care 92% and Urgent Care 89.6%.	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 March there were 15 Mixed Sex Accommodation breaches, all on critical care. The majority of breaches on Critical Care are due to awaiting transfer to acute beds within the hospital. Actions to address poor flow are both system-wide and internal.	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 18 for the month of March, this is 11 more 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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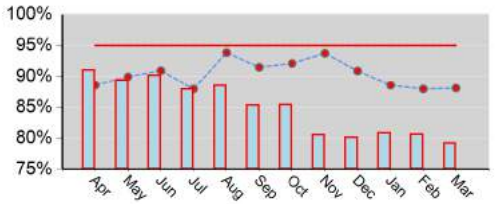
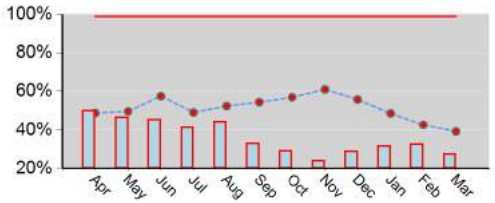
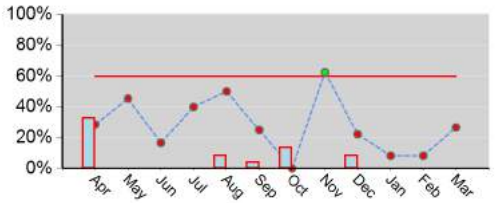
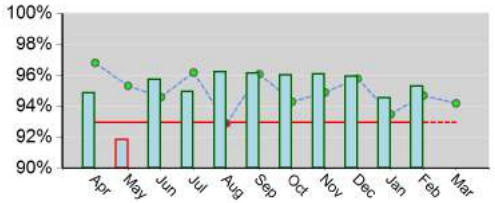
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher. Line = Last Financial Year, Bar = This Financial Year	Performance against the 4-hour target remains a challenge (79.33% in March), particularly given the inpatient pressures and high occupancy of beds at Southport. Attendances at Southport saw an overall increase of 3.6% in attendances; of particular concern majors category saw an increase of 7.3% (238 patients). EY remain on site supporting improvement work around urgent care flow. The new modular build is due to go live w/c 23 April with an 8-trolley assessment area. Further capital monies have been allocated to support further re-design of the 'front door' with extended triage and ambulance assessment capacity (expected completion date of August 18) and a fully functioning discharge lounge will improve 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 pressing concern with some significant delays in timely release of ambulance crews. The current ED estate is insufficient to meet the demands of the current case mix, given the month on month increase in majors category patients and the frailty of the local population. The new modular build, extended triage and ambulance cubicle capacity and discharge lounge will all support some improvements in flow across ED.	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 March relating to 6 patients.	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	Compliance was 95.3% in February. Further work engaging with GPs is underway to ensure patients are aware of why they are being referred into the Trust and emphasising the importance of attending appointments.	Finance, Performance & Investment Committee	

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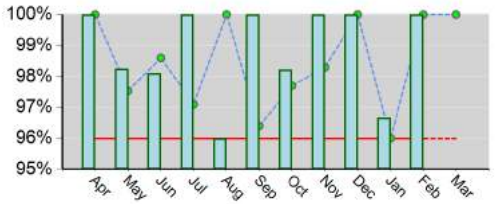
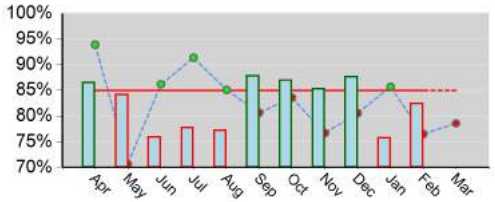
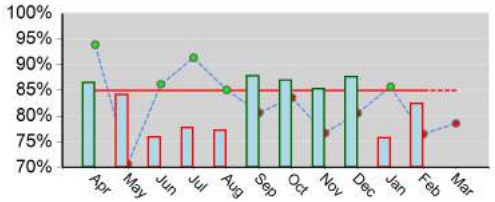
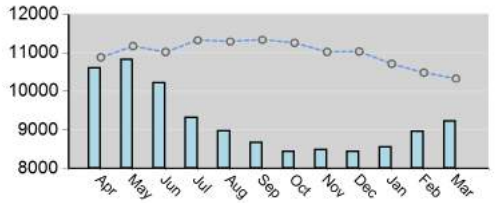
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
31 day treatment	Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Target 96%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Compliance was 100% In February.	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	Compliance was 82.6% in February. There were 10 patients who breached - 2 full and 8 half. The 2 full were an urology and an upper GI patient. The patients treated passed breach date at tertiary centres who incurred half a breach were one head & neck, two lung, two colorectal and 3 urology.	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	Breaches can be attributed to a number of reasons. 3 were due to patient choice, 2 to robotic capacity at the Royal Liverpool for prostate surgery, 2 were complex and required additional tests, 1 patient was unfit, 1 was due to clinic capacity and 1 was due to a radiology delay.	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 increased again in March'18 by 281 patients taking us up to 9258.	Finance, Performance & Investment Committee	

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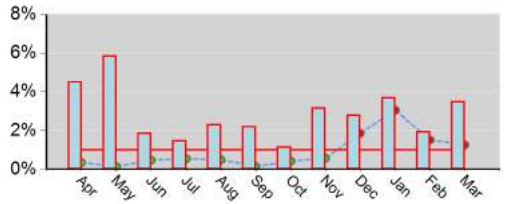
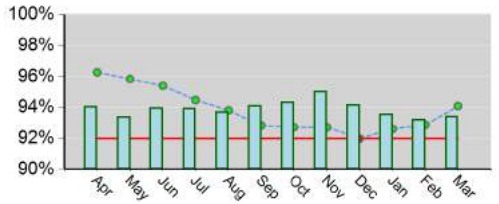
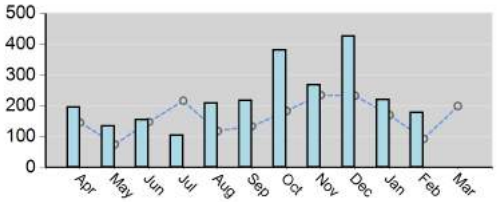
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower. Line = Last Financial Year Bar = This Financial Year	We saw an increase in Diagnostic Breaches in March across the following areas; - Planned care specialties due to a lack of capacity as no additional sessions were agreed due to issues surrounding the reduced WLI/Backfill rate. All breached patients were escalated to the ADO & Deputy CCO and as clarity around the payments has now been received additional activity for April has been set up. – Echo service, capacity and demand and a new template in place that will improve capacity for both inpatient and outpatient activity. Anticipated that the benefits will be seen June. - Radiology, i.e. CT, MRI, increases in breaches this month due to reduction in additional activity undertaken by consultant radiologists. Additional capacity has been arranged with fourways to outsource appropriate scans to be reported.	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 March'18 which was recorded at 93.4%. We have been compliant for the past 14mths. Patients are still being booked in chronological order. This overall Trust figure does not reflect the challenges faced in some sub-speciality areas i.e. Rheum 83.2% and Gen Surg 84%.	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 February there were 181 delayed bed days due to delayed transfers of care. 94 bed days were due to patient/family choice, 9 days due to awaiting assessment, 25 due to awaiting a place within a Nursing Home, 10 days due to public funding, 35 due to awaiting further non-acute NHS care and 8 due to awaiting community equipment/adaptations.	Quality & Safety Committee	

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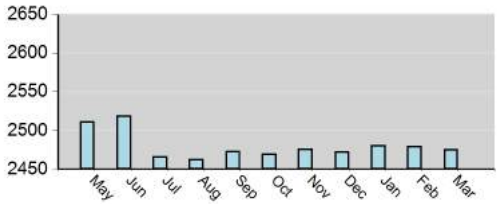
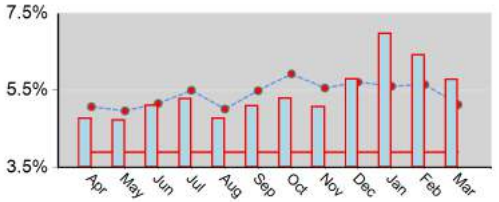
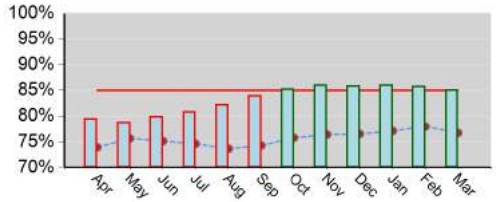
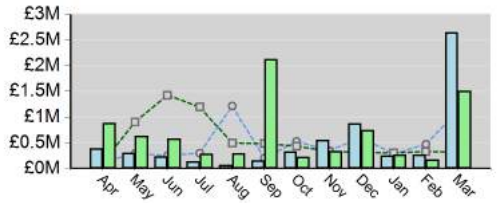
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
WTE (Whole time equivalents) in post	The number of WTE staff with substantive and fixed-term contracts employed directly by the Trust. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due 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 2476.	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 absence level has decreased again in month. 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 will be taking placed on 30/04/18.	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	In March, the overall % compliance for mandatory training fell by 0.72% but remained above the Trust's mandatory training target of 85% with compliance at 85.2%. Over the last 3 months extensive work has been undertaken to map all resuscitation competences on OLM, this has impacted on basis resuscitation (non-renewal and annual) with the inclusion of a further 600 people to the annual renewal competence. In the short term this has impacted on overall compliance but we are confident this will rise progressively with the introduction of an eLearning element to the training approach.	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	The Trust has achieved its statutory Capital Resource Limit (CRL) with a spend after adjustments for donations and disposals of £6,041k against a target of £6,048k. This represents a small underspend of £7k. Of note in month the Trust successfully bid and received additional monies for A&E redesign (£850k), paediatric A&E safe room (£37k) and cyber security (£152k).	Finance, Performance & Investment Committee	

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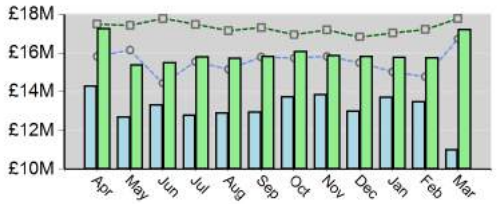
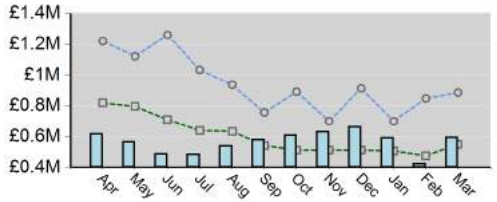
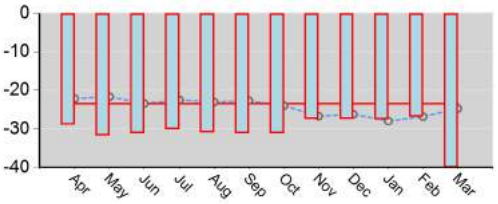
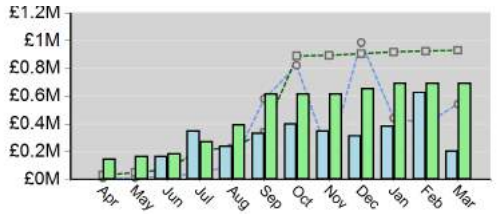
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Income & Expenditure	This indicator looks at the relationship between Trust income and Trust expenditure at monthly intervals. Green = Expenditure, Blue = Income Line = Last Financial Year, Bar = This Financial Year	A year end deficit of £33.6m was achieved. This includes a total of £4.5M estimated for the impact of Expert Determination on contract disputes and sanctions for contract performance. The net deficit was £29.1M which achieves the FRP agreed with NHS Improvement. A number of pressures were absorbed within the achievement of the year end position.	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	The NHS Improvement target of £7.2m was achieved. Agency spend will need to reduce further to comply with the 2018/19 reduced agency cap.	Finance, Performance & Investment Committee	
Liquidity	Liquidity (days) Liquidity indicates whether the provider can meet its operational cash obligations.	Significant decline in liquidity metric due to the re-classification of a DH loan to a current liability as it is repayable within 12 months. However, the Trust is able to access cash support from DH each month by submitting rolling 13 week forecasts so there is no risk to the Trust being able to meet its liabilities.	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	£3.4m was delivered against the £5.6m target.	Finance, Performance & Investment Committee	

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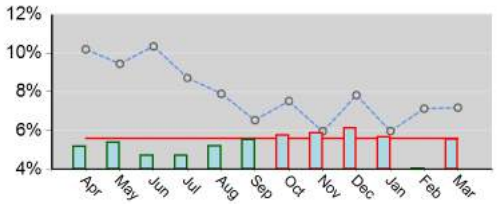
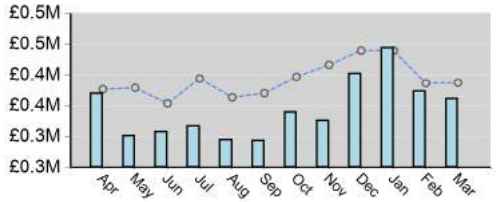
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system. Line = Last Financial Year Bar = This Financial Year	The proportion of the workforce spend made up of Agency workers increased to 5.6% in March 18. 2.9% was accounted for Doctors,1.3% Nurses, 1.18% Admin staff, 0.11% AHP's and 0.12% 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 Staff Sickness dropped slightly in March from £375,000 to £363,000.	Finance, Performance & Investment Committee	

NHS
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NHS Trust

Board of Directors
2nd May 2018

Agenda Item	**TB122/18**	**Report Title**	**Director of Finance Report Month 12**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☑To Note ☑To Receive

Key Messages and Recommendations

Key Messages:

- Deficit at the end of the year is £33.6m; £15.5m worse than plan
- The final position includes provision for sanctions (the full value of which was not applied by Southport & Formby CCG0 and the outcome of the Expert Determination.
- Before taking account of these provisions the Trust deficit would have been £29.2m as per forecast.
- CIP achieved 60.7% of plan; shortfall was £2.2m against a plan of £5.6m
- Agency spend was £6.8m, £400,000 lower than the agency control total set by NHSI.
- Cash balance was £1.079m and this represents an under-spend against the External Financing Limit (EFL) of £75k; Trusts are not permitted to over-spend against its EFL
- The Capital Resource Limit (CRL) of £6.048m was under spent by £7,000.

Recommendations:

The Board is asked to **receive** the financial outturn position for 2017/18 (subject to External Audit) is a deficit of £33.6m.

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

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…..)*

☐ Annual Business Plan Priority
☐ Best Practice

☐ Linked to a Key Risk on BAF / Risk Register Ref No.: _____ ☐ Other List (Rationale) _____ ☐ Service Change ✓ Statutory requirement
Impact *(is there an impact arising from the report on the following?)*

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

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

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

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

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

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

Information: Literally, to inform the Board

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

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

1. Introduction

1.1. This report provides the Board with the financial position of the Trust for the financial period ending 31st March 2018.

1.2. The report asks the Board to discuss the contents, note the financial performance at month 12 and how the Trust has performed against the Financial Recovery Plan (FRP).

1.3. The Trust has planned for a deficit of £18.1m (the control total of £15.1m was not accepted). A revised deficit forecast of £31.7m was agreed at the December Trust Board but subsequently reduced to a deficit of £29.2m following a number of issues that would collectively generate an improvement.

1.4. In month 12 the Trust has made a provision of £4.5m for the expected income reduction following the Expert Determination process and the imposition of sanctions; the technical adjustment in respect of the managed service contract has also been applied this month.

1.5. The outcome of the Expert Determination process is scheduled for the 19th April. The Trust will need to make a further income adjustment in "month 13" when the results of this are known.

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2. Month 12 Financial Performance

2.1. The Trust performance against a £18.119m deficit plan **was a deficit of £33.601m,** a £15.482m shortfall against plan.

2.2. The table below is the I&E statement for March:

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	149,923	142,504	(7,418)	12,195	8,663	(3,532)
PP, Overseas & RTA	2,321	2,321	1,458	(863)	195	133	(62)
Other Income	15,254	15,254	14,162	(1,092)	2,098	2,113	15
Total Income	**167,498**	**167,498**	**158,125**	**(9,373)**	**14,488**	**10,909**	**(3,579)**
Operating Expenditure							
Pay	(122,663)	(122,663)	(127,608)	(4,945)	(10,262)	(10,694)	(432)
Non-Pay	(53,712)	(53,712)	(53,613)	99	(4,704)	(4,216)	488
Total Expenditure	**(176,375)**	**(176,375)**	**(181,221)**	**(4,846)**	**(14,966)**	**(14,910)**	**56**
EBITDA	**(8,877)**	**(8,877)**	**(23,096)**	**(14,219)**	**(478)**	**(4,001)**	**(3,523)**
Non-Operating Expenditure	(9,237)	(9,237)	(10,555)	(1,318)	(769)	(813)	(44)
Retained Surplus/(Deficit)	**(18,114)**	**(18,114)**	**(33,651)**	**(15,537)**	**(1,247)**	**(4,814)**	**(3,567)**
Technical Adjustments	(5)	5	50	55	0	(598)	(598)
Break Even Surplus/(Deficit)	**(18,119)**	**(18,119)**	**(33,601)**	**(15,482)**	**(1,247)**	**(5,412)**	**(4,165)**

2.3. Commissioning income levels exceeded the levels expected within the FRP.

2.4. The in month actual position includes a reduction for sanctions and further provision for Expert

Determination.

2.5. 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.

2.6. West Lancashire CCG has confirmed they will impose penalties of £1.140m and Southport & Formby CCG are imposing penalties of £0.523m. The total cost to the Trust is £1.663m.

2.7. The Trust made a further provision of £2.1m in month 12 in relation to the outcome of Expert Determination.

2.8. The Expert Determination outcome in respect of GPAU coding went against the Trust and an additional provision of £0.7m for the second half of year activity was required.

2.9. A final provision of £0.3m for CQUIN relating to 2017/18 forecast performance delivery has also been made in month 12.

2.10. The Trust did not receive £0.4m of £1.2m winter funding as expected.

2.11. Total underlying expenditure levels (pay and non pay) remain consistent across the last few months (once non recurrent issues have been excluded).

2.12. The technical adjustment relating to the Veolia contract has been applied in month 12.

2.13. This same methodology was also applied to the GE radiology contract.

2.14. The adjustment impacts on non-pay and non-operating expenditure.

2.15. The overall impact of both schemes was a benefit of £1m to the Income & Expenditure account; GE contract was an additional cost of £0.3m thus reducing the expected £1.3m benefit.

2.16. A 0.5% CQUIN contribution was also received in month12 but could not be shown as an improvement on the Trust's break-even position; therefore, the value of £0.6m is shown as a technical adjustment (see table above).

3. Income

3.1. **Commissioning Income**

3.2. Commissioning income levels were higher in March than the levels planned within the FRP.

3.3. The Trust did not receive £0.4m of the £1.2m winter pressures funding; this was due to the timing of the delivery of the modular build for the A&E department.

3.4. **Private Patients (PP), Overseas and Road Traffic Accident (RTA)**

3.5. Income levels remain at a consistent level.

4. Expenditure

4.1. **Pay Expenditure**

4.2. Pay expenditure in March is consistent with previous month's performance once non-recurrent elements are excluded.

4.3. All pay budgets are overspent in month.

4.4. CIP unachieved in month £298k, year to date £2.026m.

5. Agency spend

5.1. The Trust has spent £6.86m on agency staff which is below the control total of £7.2m set by NHSI.

5.2. The agency cap for 2018/19 has been reduced to £5.6m.

5.3. Agency pressures remain across all staff groups particularly medical and nursing.

5.4. **Nurse Agency**

5.5. Nurse agency levels increased in March across all areas.

5.6. The majority of the monthly nurse agency spend continues to be incurred within A&E; with the remaining spend incurred in medical wards, ITU, spinal injuries and theatres.

5.7. Bank levels remain high and the focus continues to be recruiting to substantive posts and filling with bank wherever possible with agency being the last resort.

5.8. Medical wards and A&E also have high bank usage. There were considerable pressures in March with regard to securing adequate nursing resource.

5.9. **Medical Agency**

5.10. 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.

5.11. 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.

5.12. The Trust is in the process of reviewing bank rates for medical staff to ensure they are competitive but also reflect the pool of staff willing to do additional shifts.

5.13. In March bank expenditure reduced with agency costs increasing.

6. Cost Improvement Plan (CIP)

6.1. The Trust's efficiency requirement for 2017/18 was £5.6m; £3.42m was achieved; £1.32m non recurrently..

6.2. The table below gives the updated detailed performance by CBU.

CBU	Plan		
	Plan £000	Actual £000	Variance £000
Corporate	524	1,414	890
Planned	2,100	581	(1,519)
Specialist	930	1,086	156
Urgent	2,046	337	(1,709)
Total	**5,600**	**3,418**	**(2,182)**

7. Cash

7.1. The Trust achieved its cash holding target and external financing limit (EFL) target at the year-

end.

7.2. Final balance was £1.079m and this represents an under-spend against the EFL of £75k; Trusts are not permitted to over-spend against its EFL.

7.3. March was a cash rich month as on top of the loan of £3.048m, the Trust received additional capital investment of £1.039m together with winter pressure monies £0.926m and other receipts. Cash inflows exceeded £19.0m.

7.3 The extra cash was utilised to pay suppliers and this gives the Trust assistance into the new financial year, as its initial borrowing requirements should be lower but was subject to the outcome of Expert Determination.

7.4 Total loan draw-down for the year amounted to £30.804m with the cumulative value of the Trust loans at 31st March is £72.635m.

8. Capital

8.1 The Trust has achieved its statutory Capital Resource Limit (CRL) target with an underspend of £7k at the end of March.

8.2 A high spend was required in March (£2.7m) to achieve the target

9. Recommendations

9.1. The Board is asked to discuss the contents of the report and note the final outturn position for 2017/18 (subject to External Audit) is a deficit of £33.6m.

Southport and Ormskirk Hospital NHS Trust

Statement of Comprehensive Income (Income & Expenditure Account)

I&E (including R&D)	Annual Budget £000	Year to Date Budget £000	Year to Date Actual £000	Year to Date Variance £000	In Month Budget £000	In Month Actual £000	In Month Variance £000	
Operating Income								
Commissioning Income	149,923	149,923	142,504	(7,418)	12,195	8,663	(3,532)	• Lower income in month 12 re Expert Determination and Penalties (£4.5M). Partially mitigated by winter pressures funding.
PP, Overseas & RTA	2,321	2,321	1,458	(863)	195	133	(62)	Consistent with previous months performance
Other Income	15,254	15,254	14,162	(1,092)	2,098	2,113	15	• Funding for EY review and NHSI funding for various quality initiatives
Total Income	**167,498**	**167,498**	**158,125**	**(9,373)**	**14,488**	**10,909**	**(3,579)**	
Operating Expenditure								
Pay	(122,663)	(122,663)	(127,608)	(4,945)	(10,262)	(10,694)	(432)	
Non-Pay	(53,712)	(53,712)	(51,915)	1,797	(4,704)	(2,518)	2,186	• £2.2m fav variance relating to the revised accounting treatment of the Veolia and GE contracts as agreed with audit (offset by an increase of £1.7m in Non-Operating Expenditure relating to the agreed Contingent Rent) ; overspends on supplies and services clinical and services from other NHS bodies following year end agreement
Total Expenditure	**(176,375)**	**(176,375)**	**(179,523)**	**(3,148)**	**(14,966)**	**(13,212)**	**1,754**	
EBITDA	**(8,877)**	**(8,877)**	**(21,398)**	**(12,521)**	**(478)**	**(2,303)**	**(1,825)**	
Non-Operating Expenditure	(9,237)	(9,237)	(12,253)	(3,016)	(769)	(2,718)	(1,949)	• £1.9m adv variance relates to a Contingent Rent of £1.7m (reclassified from Non-Pay) and an increase in Interest Payable of £0.2m
Retained Surplus/(Deficit)	**(18,114)**	**(18,114)**	**(33,651)**	**(15,537)**	**(1,247)**	**(5,021)**	**(3,774)**	
Technical Adjustments	(5)	5	50	55	0	(598)	(598)	
Break Even Surplus/(Deficit)	**(18,119)**	**(18,119)**	**(33,601)**	**(15,482)**	**(1,247)**	**(5,619)**	**(4,372)**	

Statement of Financial Position (Balance Sheet)

Southport & Ormskirk Hospital NHS
NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2017	31/03/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,991	126,790	2,799	2,152
Other assets	1,267	1,382	115	(229)
TOTAL NON CURRENT ASSETS	**125,258**	**128,172**	**2,914**	**1,923**
CURRENT ASSETS				
Inventories	2,586	2,454	(132)	49
Trade and other receivables	8,042	9,591	1,549	5,237
Cash and cash equivalents	1,623	1,079	(544)	(919)
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**12,251**	**13,124**	**873**	**4,367**
CURRENT LIABILITIES				
Trade and other payables	(21,083)	(20,650)	433	(3,167)
Provisions	(164)	(5,204)	(5,040)	(5,068)
PFI/Finance lease liabilities	(1,559)	(1,746)	(187)	(79)
DH revenue loans	0	(4,220)	(4,220)	(4,220)
DH Capital loan	(400)	(400)	0	0
TOTAL CURRENT LIABILITIES	**(23,206)**	**(32,220)**	**(9,014)**	**(12,534)**
NET CURRENT ASSETS/(LIABILITIES)	(10,955)	(19,096)	(8,141)	**(8,167)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**114,303**	**109,076**	**(5,227)**	**(6,244)**
NON CURRENT LIABILITIES				
Provisions	(303)	(278)	25	16
DH revenue loans	(40,031)	(66,615)	(26,584)	1,172
PFI/Finance lease liabilities	(15,716)	(13,807)	1,909	1,072
DH Capital loan	(1,800)	(1,400)	400	0
TOTAL NON CURRENT LIABILITIES	**(57,850)**	**(82,100)**	**(24,250)**	**2,260**
TOTAL ASSETS EMPLOYED	**56,453**	**26,976**	**(29,477)**	**(3,984)**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	96,202	97,241	1,039	1,039
Retained earnings	(49,977)	(83,505)	(33,528)	(5,023)
Revaluation reserve	10,228	13,240	3,012	0
TOTAL TAXPAYERS EQUITY	**56,453**	**26,976**	**(29,477)**	**(3,984)**

In month material movements are as follows:

High capital spend in month in order to achieve statutory capital resource limit (CRL). Note the Trust received an additional £1,039k capital PDC to cover the costs of A&E redesign, paediatric safe room and cyber security.

Re-classification of trade receivables and payables resulting in a swing of £5m on each.

The DH loan of £4.22m due for repayment in Feb-19 now re-classified as a current liability.

Increase in provision associated with the expert determination. This will be reversed in month 13 and the final outcome put into the statutory accounts.

Prior period adjustment on PFI assets.

Source of information from Financial se\controlxxYY\balance sheets

Statement of cash flows

NHS
Southport and Ormskirk Hospital
NHS Trust

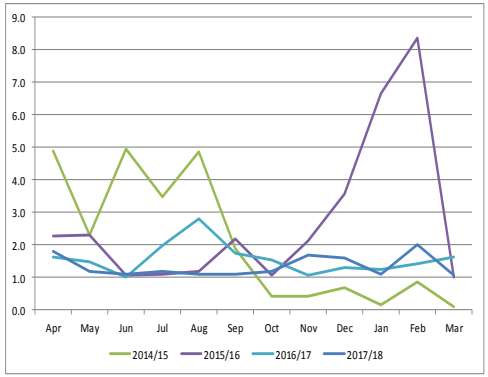
	Actual Apr-17	Actual May-17	Actual Jun-17	Actual Jul-17	Actual Aug-17	Actual Sep-17	Actual Oct-17	Actual Nov-17	Actual Dec-17	Actual Jan-18	Actual Feb-18	Actual Mar-18	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,681)	(2,357)	(1,859)	(2,688)	(2,501)	(2,556)	(1,938)	(1,640)	(2,481)	(1,781)	(1,990)	(2,817)	(27,289)
Income recognised in respect of capital donat	0	(13)	(5)	(14)	(25)	0	(91)	(30)	(17)	0	0	(11)	(206)
Depreciation and Amortisation	486	485	486	485	487	489	487	487	489	488	515	506	5,890
Impairments and Reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase) in Inventories	(37)	59	100	(45)	130	(3)	72	(6)	(72)	(35)	18	(49)	132
(Increase) in Trade and Other Receivables	2,279	796	(593)	565	769	674	(487)	103	(2,640)	2,562	(683)	(5,009)	(1,664)
Increase in Trade and Other Payables	(614)	(927)	(486)	(1,077)	(744)	80	924	(2,297)	3,178	(3,969)	1,710	(79)	(4,301)
Increase in Provisions	(24)	0	(6)	(21)	8	26	8	(3)	(6)	(20)	1	5,141	5,104
Net Cash Inflow/(Outflow) from Operating Activities	(591)	(1,957)	(2,363)	(2,795)	(1,876)	(1,290)	(1,025)	(3,386)	(1,549)	(2,755)	(429)	(2,318)	(22,334)
Cash Flows from Investing Activities													
Interest Received	2	2	0	2	(1)	1	1	1	3	3	2	5	21
(Payments) for Intangible Assets	(165)	(80)	(12)	(25)	(66)	(14)	(13)	(11)	(64)	37	(12)	275	(150)
(Payments) for PPE and investment property	(177)	(314)	(93)	(136)	(137)	(118)	(416)	(6)	(894)	84	(210)	(1,799)	(4,216)
Receipts from disposal of fixed assets	0	13	0	(13)	49	0	3	0	0	0	0	13	65
Receipt of cash donations to purchase capital assets	0	0	0	36	21	0	91	30	17	0	0	11	206
Net Cash Inflow/(Outflow) from Investing Activities	(340)	(379)	(105)	(136)	(134)	(131)	(334)	14	(938)	124	(220)	(1,495)	(4,074)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	0	0	0	0	0	0	1,039	1,039
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	3,048	30,804
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	(81)	(288)	(1)	(984)
Capital element of PFI, LIFT	(6)	(6)	(6)	(130)	(6)	(6)	(130)	(6)	(131)	(6)	(76)	(96)	(605)
Interest Paid	(30)	0	(56)	(8)	(57)	(371)	(53)	(33)	(100)	100	(261)	(415)	(1,284)
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)	(183)	(275)	(1,100)
PDC dividend (paid)/refunded	0	0	0	0	0	(721)	0	0	0	0	0	(406)	(1,127)
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	2,163	1,550	2,894	25,864
NET INCREASE/(DECREASE) IN CASH	**197**	**(591)**	**(144)**	**138**	**(109)**	**(2)**	**113**	**470**	**(130)**	**(468)**	**901**	**(919)**	**(544)**
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	1,097	1,998	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**	**1,097**	**1,998**	**1,079**	**1,079**

The Trust held enough cash to cover 2 days of operating expenditure at the end of March 2018 (February = 4 days).

Note the split between intangible and tangible assets has not yet been calculated but the total of the two is correct.

A provision has been input for the expert determination. Once this is known this will be reversed and recorded against trade payables.

Month end cash balances held in the last 3 years



Capital Programme

Gross capital spend	Mth 12 YTD Actual £000's
Electronic Patient Record (EPR)	275
Telephony system replacement	422
Data warehouse infrastructure incl storage	83
Desktop devices/network readiness	118
Vitalpac	44
eDMS (Evolve)	116
Wheelchair Database * ±	28
Capital Team	171
Estates schemes	41
Fire precautions - Dampers	0
Fire Precautions - Compartmentation	481
Spinal pool filter replacement * =	70
X-ray room works	36
Ward Reconfiguration * ≥	259
Catering equipment	48
Legionella preventions	44
Medical Gasses * ≤	66
UPS Theatre	153
Medical equipment including beds	1,661
Contingency / Prior Year	543
Board approved capital programme	**4,659**
Additional schemes	
A&E Streaming	352
CAMHS Safe Room	35
Cyber security	134
Additional estates works **	
	521
Donate assets/IFRIC12	
Donated assets	206
GE radiology equipment	884
	1,090
Gross Capital Spend	**6,270**
Available capital resources	
Remaining capital resources	

Southport and Ormskirk Hospital NHS Trust

The Trust's capital resource limit (CRL) is £6,048k.

Performance against this target is measured as follows:

	£'000s
Gross capital spend	6,270
Less book value of asset disposals	-23
Less capital donations	-206
	6,041

This represents an underspend of £7k against the statutory CRL target.

CRL target has therefore been achieved.

* New scheme for 17/18
± Funded by a reduction in EPR planned spend
≥ Funded by a reduction in planned spend on medical equipment
≤ Funded by a reduction in legionella prevention planned spend
= Funded by deferring the fire dampers to 18/19
** Net asset disposals

Southport and Ormskirk Hospital NHS Trust

Board of Directors
2nd May 2018

Agenda Item	**TB123a/18**	**Report Title**	**Financial Plan 2018/19 – Update**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☑To Approve ☐ To Assure ☐ For Information		☑To Note ☑To Receive

Key Messages and Recommendations

Key Messages

- The Trust submitted a draft 2018/19 Operational Plan on 8 March 2018 which included a gross deficit plan of £33.3m and a £7.0m CIP, a net deficit plan £26.3m;
- Trust is required to submit the final Operational Plan at midday on Monday 30 April 2018.
- The financial plan for 2018/19 to be submitted as part of this process has increased from £33.3m to £35.8m;
- A Cost Improvement Programme (CIP) of £7m (c3.5% of total expenditure) remains the target to give a net deficit plan of £28.8m;
- The Trust must achieve a reduction in agency spend of £1.2m to achieve its 2018/19 Agency Ceiling of £5.625m.
- Key Risks to the plan are:
    - The development of a deliverable CIP plan with current year effect(CYE) of existing plans 44% of the target required at £3.1m; and
    - The outcome of the Expert Determination on ACU activity for 2018/19.

Recommendation

The Board is asked to discuss the contents of the report and approve the final 2018/19 financial plan

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

SO1 Agree with partners a long term acute services strategy
SO2 Improve clinical outcomes and patient safety
☑ 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…..)*

☑Annual Business Plan Priority

☐ Best Practice

☐ Linked to a Key Risk on BAF / Risk Register Ref No.: _____

☐ Other List (Rationale) _____

☐ Service Change

☑Statutory requirement

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

☑ Compliance	☐ Quality
☐ Equality	☐ Risk
☑ Finance	☑ Workforce
☐ Legal	

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

Next Steps *(List the required actions following agreement by Board*

Issue the 2018-19 Budget Booklet to managers

Previously Presented at:

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

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

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

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

Information: Literally, to inform the Board

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

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

1 Introduction

1.1 The guidance on refreshing 2018/19 Operational Plan was published jointly by NHS Improvement and NHS England on 7 February 2018, supplemented by notification of the indicative 2018/19 Control Total and Agency Ceiling.

1.2 Draft operational plans were submitted to NHS Improvement on 8th March 2018; final Board approved operational plans are due at midday on 30th April 2018.

1.3 There are three key returns; finance plan, manpower plan and activity plan. These must be accompanied by a summary narrative which should only show any changes to the narrative that was provided as part of the two year (2017-19) planning submission in March 2017.

1.4 This report updates the financial plan that was shared with the Board and the Finance Performance and Investment Committee at the draft planning stage.

1.5 Much of the report is unchanged (from the report previously discussed). However, since the draft submission the financial plan has been progressed to reflect known changes and this has led to an increase in the gross deficit position from £33.3m to £35.8m.

2 Planning Assumptions

2.1 The draft financial plan is based upon the Month 10 2017/18 forecast out-turn, as advised by and reported to NHS Improvement.

2.2 Any non recurrent elements of income and expenditure have been removed in order to arrive at an underlying recurrent deficit position.

2.3 The Trust has now closed down the 2017/18 financial year and, therefore, was able to review both month 11 and month 12 to ensure that this baseline planning assumption remained robust.

2.4 Although month 12 did contain a number of non recurrent transactions the underlying gross recurrent month expenditure remains consistent.

2.5 Clinical income is driven by activity and performance has been analysed in order to determine a forecast outturn position (FOT).

2.6 The recent improvements in coding are contained within the FOT but an assessment of the full year effect (FYE) has been made.

2.7 2018/18 Contract Variation process has resulted in a gap of £2.5m between Trust and CCG expectations.

2.7.1 Forecast Outturn £473,000

2.7.2 West Lancashire CCG QiPP plans £486,000

2.7.3 Local growth £1.5m; Southport & Formby £1.1m; Sefton £0.2m;West Lancs £0.2m

2.8 Trust's assumptions were based on CBU signed off activity plans which were submitted 8 March and did not include national growth assumptions as per planning guidance

2.9 Trust has agreed with NHSI that there will be no changes to its initial income and activity plan for our local commissioners and that the gap will be incorporated into "Non Contract Activity".

2.10 All remaining income has been set at outturn levels taking into account the most recent monthly performance and deducting any non-recurrent items received in 2017/18.

2.11 The gross expenditure figures as reported to the the Board, up to and including Month 11, are shown below (April 2017 include the costs of providing the Community services).

2.12 There have been a number of other adjustments made in order to understand the monthly average spend eg Consultant back pay of £200,000 in December 2017 pay costs.

2.13 For the purpose of this exercise month 12 has not been included in this table due to the number of adjustments; the effect of the Veolia and GE contracts; funding for the EY project; funding for winter pressures; NHSI funding for Quality Improvement.

Gross Expenditure Run Rate	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M	£M
Pay Costs	(11.91)	(10.47)	(10.33)	(10.29)	(10.37)	(10.49)	(10.56)	(10.79)	(10.80)	(10.43)	(10.47)
Non Pay Costs	(4.61)	(4.14)	(4.42)	(4.76)	(4.59)	(4.57)	(4.66)	(4.27)	(4.24)	(4.61)	(4.53)
Non Operating Costs	(0.78)	(0.82)	(1.38)	(0.78)	(0.79)	(0.81)	(0.81)	(0.83)	(0.81)	(0.91)	(0.81)
Gross Expenditure	**(17.30)**	**(15.43)**	**(16.12)**	**(15.83)**	**(15.75)**	**(15.87)**	**(16.03)**	**(15.88)**	**(15.85)**	**(15.96)**	**(15.81)**
Adjust for Transfer by Absorption	0.00	0.00	0.57	0.00	0.00	0.00	0.00	0.00	0.00	0.12	0.00
Gross Recurrent Expenditure	**(17.30)**	**(15.43)**	**(15.55)**	**(15.83)**	**(15.75)**	**(15.87)**	**(16.03)**	**(15.88)**	**(15.85)**	**(15.84)**	**(15.81)**

2.14 Following this review it has been determined that the average monthly expenditure is running at £15.8m per month. The expenditure plan is based on an initial £189.6M (12X £15.8m).

2.15 The tariff uplift and inflation factors used in the draft financial plan are those given in the NHS Improvement Planning Templates and are also contained in Appendix A:

NHS Improvement - Planning Assumptions	
National Tariff - Cost Uplift	2.10%
National Tariff - Efficiency Factor	(2.00%)
National Tariff - Inflator	**0.10%**
Cost inflation - Pay costs	2.10%
Cost Inflation - Drugs costs	2.10%
Cost Inflation - CNST	0.02%
Cost Inflation - Capital costs	2.90%
Cost Inflation - Other operating costs	2.10%

2.16 It should be noted that the Guidance stated that the 2018/19 pay costs in financial planning returns are to be an accurate reflection of the cost of the current, published pay assumptions.

2.17 This is because the implications of the Government commitment on NHS pay, described in the 2017 Autumn Budget, are still being worked through and will be the included in any supplementary guidance that is published.

2.18 Since this guidance a pay award has been recommended and discussions with unions are ongoing.

2.19 This plan assumes that any pay award generating a 2018/19 cost above 2.1% of the pay bill will be subject to further funding.

2.20 The Trust has been notified of the increase in CNST contributions for 2018/19 of £1.77m.

2.21 It is estimated that £1.1m is funded in the revised tariff prices which indicates a £0.67m cost pressure.

2.22 Although control totals have been amended to take account of this pressure it has a direct impact on the trust's deficit position.

2.23 This plan has funded all of the cost planning assumptions set out in the table above with the exception of "other operating costs".

2.24 The value of this is approximately £0.8M (2.1% of £37M exclusive of drugs and CNST which have been budgeted).

3 Control Total and Agency Ceiling

3.1 The Trust has been informed by NHS improvement that its control total is £13.7m deficit.

3.2 The control total does not take into account the Trust's 2017/18 adverse performance and is the same figure which was notified to the Trust in the 2017/19 planning round back in December 2016 (adjusted for CNST as highlighted above).

3.3 If the Trust accepted the control total it would also have access to Provider Transformation Funding (formerly STF) of £6.8M resulting in a deficit of £6.9M.

3.4 The draft financial plan cannot deliver the control total which means that the Trust will not have access to any Provider Transformation Funding in 2018/19.

3.5 NHS Improvement advised that the Trust 2018/19 Agency Ceiling is £5.625m.

3.6 Agency expenditure in 2017/18 was £6.8M so further reductions to the monthly agency levels will be required throughout 2018/19 if this target is to be achieved.

3.7 Performance against the Agency Ceiling is the driver for the Agency Rating component of the Financial Risk Rating.

4 Financial Risk Rating

4.1 As at Month 10, the financial Risk Rating was 3. The details of this are outlined below:

Overall finance and use of resources risk rating	Actual 31/01/2018 YTD	Forecast 31/03/2018 Year ending
Overall rating unrounded	3.40	3.40
If unrounded score ends in 0.5	0.00	0.00
Risk ratings after overrides	3	3
Finance and use of resources rating	**Actual 31/01/2018 YTD**	**Forecast 31/03/2018 Year ending**
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
I&E margin: distance from financial plan	4	4
Agency rating	1	1

4.2 The implication of breaching the agency cap in 2018/19 is that the Financial Risk Rating will change to a 4, being the Highest Financial Risk Rating as follows:

Overall finance and use of resources risk rating	Plan 31/03/2019 Year ending
Overall rating unrounded	3.60
If unrounded score ends in 0.5	0.00
Risk ratings after overrides	4
Finance and use of resources rating	**Plan 31/03/2019 Year ending**
Capital service cover rating	4
Liquidity rating	4
I&E margin rating	4
I&E margin: distance from financial plan	4
Agency rating	2

5 Income & Expenditure 2018/19

5.1 The Trust's underlying deficit position shared with the the Board and the Finance Performance and Investment Committee at the draft planning stage was estimated to be £31.8m deficit as illustrated in the table below:

	FOT	Winter	Community	Other	Underlying
	£M	£M	£M	£M	£M
Clinical income	146.4	(1.2)	(2.0)		143.2
PP/RTA/overseas	1.6			(0.2)	1.4
Other income	13.2				13.2
Total Income	**161.2**	**(1.2)**	**(2.0)**	**(0.2)**	**157.8**
Expenditure	**(191.7)**		**2.0**	**0.1**	**(189.6)**
Deficit	**(30.5)**	**(1.2)**	**0.0**	**(0.1)**	**(31.8)**
Tech adjustment	*1.3*				*0.0*
Deficit	***(29.2)***				***(31.8)***

5.2 Using the underlying deficit as a baseline a number of adjustments were made to both income and expenditure based on the planning assumptions and any known local factors.

5.3 This resulted in a £33.3M gross deficit at the draft planning stage.

5.4 The gross deficit has now increased to £35.8M due to two main issue as shown below:

	£M
Gross Deficit - draft plan	(33.30)
Non-operating expenditure	(0.90)
Locally pressures above 2017/18 run rate	(1.60)
Gross deficit - final plan	**(35.80)**

5.5 The Trust's non-operating expenditure has increased significantly due to a number of issues.

5.6 Depreciation has increased £by £0.377M.

5.7 Interest Payable has increased by £1.462M due to the interest charges on an increasing loan.

5.8 PDC dividend has reduced by £0.9M.

5.9 The net impact of these items is £0.9M

5.10 The Trust has a number of "local pressures" that are not contained within the national assumptions and have been agreed and signed off by the Executive Team.

5.11 A 3.5% CIP would generate a saving of £7.0m and reduce the deficit to £28.8M.

5.12 This is the minimum CIP the Trust will incorporate into the 2018/19 financial plan.

6 Cost Improvement Programme

6.1 The construct of the national tariff means that a further 2% CIP is required just to fund expected costs of 2.1% and maintain the current underlying deficit.

6.2 The rise in CNST costs also increases the Trust deficit as explained above. Non-operating expenditure and local pressures are also not funded.

6.3 The Trust must show progress towards an improved underlying deficit position (2017/18 FOT £31.7m before non recurrent issues) and, therefore, a higher percentage CIP must be delivered in 2018/19.

6.4 The majority of the identified CIP is down to cross-cutting themes such as theatres and outpatients.

6.5 CBUs are struggling to identify the required level of savings

6.6 The individual CBUs have identified green rated schemes worth a total of £356k CYE/£429k FYE.

6.7 Budgets for 2018/19 are being set at 2017/18 run rate so what was spent last year is being put into budget this year which should give CBU's greater opportunity to reduce cost.

6.8 At the latest round of run rate meetings on the 17th April 2018, CBUs along with members of the Executive Team went through the currently identified schemes to look at their current status and likely delivery.

6.9 Schemes have been RAG rated accordingly to the following criteria:

- RED – no plan and unlikely to deliver
- AMBER – plan in place and should deliver
- GREEN – plan and PID in place and high confidence of delivery or already being delivered

6.10 The current position by scheme (as at 18th April 2018) is outlined in the table below:

Scheme	**Value CYE**	**Value FYE**	**RAG**
Theatres	£247,401	£247,401	G
Endoscopy	£371,000	£371,000	G
Outpatients	£500,000	£500,000	A
Medical Workforce	£450,000	£600,000	A
Clinical Admin	£148,000	£148,500	A
Procurement	£336,000	£700,000	G
Corporate	£300,000	£461,812	G
Estates	£93,000	£128,000	G
Individual CBU CIPs:			
— Urgent Care	£277,503	£340,000	G
— Planned Care	£78,366	£89,000	G
— Specialist Services	£387,643	£400,000	R
TOTAL	**£3.1m**	**£4.0m**	

The table below shows the split by scheme status:

Status	**Value CYE**	**Value FYE**
Green	£1.7m	£2.3m
Amber	£1.0m	£1.2m
Red	£0.4m	£0.4m

6.11 Each scheme has an executive lead and senior manager responsible for delivery.

6.12 The current level of identified CIP stands at £4m (FYE) with £2.3m being 'green' which is only a 1.2% saving on expenditure which is too low..

6.13 In order to support the work to bridge the gap in planns needed to deliver a £7.0m CIP, the CEO has commissioned KPMG to provide

6.13.1 A comparison of the Trust's CIP governance processes against good practice.

6.13.2 Provide a view on the proposed level of PMO resource to be assigned to CIP delivery under the new PMO structure.

6.13.3 Comment on adherence to the Trust's CIP governance processes during the 17/18 financial year assessed through interviews with relevant members of the Trust's staff and sample testing of CIP documentation.

6.13.4 In respect of 1, 2 and 3 above, highlight areas which could enhance the Trust's ability to deliver CIPs and provide recommendations on how these could be addressed.

6.13.5 Provide a high level assessment on progress towards identifying schemes to meet the FY18/19 CIP target.

6.14 The draft report from KPMG is expected to be completed by 7 May.

7 Cash

7.1 As the Trust is forecasting another significant deficit in 2018/19 it will continue to need cash support in the form of interest-bearing, repayable loans from the Department of Health.

7.2 Given that there will be a deficit in 2018/19 the Trust is not generating cash to be able to repay these loans.

7.3 As such the Trust will not be able to repay the loan of £4.22m due on 18th February 2019.

7.4 Note the loan repayable after that is £20.149m and that is due on 14th April 2020.

7.5 The value of loans as a minimum will equal the value of the deficit (after technical adjustments).

7.6 In addition the Trust must comply with the loan conditions to ensure that the bank balance held does not fall below £1m at any point.

7.7 The Trust will not be signing up to its control total which means the interest rate will be 3.5% unless the Trust goes into financial special measures, in which case the interest rate rises to 6%.

7.8 The cash position has changed from the draft plan submission to accommodate two issues. Firstly, the results of the Expert Determination process and the imposition of penalties will mean a further cash requirement. In addition, as the gross deficit has worsened by £2.5M a higher loan will be required. Any change to the £7M CIP would also impact on the loan request.

8 Risks

8.1 The plan requires a CIP of £7M.

8.2 The outcome of the Expert Determination received on 19th April; regarding the tariff charged for ACU/GPAU activity went in the CCG's favour. This will have an adverse impact on the Trust's income position once the details have been understood and a fair revised tariff negotiated and agreed.

8.3 No contingency has been provided for.

9 Capital Plan 2018-2023

9.1 A revised 5 year capital plan, as shown in Appendix B, has been produced following discussions at the Capital Investment Group (CIG) on 23rd March and 16th April 2018.

9.2 There has been a minor change to the value of the 18/19 capital resource limit (CRL), due to a revised recalculation of lease liabilities on the IFRIC 12 contracts.

9.3 The amendments to the plan, including the removal of schemes is consistent with the Trust's risk based approach to capital decision making.

9.4 The changes the 5 year capital plan that have been made following the submission to NHSI on 8th March 2018, are summarised as follows:

9.4.1 The plan has been categorized to identify spend available for specified areas
9.4.2 £10k reduction in CRL has reduced the 2018/19 contingency
9.4.3 Inclusion of new schemes 'Discharge lounge' (£70k) and 'Spinal isolation works' (£200k) is funded by the removal of estates schemes (£120k), nurse call replacement (£80k) and a reduction in medical equipment (£70k)
9.4.4 Inclusion of 'Aseptic Isolator work' (£30k) is funded by a reduction in the ward reconfiguration (£5k), medical equipment (£10k) and contingency (£15k).
9.4.5 Removed laundry equipment (£50k), transferred spend to contingency
9.4.6 Additions to the GE radiology equipment replacement programme (£659k) of the IFRIC 12 elements, based on a new model received from GE.
9.4.7 Addition of the boiler change in the Veolia Energy Centre at Ormskirk 2020/21 (£724k) to the IFRIC 12 elements.
9.4.8 Various phasing amendments based on the priorities of the estates improvement works

9.5 A detailed breakdown of the medical equipment line will not be provided as we have agreed to manage the need for medical equipment on a contingency basis.

10 Recommendations

10.1 The Board is asked to discuss the contents of the report and approve the final financial plan.

Appendix A

NHS IMPROVEMENT INFLATION ESTIMATES FOR 2017/18 AND 2018/19

1 Pay

1.1 Pay-related inflation has four elements. These are:

1.1.1 Pay settlements: the increase in the unit cost of labour reflected in pay awards for the NHS ;

1.1.2 Pay drift: the tendency for staff to move to a higher increment or to be upgraded and also includes the impact of overtime;

1.1.3 Staff group mix: the movement in the average unit cost of labour due to changes in the overall staff mix (e.g. the relative proportions of senior and junior staff, or the relative proportions of specialist and non-specialist staff);

1.1.4 Extra overhead labour costs: there are two new charges for NHS providers, the apprenticeship levy and the immigration skills charge, both due to be implemented from 1 April 2017.

1.2 The Department of Health (DH) central estimates have been used for these components. The DH maintains the most accurate and detailed records of labour costs in the NHS, and is directly involved in pay negotiations. From these, it has been assumed that the pay drift and group mix effects will be 0.7% in 2017/18 and 1.0% in 2018/19. In arriving at these figures, an adjustment of (0.3)% has been made to the DH projections for pay drift and staff mix, to reduce or exclude elements of pay inflation that lead to extra output and are therefore remunerated through activity rather than price.

1.3 The pay award is in line with public sector pay policy of 1% and this is assumed to be the same for both 2017/18 and 2018/19. The 1% pay award assumption is a limit to the average pay award set by HM Treasury. A greater increase for lower paid staff would have to be offset by a lower increase for higher paid staff.

1.4 The combined impact of pay drift and group mix for tariff purposes is assumed to be 0.7% in 2017/18 and 1.0% in 2018/19.

1.5 The Apprenticeship Levy is estimated to add a net 0.3% to the total wage bill in 2017/18 (with no further impact in 2018/19). This comprises 0.4% expected gross costs, offset by 0.1% financial benefit, as employers can access funding for the training of apprentices.

1.6 The immigration skills charge is estimated to add 0.1% to the total wage bill in 2017/18 (with no further impact in 2018/19).

1.7 In total, the NHS Improvement projection is an increase in the pay bill of 2.1% in 2017/18 and 2.0% in 2018/19.

2 Drugs Costs

2.1 The drugs cost uplift is intended to reflect increases in drugs expenditure per unit of activity. Although drugs costs are a relatively small component of total provider expenditure (approximately 8%), they have historically grown faster than other costs. This has made drugs costs one of the larger cost uplift components in some years.

2.2 Our approach is a development of that used in previous years which uses a forecast increase in expenditure and removes the increase in costs resulting from activity to identify the cost increase due to price increases. This is because providers will be paid for increased drugs use because of the increase in volumes and therefore payments. NHS Improvement has also made a new adjustment to seek to exclude the impact of the more rapid forecast of price growth in high cost drugs paid for on a pass-through basis outside of tariff. As the cost of these drugs is remunerated outside the tariff, it is not correct to include it in The NHS Improvement calculation of tariff inflation.

2.3 To reflect the expected increase in drugs costs, NHS Improvement has used the DH estimates as the basis for The NHS Improvement calculation. This estimate is based on long-term trends and the DH expectation of new drugs coming to market, and other drugs that will cease to be provided solely under patent in the coming 12 months. DH has provided us with its best estimate of the increase in drugs total costs for providers. The figures are 5.8% in 2017/18 and 5.0% in 2018/19. They are then adjusted by:

2.3.1 Calculating a revised figure for tariff drugs, by assuming 6.2% cost growth in the proportion of drugs expenditure accounted for by pass-through drugs. This figure is based on NHS England analysis of likely expenditure growth in high cost drugs (9% average growth) less an assessment of overall efficiencies required of specialised commissioning (2.6%);

2.3.2 Removing assumed underlying activity growth of 2.5% in both years as increases in activity are covered by each additional unit paid for not increases in price per unit;

2.3.3 Recognising the uncertainty associated with these adjustments, particularly for pass through drugs, setting the growth figure to be at least the Gross domestic product (GDP) deflator estimated by the Office of Budget Responsibility (OBR) each year.

2.4 This results in assumed drugs cost inflation of 2.8% in 2017/18 and 2.1% in 2018/19.

3 Other operating costs

3.1 Other operating costs include general costs such as medical, surgical and laboratory equipment and fuel. For this category of cost uplift, NHS Improvement has used the forecast of the GDP deflator estimated by the OBR as the basis of the expected increase in costs. The GDP deflator, from June 2016, is 1.8% in 2017/18 and 2.1% in 2018/19. In both years this translates to 0.4% uplift, once the weighting of the increase is taken into consideration.

3.2 Clinical Negligence Scheme for Trusts:

3.2.1 The Clinical Negligence Scheme for Trusts (CNST) is an indemnity scheme for clinical negligence claims. Providers make a contribution to the scheme to cover the legal and compensatory costs of clinical negligence. The NHS Litigation Authority (NHSLA) administers the scheme and sets the contribution that each provider must make to ensure that the scheme is fully funded each year.

3.2.2 Following the previous DH approach, NHS Improvement has allocated the increase in CNST costs to core HRG subchapters, to the maternity delivery tariff and A&E services in line with the average cost increases that will be paid by providers. This approach to the CNST uplift is different to other cost uplifts. While other cost uplifts are estimated and applied across all prices, the estimate of the CNST cost increase differs according to the mix of services delivered by providers. To reflect these differences in CNST payments, the cost uplift is differentially applied across HRG subchapter, A&E services and for the maternity delivery tariff. Each relevant HRG is uplifted based on the change in CNST cost across specialties mapped to HRG subchapters. This means that The NHS Improvement cost uplifts reflect, on average, the relative exposure to CNST cost growth for each provider, given the individual mix of services and procedures.

3.2.3 Most of the increases in CNST costs are allocated at HRG subchapter level, maternity tariff or A&E, but a small residual amount (about £18m in 2017/18 and £22.1m in 2018/19) is unallocated at a specific HRG level. This unallocated figure is redistributed as a general uplift across all prices. NHS Improvement has calculated the uplift due to this pressure as 0.02% in both 2017/18 and 2018/19. (Though this is given as 0.0% in the Table 1 below due to rounding).

4 Capital Costs (Changes in Depreciation and Private Finance Initiative Payments)

4.1 Provider costs typically include depreciation charges and PFI payments. As with increases in operating costs, providers should have an opportunity to recover an increase in these capital costs.

4.2 In previous years, DH reflected changes in these capital costs when calculating cost uplifts, and NHS Improvement has adopted the same approach for 2017/18 and 2018/19. Specifically, NHS Improvement has applied the DH projection of changes in overall depreciation charges and PFI payments.

4.3 In aggregate, DH projects PFI and depreciation costs to grow by 3.0% in 2017/18 and 2.9% in 2018/19. These both translate to an uplift of 0.2% on tariff prices.

5 Service Development

5.1 The service development uplift factor reflects the expected extra unit costs to providers of major initiatives that are included in the Mandate.64 There are no major initiatives anticipated in the Mandate to be funded through national prices in 2017/18 or 2018/19, and no uplift is to be applied for either year.

6 Summary of Data for Cost Uplifts

6.1 Given the above, NHS Improvement has calculated the total weighted cost uplift factor (excluding the targeted CNST adjustments) for both 2017/18 and 2018/19 national prices as 2.1%, as shown in Table 1 below:

Table 1: Cost uplift factors

Uplift factors	Weighted average estimate (uplift x weighting)	
	2017/18	2018/19
Pay costs	1.30%	1.30%
Drugs costs	0.20%	0.20%
Other operating costs	0.40%	0.40%
Unallocated CNST	0.00%	0.00%
Capital costs	0.20%	0.20%
Total	**2.10%**	**2.10%**

Appendix B
5 YEAR CAPITAL PLAN 2018 TO 2023

CAPITAL SCHEME DESCRIPTIONS	Plan 30/04/2018 Month 1 £'000	Plan 31/05/2018 Month 2 £'000	Plan 30/06/2018 Month 3 £'000	Plan 31/07/2018 Month 4 £'000	Plan 31/08/2018 Month 5 £'000	Plan 30/09/2018 Month 6 £'000	Plan 31/10/2018 Month 7 £'000	Plan 30/11/2018 Month 8 £'000	Plan 31/12/2018 Month 9 £'000	Plan 31/01/2019 Month 10 £'000	Plan 28/02/2019 Month 11 £'000	Plan 31/03/2019 Month 12 £'000	Plan 31/03/2019 Year Ending £'000	Plan 31/03/2020 Year Ending £'000	Plan 31/03/2021 Year Ending £'000	Plan 31/03/2022 Year Ending £'000	Plan 31/03/2023 Year Ending £'000	Plan 31/03/2023 5 Year Plan £'000
MEDICAL DEVICES																		
Medical Equipment fund		100		50	470		50		100		100		**870**	1,150	1,000	1,150	1,200	**5,370**
Beds / Trolleys		50											**50**	50	50	50	100	**300**
Sub total MEDICAL DEVICES	**0**	**150**	**0**	**50**	**470**	**0**	**50**	**0**	**100**	**0**	**100**	**0**	**920**	**1,200**	**1,050**	**1,200**	**1,300**	**5,670**
IM&T																		
Electronic Patient Record				45	25	25	40	10	25	10	10		**190**	635	995	370	325	**2,515**
Vitalpac		3	3	3	3	3	3	3	3	3	3		**30**	10	30	10	30	**110**
eDMS	13	14	13	14	13	13	14	13	13	14	13	13	**160**	80	80	40	40	**400**
Wireless network upgrade	150												**150**	150	150	0	0	**450**
Server warehouse infrastructure incl storage	75												**75**	75	75	320	320	**865**
Telephony system replacement	120												**120**	60	60	60	30	**330**
Cyber security	5	4	4	4	4	5	4	4	4	4	4	4	**50**	80	25	25	25	**205**
Fixed network infrastructure	8	8	8	8	10	8	8	8	10	8	8	8	**100**	50	0	250	150	**550**
Datacentre			25	25									**50**	0	0	0	150	**200**
Virtual desktop infrastructure		3	2	3	2	3	2	3	2	3	2		**25**	0	0	140	0	**165**
Equipment refresh	4	4	5	4	4	5	4	4	4	4	4	4	**50**	30	30	50	50	**210**
Sub total IM&T	**375**	**36**	**60**	**106**	**61**	**62**	**75**	**45**	**61**	**46**	**44**	**29**	**1,000**	**1,170**	**1,445**	**1,265**	**1,120**	**6,000**
ESTATE IMPROVEMENT SCHEMES																		
GE Turnkey works for Radiology equipment replacement programme			50				100			250			**400**	40			250	**690**
Southport A&E Redesign		100	50	50	50	50	50						**350**					**350**
Ward reconfigurations		40		100									**140**					**140**
Medical gasses	15	15											**30**					**30**
UPS Theatre		50											**50**					**50**
Waste management storage facilities			50	50									**100**	80				**180**
Theatre airplant controls				45									**45**					**45**
Generator connectors			65										**65**	65				**130**
Fire comparmentation			30	30	45	30	30						**165**	350	350	350	350	**1,565**
Fire Precautions - Fire Doors					45								**45**	300	300	300		**945**
Discharge lounge		35	35										**70**					**70**
Spinal isolation works				25	50	50	75						**200**					**200**
Capital team	15	15	15	13	13	12	12	12	12	12	12	12	**155**	155	155	160	160	**785**
Aseptic isolator						30							**30**					**30**
Legionella prevention													**0**	60		60		**120**
Fire alarm programme													**0**	50	50	50	50	**200**
Fire dampers													**0**	50				**50**
CCTV													**0**	150	150	150		**450**
Sub total ESTATE IMPROVEMENT SCHEMES	**30**	**255**	**295**	**313**	**203**	**172**	**267**	**12**	**12**	**262**	**12**	**12**	**1,845**	**1,300**	**1,005**	**1,070**	**810**	**6,030**
FACILITIES																		
Catering equipment			60			40							**100**	75	75	75	75	**400**
Vehicle replacement													**0**		100		100	**200**
Accomodation refurbishment													**0**	30	30	30	30	**120**
Sub total FACILITIES	**0**	**0**	**60**	**0**	**0**	**40**	**0**	**0**	**0**	**0**	**0**	**0**	**100**	**105**	**205**	**105**	**205**	**720**
CONTINGENCY	**30**	**25**	**30**	**25**	**30**	**25**	**25**	**30**	**25**	**25**	**25**	**24**	**319**	**387**	**337**	**387**	**567**	**1,997**
Capital plan excluding donations and IFRIC 12	**435**	**466**	**445**	**494**	**764**	**299**	**417**	**87**	**198**	**333**	**181**	**65**	**4,184**	**4,162**	**4,042**	**4,027**	**4,002**	**20,417**
Donated asset; equipment			30			30			30			30	**120**	150	150	150	150	**720**
GE Radiology equipment replacement programme (IFRIC 12)			175	172	210	235	350	250	96	680			**2,168**	300	543	39	1,021	**4,071**
Veolia energy centre contract (IFRIC 12)															724			**724**
Sub total Donations and IFRIC 12	**0**	**0**	**205**	**172**	**210**	**265**	**350**	**250**	**126**	**680**	**0**	**30**	**2,288**	**450**	**693**	**189**	**1,171**	**4,791**
TOTAL CAPITAL SPEND	**435**	**466**	**650**	**666**	**974**	**564**	**767**	**337**	**324**	**1,013**	**181**	**95**	**6,472**	**4,612**	**4,735**	**4,216**	**5,173**	**25,208**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
2nd May 2018

Agenda Item	**TB123b/18**	**Report Title**	**5 Year Capital Plan (2018 to 2023)**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Suzanne McGrath, Deputy Financial Accountant		
Action Required *(Definitions below)*	☐ To Receive ☑ To Approve ☐ To Assure		☑ To Note ☐ For Information

Key Messages and Recommendations

Key messages:

- Recalculation of the 18/19 capital resource limit has reduced the value of the 18/19 plan by £10k.
- The plan has been amended to include estates improvement work to create a discharge lounge and isolation works in the Spinal Injuries Unit.
- Annual capital spend is consistently between £4m and £4.2m per annum (excluding donations and managed service contracts).
- The revised plan was agreed at Capital Investment Group and has been to Finance Committee prior to requesting final Board approval.

Recommendations:

- The Board is asked to **approve** that the capital plan in Appendix 1.

☐ **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 ☐ 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. Introduction

1.1 A revised 5 year capital plan shown in appendix 1, has been produced following discussions at the Capital Investment Group (CIG) on 23rd March and 16th April 2018.

1.2 There has been a minor change to the value of the 18/19 capital resource limit (CRL), due to a revised recalculation of lease liabilities on the IFRIC 12 contracts.

1.3 The amendment of the plan to include estates works for the isolation works required in the Spinal Injuries Unit and creation of a discharge lounge on the Southport site, is consistent with the risk-based approach to managing capital spend.

1.4 The plan contained in appendix 1 was agreed at CIG on 16th April 2018 and approved at Finance, Performance and Investment (FP&I) Committee on 23rd April 2018.

2. Revised plan

2.1 Changes to the 5 year capital plan, that have been made following the submission to NHSI on 8th March 2018, are summarised as follows:

- → The plan has been categorised to identify spend available for specified areas
- → £10k reduction in CRL has reduced the 18/19 contingency
- → Inclusion of new schemes 'Discharge lounge' (£70k) and 'Spinal isolation works' (£200k) is funded by the removal of estates schemes (£120k), nurse call replacement (£80k) and a reduction in medical equipment (£70k)
- → Inclusion of 'Aseptic Isolator work' (£30k) is funded by a reduction in the ward reconfiguration (£5k), medical equipment (£10k) and contingency (£15k).
- → Removed laundry equipment (£50k), transferred spend to contingency
- → Additions to the GE radiology equipment replacement programme (£659k) of the IFRIC 12 elements, based on a new model received from GE.
- → Addition of the boiler change in the Veolia Energy Centre at Ormskirk 2020/21 (£724k) to the IFRIC 12 elements.
- → Various phasing amendments based on the priorities of the estates improvement works

2.2 The removal of the schemes detailed above is consistent with the Trust's risk based approach to capital decision making. If capital investment is required in these areas, they would be invited to make a bid for capital contingency monies at the CIG.

2.3 A detailed breakdown of the medical equipment line will not be provided as we have agreed to manage the need for medical equipment on a contingency basis.

3. Conclusion

3.1 The final capital plan will be included in the overall detailed 18/19 planning submission to NHSI that is due in on 30th April 2018.

3.2 Although the Board approved the initial 5 year capital plan at its last meeting, this revision in appendix 1 also requires approval.

4. Recommendation

4.1 It is recommended that the Board approve the revised capital plan.

Appendix 1 – 5 year capital plan 2018 to 2023

CAPITAL SCHEME DESCRIPTIONS	Plan 30/04/2018 Month 1 £'000	Plan 31/05/2018 Month 2 £'000	Plan 30/06/2018 Month 3 £'000	Plan 31/07/2018 Month 4 £'000	Plan 31/08/2018 Month 5 £'000	Plan 30/09/2018 Month 6 £'000	Plan 31/10/2018 Month 7 £'000	Plan 30/11/2018 Month 8 £'000	Plan 31/12/2018 Month 9 £'000	Plan 31/01/2019 Month 10 £'000	Plan 28/02/2019 Month 11 £'000	Plan 31/03/2019 Month 12 £'000	Plan 31/03/2019 Year Ending £'000	Plan 31/03/2020 Year Ending £'000	Plan 31/03/2021 Year Ending £'000	Plan 31/03/2022 Year Ending £'000	Plan 31/03/2023 Year Ending £'000	Plan 31/03/2023 5 Year Plan £'000
MEDICAL DEVICES																		
Medical Equipment fund		100		50	470		50		100		100		**870**	1,150	1,000	1,150	1,200	**5,370**
Beds / Trolleys		50											**50**	50	50	50	100	**300**
Sub total MEDICAL DEVICES	**0**	**150**	**0**	**50**	**470**	**0**	**50**	**0**	**100**	**0**	**100**	**0**	**920**	**1,200**	**1,050**	**1,200**	**1,300**	**5,670**
IM&T																		
Electronic Patient Record				45	25	25	40	10	25	10	10		**190**	635	995	370	325	**2,515**
Vitalpac		3	3	3	3	3	3	3	3	3	3		**30**	10	30	10	30	**110**
eDMS	13	14	13	14	13	13	14	13	13	14	13	13	**160**	80	80	40	40	**400**
Wireless network upgrade	150												**150**	150	150	0	0	**450**
Server warehouse infrastructure incl. storage	75												**75**	75	75	320	320	**865**
Telephony system replacement	120												**120**	60	60	60	30	**330**
Cyber security	5	4	4	4	4	5	4	4	4	4	4	4	**50**	80	25	25	25	**205**
Fixed network infrastructure	8	8	8	8	10	8	8	8	10	8	8	8	**100**	50	0	250	150	**550**
Datacentre			25	25									**50**	0	0	0	150	**200**
Virtual desktop infrastructure		3	2	3	2	3	2	3	2	3	2		**25**	0	0	140	0	**165**
Equipment refresh	4	4	5	4	4	5	4	4	4	4	4	4	**50**	30	30	50	50	**210**
Sub total IM&T	**375**	**36**	**60**	**106**	**61**	**62**	**75**	**45**	**61**	**46**	**44**	**29**	**1,000**	**1,170**	**1,445**	**1,265**	**1,120**	**6,000**
ESTATE IMPROVEMENT SCHEMES																		
GE Turnkey works for Radiology equipment replacement programme			50				100			250			**400**	40			250	**690**
Southport A&E Redesign		100	50	50	50	50	50						**350**					**350**
Ward reconfigurations		40		100									**140**					**140**
Medical gasses	15	15											**30**					**30**
UPS Theatre		50											**50**					**50**
Waste management storage facilities			50	50									**100**	80				**180**
Theatre airplant controls				45									**45**					**45**
Generator connectors			65										**65**	65				**130**
Fire compartmentation			30	30	45	30	30						**165**	350	350	350	350	**1,565**
Fire Precautions - Fire Doors					45								**45**	300	300	300		**945**
Discharge lounge		35	35										**70**					**70**
Spinal isolation works				25	50	50	75						**200**					**200**
Capital team	15	15	15	13	13	12	12	12	12	12	12	12	**155**	155	155	160	160	**785**
Aseptic isolator						30							**30**					**30**
Legionella prevention													**0**	60		60		**120**
Fire alarm programme													**0**	50	50	50	50	**200**
Fire dampers													**0**	50				**50**
CCTV													**0**	150	150	150		**450**
Sub total ESTATE IMPROVEMENT SCHEMES	**30**	**255**	**295**	**313**	**203**	**172**	**267**	**12**	**12**	**262**	**12**	**12**	**1,845**	**1,300**	**1,005**	**1,070**	**810**	**6,030**
FACILITIES																		
Catering equipment			60			40							**100**	75	75	75	75	**400**
Vehicle replacement													**0**		100		100	**200**
Accommodation refurbishment													**0**	30	30	30	30	**120**
Sub total FACILITIES	**0**	**0**	**60**	**0**	**0**	**40**	**0**	**0**	**0**	**0**	**0**	**0**	**100**	**105**	**205**	**105**	**205**	**720**
CONTINGENCY	**30**	**25**	**30**	**25**	**30**	**25**	**25**	**30**	**25**	**25**	**25**	**24**	**319**	**387**	**337**	**387**	**567**	**1,997**
Capital plan excluding donations and IFRIC 12	**435**	**466**	**445**	**494**	**764**	**299**	**417**	**87**	**198**	**333**	**181**	**65**	**4,184**	**4,162**	**4,042**	**4,027**	**4,002**	**20,417**
Donated asset; equipment			30			30			30			30	**120**	150	150	150	150	**720**
GE Radiology equipment replacement programme (IFRIC 12)			175	172	210	235	350	250	96	680			**2,168**	300	543	39	1,021	**4,071**
Veolia energy centre contract (IFRIC 12)															724			**724**
Sub total Donations and IFRIC 12	**0**	**0**	**205**	**172**	**210**	**265**	**350**	**250**	**126**	**680**	**0**	**30**	**2,288**	**450**	**1,417**	**189**	**1,171**	**4,791**
TOTAL CAPITAL SPEND	**435**	**466**	**650**	**666**	**974**	**564**	**767**	**337**	**324**	**1,013**	**181**	**95**	**6,472**	**4,612**	**5,459**	**4,216**	**5,173**	**25,208**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

2 May 2018

Agenda Item	**TB124/18**	**Report Title**	**Board Assurance Framework (BAF)**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Interim Company Secretary		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Key Messages and Recommendations

We continue to improve the Board Assurance Framework in terms of format and updating and monitoring of risks.

The whole BAF is now on Datix and a monitoring and reporting framework via the electronic risk management system is being developed with the help of Business Intelligence. Placing the BAF on Datix it provides a one-stop-shop through which Risk Owners receive alerts about the update of their risks, controls, assurances and action plan and help them to take a *Just In Time* approach to managing their risks.

Although risk areas have received assurances and additional controls were put in place, the risks scores remain the same as the changes were not significant enough to warrant a lowering of scores.

The **Tables 1** below explains levels of assurance and Table 2 gives additional assurances received since the last report to the Board..

Updates in **Appendix 1,** the BAF risks, controls, assurances, gaps and action plans, are shown in RED Font.

Recommendation

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

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

- ✓ **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…..)*

- ✓ Annual Business Plan Priority
- ✓ Best Practice
- ✓ Linked to a Key Risk on BAF / Risk Register Ref No.: _____
- ✓ Other List (Rationale) _____
- ✓ Service Change
- ✓ Statutory requirement

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

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

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

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

Previously Presented at:

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

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

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

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

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

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

For Information: Literally, to inform the Board

PURPOSE OF THE REPORT

The purpose of the report is to update the Board on the latest position with regards to the principal risks that threaten the achievement of the Trust's strategic objectives and to give assurance of controls in place and planned actions to close gaps in both controls and assurance. This is the first BAF report for the 2018-19 financial year. The report will come to the Board on a quarterly basis with a review in September.

KEY ISSUES

The whole BAF is now on Datix and a monitoring and reporting framework via the electronic risk management system is being developed with the help of Business Intelligence. Placing the BAF on Datix it provides a one-stop-shop through which Risk Owners receive alerts about the update of their risks, controls, assurances and action plan and help them to take a *Just In Time* approach to managing their risks.

Although risk areas have received assurances and additional controls were put in place, the risks scores remain the same as the changes were not significant enough to warrant a lowering of scores.

The **Tables 1** below shows the objectives and principal risks for 2018-19 and the areas of concerns that are the key drivers of the objectives and principal risks.

Table 2 explains the levels of assurance received against the principal risks and **Table 3** gives additional assurances received since the last BAF report to the Board.

Updates in **Appendix 1-** the BAF risks, controls, assurances, gaps and action plans, are shown in **RED TYPE**

Table 1- objectives for 2017/18 and the associated principal risks

Key Area of Concern	Proposed Objective	Principal Risk
Lack of Strategic Direction	***SO1 Agree with partners a long term acute services strategy***	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards
Aspects of Clinical Quality, e.g. mortality figures	***SO2 Improve clinical outcomes and patient safety***	Poor clinical outcomes and safety records
Financial Performance	***SO3: Provide care within agreed financial limit***	Failure to live within resources leading to increasingly difficult choices for commissioners
Performance on statutory targets	***SO4 Deliver high quality, well-performing services***	Failure to meet key performance targets leading to loss of services
Staffing Issues, including morale, sickness levels and need to meet safe staffing levels	***SO5 Ensure staff feel valued in a culture of open and honest communication***	Failure to attract and retain staff
Managerial capacity and capability	***SO6 Establish a stable, compassionate leadership team***	Inability to provide direction and leadership

LATEST POSITION ON BAF RISKS

. **Table 2 Levels of Assurance explanations are set out in the table below:**

Level 1	Received via Operational (management) activities, reports etc
Level 2	Received via oversight functions- by the Board and/or Committees
Level 3	Received via Independent sources (Audits/Reviews/Inspections)

Table 2 shows where assurances on the effectiveness of controls were received or monitored

Risk No.	Principal Risks	Level1	Level 2	Level 3
1	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards	**6** ETM CEC MoG	**9** QSC FPI Board	**2** Audit Committee MIAA
2	Poor clinical outcomes and safety records	**9** ETM CEC MoG	12 QSC Board WFC Board	**4** CQC Report/NHSI Compliance Reports MIAA EY -Patient Flow Project
3	Failure to live within resources leading to increasingly difficult choices for commissioners	**12** CBUs Budget Meetings/Governance Meetings	**6** **FPI** **Board**	**1** Audit
4	Failure to meet key performance targets leading to loss of services	**12** CBUs Governance meetings	**15** FPI QSC IM&T IGSG Board	**2** NHSI SOF Returns EY –Patient Flow Project
5	Failure to attract and retain staff	Multiple PDRs	**3** WFC Board	1 NHSI Single Executive Leadership Plan
6	Inability to provide direction and leadership	• New substantive CEO appointed and started • New Director of Nursing starting in May • Two new NEDS appointed -full complement of NEDs in place • Executive Leadership Plan developed and shared with NHSI	**6** WFC Board	**1** NHSI

Recommendation:

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

NHS
Southport and Ormskirk Hospital
NHS Trust

Appendix 1 SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST-BOARD ASSURANCE FRAMEWORK AS AT 2 MAY 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 1: 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	**(LxS)** **3x5** **15**	**Clear/operational** strategy developed with commissioners. • Commissioner alignment meetings in place. • Contingency plans for withdrawal from services developed. Operational Plan Board to Board meetings with CCGs Sefton Transformation Board Programme **Service change Programme with KPMG (Acute Services Transformation)** **Deliver Northern Clinical Senate Report Clinical Pathways**	Reported to Board: • CEO's reports to Board – **Strategic Direction (L1)** • Director of Clinical Services reports re review of services (**L1**). • Finance Reports include contractual and commissioning issues, where relevant. (**L1**) • Progress of agreeing contracts reported via Finance to Board annually (**L1)** Reported elsewhere • Minutes of Network/Alliance meetings (**L2**). • Update reports from Community Partnership Network (**L2**).	**Monthly** Board – CEO Report **Monthly** CBUs Governance meetings **Monthly** FP&I; Board **Monthly** CEO Report **Monthly** FP&I Report • **Monthly** meetings with CCGs DoF's Monthly Report to Board	**(LxS)** **3x5** **15**	Operational Plan not visible and sighted Communication and Engagement Strategy not in Place No 5 Year Strategic Plan Quality & Clinical Workforce Engagement **Strategic Plan not yet in place, cascaded, embedded and sustained.**	Business Cases involving commissioners reported, where these occur (**L1)** Not well led. Leadership Governance Culture from CQC Report	**CEO/ COO**	Consider the need for review of strategic planning • Produce reports on Operational Plan to the Board Develop, implement, embed and review Communication and Engagement Strategy Strategic Plan to be developed Clinical Strategy to be developed Quality Strategy to be developed	**July 2018** **July 2018** **July 2018** **July 2018** **July 2018** **July 2018**	⟺	**(LxS)** **3x4** **12**

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**
	plans. **Potential Impact:** Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance.		IT Strategy Healthwatch liaison meetings Friends and Family Test Local patient questionnaires and feedback **Pledge Groups x 8** Patient survey Dementia Friends Complaints and Compliments Policy Safe At All Times Vanguard and partnership working- mutual aid Local Authority Scrutiny Committee attendance A&E delivery Group Commissioner Contract and Quality Meetings Discharge to assess with community providers and commissioners **Referral Assessment Service**	• Minutes of Monthly Contract Review Meetings (**L2**)) CEO Patch Meetings-monthly **(L2)** **Sefton Transformation Board** **Service change** **KPMG Service Change Project**	Executive Team meeting-weekly								

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 2: Improve clinical outcomes and patient safety												
	Principal Risk 2: ***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 experience. • Increase in serious untoward incidents • Increase in litigation • Decrease in retention • Increase in sickness • 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	**(LxS)** **3x5** **15**	Quality Visits by NEDs and EDs Duty of Candour **Policy** Healthwatch Review Freedom to Speak Up **Policy** Freedom to Speak Up Board (NED Lead) appointed by Board **Substantive** Speak Up Guardian Appointed Freedom to Speak Up Policy Monthly CBU Quality and Safety Reports Incident Reporting **STEIS Monthly** Quality Account CQC Improvement Plan **(2016 & 2018)** Partnership working across STPs Trust SCOPE Values "Safe at all times" Programmes established. Governance structure and	STEIS and Incident Reporting FPPT Report for staff Statutory Governance Reports Staff Magazine Integrated Performance Report **Safe Staffing Report - monthly** **Patient Experience Report** **E&D Manager appointed** Annual Report Quality Improvement Patient Flow Project by EY QIDG Lessons Learned Bulletin Trust News	Quality and Safety Committee (L2) Board (L2) Workforce Committee (L2) Clinical Effectiveness Committee (L1) Quality Improvement Development Group –weekly (L1) Patient Flow Project Report-weekly to ETM (L1) **A&E Performance Report - monthly** Monthly Report to Board (L2) Infection Control Report Safeguarding Annual Report Health & Safety Annual Report	**(LxS)** **3x5** **15**	Lack of robust Feedback from Staff and patients Clinical leadership development to provide a culture of trust and candour **Staff engagement strategy** Perceived inequity of treatment or rewards between and within staff groups No Clinical Engagement Strategy Communication and Engagement Strategy not in Place Workforce Strategy not embedded.	No Workforce Strategy No **Staff** Engagement Strategy **Lack of substantive MD – interim for past 7 months.** **No date of engagement strategy** Local FTSU Champion Workforce Strategy not yet embedded and sustained. Governance Strategy not fully embedded **Safety indicator not yet achieved.** **A&E performance indicator not yet achieved**	**DoN/ MD**	FTSU Champions across the Trust to be appointed Developing the Experience of Care Strategy (including FFT). Finalise Workforce & OD Strategy Develop Clinical Engagement Strategy Implement Recommendations of Culture Review Robust medical job planning process to be in place Plan Develop Workforce and OD Strategy **Establish Hospital Management Board**	**June 2018** **June 2018** **May 2018** **June 2018** **July 2018** **May 2018** **June 2018** **May 2018**	⟺	**(LxS)** **3x4** **12**

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**
	requirements. Increased mortality CQC Improvement Plan Report NHS Resolution Scorecard External NRLS (Q&S)		processes National patient surveys **Friends & Family Test** Patient forum and patient groups.(monthly) 'You Said, We Listened, We Did' Boards. **Newly approved Risk Management Strategy** **Corporate Risk Register** Lessons learned feedback to Board (monthly) Trust Vision and Values Strategic Objectives Board Assurance Framework Extreme Risk Register Operational Plan 2017/18 HR Policies Care for You programme Staff Engagement **Staff Survey** Maternity services Strategy Learning from Deaths	**Mortality Report Monthly** **Mortality Operational Group (MOG) established** CQC Report-Well Led Dr Foster Information Internal Audit Accounts National Audit	Staff Survey (see Q&S Workflow) **CQC Action Plan** **Well led Action Plan**		Quality Improvement Strategy not yet embedded. Developing gap in Care Strategy IMT strategy not finalised **Lessons learned, not fully embedded and reported on.** **Many HR Policies out of date and need updating**	Lack of robust Senior Management Forum for all Senior Staff to be involved in contributing to direction of Trust **Programme to control High mortality figures**		Embed and sustain Lessons Learned from SUIs and other incidents **Work of Mortality Operational Group to be actioned** **Embed and sustain Quality Improvement Strategy** **Embed Workforce Strategy** **Finalise IM&T Strategy** **Improve CQC rating**	**May 2018** **May 2018 and Ongoing** **June 2018 & Ongoing** **July 2018** **May 2018** **May and Ongoing**		

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**
			Trust Governance Report Safer Staffing (Medical & Nursing) Monthly Staffing Report Partnership Working – NHSI Workforce					**HR Policies not all up to date**		**Robust Programme of Monitoring to be put in place.**	**May and Ongoing**		
Strategic Objective 3: Provide care within agreed financial limits.													
	Principal Risk 3: ***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 to manage outstanding historic debt. • Services display poor cost-effectiveness *Failure to streamline corporate services. **Potential Effect**: • Additional CIPs may need to be identified and delivered. **Potential Impact:** • Reductions in services or	**(LxS)** **4x4** **16**	5 year long term financial model (LTFM) Cash support through agreed loan arrangements Annual Financial Plan including target to reduce underlying deficit Financial governance arrangements in place at a number of levels :- - FP&I committee and: - CBUs (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. CIP reviews through fortnightly Sustainability Servicing meetings.	Finance, Performance & Investment Committee (**L2**) NHSI Quarterly Review Meeting (**L3**) Internal Audit plan **(L3)** Fortnightly Sustainability Scrutiny meetings (**L1**) FPI-monthly meetings **(L1)** BAF-Quarterly to Board and Audit Committee (**L1**) 13 week rolling cashflow forecast agreed by NHSE.(L1) CBUs Financial Managers & Budget	Finance, Performance & Investment Committee Internal and External audit reports and opinion at Audit Committee Performance Meetings Executive Team Meeting Weekly Update Turnaround Director appointed in January 2018 to develop Financial Recovery Plan.	**(LxS)** **4x4** **16**	Governance arrangements for budgetary control and performance management not yet mature and inconsistency regarding format/level of challenge across CBU directorate. Modelling of Care for You programme into 5 year LTFM to provide savings from any reconfiguration in line with STP strategy **No control over sanctions**	No CIP plan for 2018/19 or beyond Lack of robust Financial recovery Plan that delivers an acceptable I&E deficit positon	**DOF**	Fortnightly discussion with NHSI regarding financial position to continue Modelling of options likely to emanate from Northern Clinical Senate with Trust input 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	**Ongoing** **May & Ongoing** **Ongoing** **May 2018**	⟺	**(LxS)** **3x5** **15**

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	the level of service provision in some areas. • Potential loss in market share and or external intervention.		Financial Turnaround Director in situ Director of Finance Report to FP&I and Trust Board NHSI's Southport Monthly Improvement Board. **Control total currently below £30m**	Holders (L1) CIP Reviews through fortnightly Sustainability Scrutiny Meetings **CIP Board Reports** **BAF/Risk Register**			**enforced by CCGs**						
	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 deliver NHS Constitutional Targets** • Failure to deliver the quality aspects of contracts for the commissioners • Patients experience indicators may show a decline in quality • Breach of CQC regulations • Poor Bed Management processes impact on patient safety **Potential Effect:** • Poor patient outcome and standards of care. • Inaccurate or inappropriate	**(LxS)** **4x4** **16**	Performance Management framework (awaiting sign-off following changes to NHSI's SOF and CQC inspection regime) Performance Development Framework (signed-off by Board) Monthly case note reviews IM&T Strategy Data Quality Policy & Reporting Integrated Performance Report + FP& I + Trust Board A & E Estates Redesign Plan 62 day cancer cre plan Southport and Ormskirk Safe at All Times Programme	Performance and Investment Committee NHS Improvement. Board Monthly Mortality Operational Group Monthly Mortality Monthly Performance Frameworks meeting CBU governance meetings QIA process to approve all CIPs Monthly contract meeting with Commissioners Engagement of EY	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)	**(LxS)** **3x5** **15**	Delivery of A&E 4 hour target Mortality Improvement Project Management of sickness absence **CQC areas of 'must dos'**	A&E 4 hour target longstanding issues in relation to poor patient flow and subsequent impact Sickness absence amongst the worst rates of all acute Trusts. Poor performance a longstanding issue Mixed sex accommodation –due to poor patient flow across the hospital estate, no assurance can be given in relation to breaches within critical care	**DoN**	HR to take urgent steps to amend Sickness Absence Policy Linked to engagement of EY to resolve long-standing patent flow issues. IT Strategy to be cascaded and embedded Address diagnostic waiting times Clear and	**May 2018** **May & Ongoing** **May and Ongoing** EY Project continuing –July 2018	⟺	**(LxS)** **3x4** **12**

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	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		EY Patient Flow Improvement **Project** CBUs Governance processes Risk Registers Leadership Executive Group Team Meetings	to address patient flow **CQC Action Plan** **CQC Well-led Action Plan**				when patients are ready to be moved to a general ward. Diagnostic waiting times not met 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		concise integrated performance report format and content to be agreed	May 2018		

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								have been realised but underlying issues within certain tumour groups remain Mortality: above expected limits for some time					
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 productivity • Higher than average sickness rates **Potential Impact:** • Poor patient experience	**(LxS)** **3x4** **12**	Workforce: • Improved recruitment and induction processes. • Divisional Staff induction *Corporate staff Induction • Education and development processes in place. • Appraisal compliance and training attendance monitored *Mandatory training Robust employment checks Disclosure Barring Service (favour CRB) Quality Visits by NEDs and EDs **Fit & Proper Person Test** Professional Bodies Checks and Balances for clinicians	Reported to Board • ADHR of Workforce Reports to Board (**L1**), • Staff survey and values update work reported specifically and through Quarterly workforce reports (**L1**). Annual NHS Staff Survey (**L3**) NHSI's Single Oversight Framework-Workforce metrics (**L3**) Appraisal and PDRs (**L1**) Staff Induction (**L1**) **Staff Survey (L1)** **Pride Awards**	Workforce & OD Committee-January 2018 Executive Team Meeting-weekly Corporate Induction - monthly JNC meeting-monthly JSMC meeting – bi-monthly E&D meeting – monthly CEO Walkabout Joint Quality Visits by NEDS and Executive Directors (Weekly)	**(LxS)** **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	No Communication & Staff Engagement Strategy No Organisational Development Strategy Survey Action Plans. • Value based interviewing project Inability to finance key projects relating to staff development No Staff Survey update report to the Board No Board Development Plan	**CEO/ ADHR**	New Policy to be Developed, approved, cascaded and embedded Workforce Strategy to be developed **Organisational Development Strategy to be developed** Communication & Engagement Strategy to be developed Take Staff Survey Report to the Board Continue to work with NHSI to	**June 2018** **May 2018** **May 2018** **June 2018** **Ongoing** **Ongoing**	⟺	**(LxS)** **3x3** **9**

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	and outcomes. • Poor CQC assessment results. • Poor patient survey results. • Loss of reputation embed new ways of working. CEO/Senior Team Visits CEO Focus Group • Reduced ability to deliver high quality service with low morale • Poor response to NHS Staff Survey		(NMC/GMC) Duty of Candour/Safe Care **Clinical review – policy in place** Staff Survey Sickness Absence Policy – under review Staff Engagement Strategy Speak Up Champion Speak Up Guardian Recruitment Strategy Retention Strategy Annual staff Appraisal Executive blog		Working with NHSI on Recruitment and Retention		comprehensive Exit Interview Procedure No Freedom to Speak Up Guardian yet appointed No Staff Consultation Engagement Strategy	And Board Development Workshops in place No Annual Staff Award **No Staff Recruitment Strategy** **No Staff Retention Strategy**		improve Recruitment and Retention As part of Annual Plan, develop Cycle of Board Development Re-instate Annual Staff Award Exit Interview Procedure to be developed and activated **Develop Staff Engagement Strategy**	**To be completed May 2018** **Sept 2018** **June 2018** **June 2018**		

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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	**(LxS)** **3x4** **12**	Trust's Mission & Value Single Leadership Plan accepted by NHSI Substantive CEO appointed **Substantive DoN appointed** **E&D Lead appointed** Training, education and development (TED) strategy & programmes based on training needs analysis. Leadership and people management policies, processes & professional support (including management training & toolkits) Staff support and occupational health and wellbeing arrangements at Trust, CBU and service levels Monthly and quarterly monitoring of Workforce Performance Committee Deep dive reports to Committee investigating specific issues when required. Staff Engagement Strategy Grievance & Disciplinary Policies Staff Survey	Workforce & Organisational Committee (**L1**) Staff Survey (**L2**) Staff Side Meeting with Management (**L2**) Trust's Vision and Values (**L2**) Internal Audit Reports (**L3**) Fit and Proper Persons' Test(FPPT) (**L3**) Directors' Code of Conduct (**L2**) Declaration of Interest for Board and Senior Managers (**L2**) Gifts and Hospitality & Commercial Interest Policy (**L2**) Standard of Business Conduct and Conflict of Interest Policy (**L2**) PDRs (**L1**) Board of Directors	Monthly Workforce & Organisational Committee Monthly Remuneration Committee Monthly Leadership Executive Group Weekly Executive Team Meeting NEDs' Orientation and Induction Pack being reviewed OD Plan at April Board Regular reports to Board as necessary: • Integrated Performance Report • Annual H&S Report) • *HR & Workforce Report*	**(LxS)** **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	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 No Healthcare Leadership Model - self assessment tool 360 degree	**CEO/ ADHR**	Board Development Programme Diversity Training for staff Develop Organisational Development Strategy - Presented at Board-to be embedded Equality & Diversity Policy Monitoring and reporting to Board and committees to be developed Staff Engagement Policy to be developed Develop and Implement R & R Strategy	**Drafted-completion May 2018** **May 2018 and Ongoing** **May 2018** **June 2018** **June 2018** **June 2018**	⟺	**(LxS)** **3x3** **9**

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			Data Protection Policy GDPR Employment checks FPPT & Code of Conduct Personal Development Review Non-Executive directors' (NED) Skills mix Academic & Professional qualifications Unitary Board: Non-Executive and Executive directors are jointly responsible for decisions taken by board Governance Structure Board Development Session Board Timeout Sessions HR Governance Meetings Workforce Committee Healthcare Leadership Model • self-assessment tool • 360 degree appraisals • Edward Jenner online leadership programme • Management & Leadership Apprenticeships Essential HR skills for managers	Annual FPPT and Code of Conduct (**L2)** LA reports to Audit Committee (**L3)** External Auditors Reports(**L3**) Counter Fraud Report to Audit Committee(**L3)** Declaration of Interests at every Board and Committees(**L2)** Health and Wellbeing Action Plan Education & Monitoring Report	Ad hoc reports to Board: • Staff Survey • Board Development Board Induction Corporate Induction NEDs Development Bi-Annual Staffing Report NEDs Induction Pack		committees Access to leadership development programmes for clini	appraisals						

NHS
Southport and Ormskirk Hospital
NHS Trust

Board of Directors
2nd May 2018

Agenda Item	**TB124b/18**	**Report Title**	**Trust Board Risk Register**
Executive Lead	Gill Murphy, Acting Director of Nursing, Midwifery &Therapies		
Lead Officer	Mandy Power, Assistant Director Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ✓ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Key Messages and Recommendations

Since the last meeting, no new risks have been added to the risk register.

4 risks have been removed from the Trust Board risk register, details as follows:

- 1760 – Equality & Diversity Lead – risk has been downgraded to high following recruitment process. Risk will be closed when E&D Lead in post.
- 1368 – Safe Staffing – risk has been downgraded to high due to Trust achieving compliance with safe staffing levels.
- 1701 – Failure of equipment, central monitoring suite ITU/HDU/CCU – risk has been downgraded to high following purchase of new equipment. Risk will be closed once equipment has been installed.
- 1624 – Lack of evidence of professional curiosity – risk has been downgraded to high due to further training, communication and changes to risk assessments.

The Committee is asked to:

- Review the Risk Register.
- Approve the changes that have been made to the Risk Register.

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

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…..)*

☐ Annual Business Plan Priority
☐ Best Practice
☐ Linked to a Key Risk on BAF / Risk Register Ref No.: _____
☐ Other List (Rationale) _____
☐ Service Change
✓ Statutory requirement

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

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

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

Review of the Risk register on a monthly basis.

Previously Presented at:

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

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 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 reported at CBU Governance Monthly Meetings The Director of Medical Education meets weekly with the CBU AMD's and has a fast track process directly to the Board The DoME prepares a report to update the Workforce Committee on a monthly basis The DoME attends the Board on a bi-monthly basis to provide an update 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 has failed 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 Under resourced administrative team and associated infrastructure - specifically for the recording, management and monitoring of quality assurance processes 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 ciritical 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 outsde 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	16/04/2018	16/05/2018	
Assurance	Medical Education Committee minutes of meetings Medical Education Governance Reports - CBU Governance Meetings (monthly) Regular meetings with the CEO and Executive MD to discuss progress on HENW Action Plan and organisational change The Job Planning Policy has been agreed with recognition of educational roles for Clinical/Educational Supervisors and Specialty Leads forming part of the job planning process up to March 2018 Full review of medical education governance structure to ensure that the Trust meets the GMC Standards and there is effective assurance from floor to Board Workforce Committee papers - minutes of meetings						**Gaps in Assurance**			
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						**Action Plan Due Date**	31/03/2018 04/01/2018 16/05/2018 21/06/2018 21/06/2018 29/06/2018 21/06/2018 31/03/2018 21/06/2018 21/06/2018 21/06/2018 31/03/2018 04/05/2018 21/06/2018 31/03/2018 21/06/2018	**Action Plan Rating**	Completed Completed Actions Almost Completed Actions Almost Completed Actions Almost Completed Actions Almost Completed Actions Almost Completed Moderate Progress Made Completed Moderate Progress Made Actions Almost Completed Actions Almost Completed Completed Actions Almost Completed Actions Almost Completed Actions Almost Completed Moderate Progress Made

	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.				

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 out patient 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	17/04/2018	17/05/2018	
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 SO4 - Deliver high quality, well-performing services						Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
19/03/2018	1815	Chief Operating Officer	Tracey Edwards	Patient Flow					
Description	If ability to egress out of A&E is compromised, then the department is overcrowded, resulting in patients waiting to be reviewed by medical staff exceeding national safety standards (4hr quality indicators), risk to patient's safety, privacy and dignity. Can result in patients being placed in the incorrect specialty ward bed without the correct nursing and medical skill mix, insufficient nursing staff to care for them and medical teams unable to review patients in a timely manner.								
Controls	Escalation policy in place Full to capacity protocol in place Infection control policy Daily huddles in place in ED Safer Staffing review Twice daily discharge meetings with external partners Three x daily escalation meetings Agreed SOP for escalation areas Aim to maximise limited capacity in ODGH EY partnership working System leadership support ED Safety Checklist Intentional rounding for ambulance queues SAFER now in place on wards, supporting expediting discharge						**Gaps in Controls**	Delay to see the patient in ED may cause harm to the patient Insufficient medical and nursing staff, particularly in ED Insufficient realtime bed availability data No permanent Integrated Discharge Team Lack of community/social care capacity No Discharge Lounge	
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	17/04/2018	17/05/2018
Assurance	Safecare/Acuity/Staffing monitoring Command and control system to support escalation by a Senior Manager Harm meetings across all CBU's Monitoring of bed occupancy Daily meetings at EMS 3 or above with regional partners Infection control monitoring						**Gaps in Assurance**		
Action Plan	Additional building to create more capacity in ED and modular building to create a CDU. External partners have agreed to fund an Integrated Discharge Team. To deliver and embed the 'Safe at all Times' project, to improve the recognition and response to the deteriorating patient. Patient Flow Improvement Programme in place - system reset agreed with incoming CEO to take patients off the corridor. New work programme to be finalised and launched end April.						**Action Plan Due Date**	31/05/2018 31/07/2018 01/06/2018 29/06/2018	**Action Plan Rating** Actions Almost Completed Moderate Progress Made Moderate Progress Made Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team					Link to BAF	BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).				
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, 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	24/04/2018	31/05/2018
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** 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	Long term financial model and an estate solution based on the sustainability report completed by the Deloitte in 2015. The Care for You programme built on the Deloitte findings. This has now been supported by the Northern Clinical Senate report. Trust is part of the Cheshire & Mersey Health & Social Care Partnership (STP); the Sefton Transformation Board provides oversight of the Care for You Programme Trust is member with Alliance LDS .						**Gaps in Controls**	The need to model the STP/LDS assumption in LTFM Accuracy of PLICS data and Model Hospital West Lancashire CCG member of Healthier Lancashire & South Cumbria (STP)
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	6	Moderate risk	24/04/2018	31/05/2018
Assurance	Monthly report to Trust Board re Progress of the Sefton Transformation Board Long Term Financial Model (LTFM)						**Gaps in Assurance**	No agreed clinical model for reconfiguration of services	
Action Plan	Development of Estate plan for reconfiguration of services; identification of land sales to support capital development costs Development of a financial revenue plan with savings for the reconfiguration of services 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 NHS Trust

PUBLIC TRUST BOARD

2nd May 2018

Agenda Item	TB125/18	Report Title	Compliance with NHSI's Provider Licence
Executive Lead	Silas Nicholls, 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

The Trust is required to submit a return as part of its annual reporting process.

Under Guidance issued by NHS Improvement (NHSI), the Regulator, the Trust is required to self-certify regarding compliance with Provider Licence Conditions: **G6 and FT4.** Where the Trust is not compliant it is required to explain why and develop an action plan to achieve compliance.

This report relates to **Condition G 6** and **FT4** of The NHS Provider Licence with evidence of the Trust's compliance.

The Board is required sign off on the self-certifications by the following deadlines:

- ***Condition G6: 31 May 2018***
- ***Condition FT4: 30 June 2018***

NHS Trusts are not required to submit their reports of compliance to NHSI but from July 2018, it may be asked to provide evidence of that compliance as part of a sample test by the regulator. Despite the deadlines for submission being different, it is recommended that the Board signs off both at the same time as the evidence for both have been provided.

This paper asserts that there is substantial evidence to suggest that the Trust is compliant with **Condition G6-**(2) which requires NHS Trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to prevent them from occurring

The report also asserts that the Trust is not compliant with Condition FT 4: which requires that:

- Providers should review whether their governance systems achieve the objectives set out in the licence condition.

- Compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems.

A Plan of action in order to be compliant is attached to this Condition.

Recommendation:
The Board is asked to **review** the evidence and **approve** the self-certification

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

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

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

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

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

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

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

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

Introduction

Last year was the first year that NHS Trusts self-certified. Although NHS Trusts are exempt from needing the provider licence, they are required to comply with conditions equivalent to the licence that NHSI has deemed appropriate.

The *Single Oversight Framework* (SOF) bases its oversight on the NHSI Provider Licence. NHS Trusts are therefore legally subjected to the equivalent of certain provider licence conditions (**including Conditions G6 and FT4**) and must self-certify under these licence provisions.

NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. **The self-certification requirement set out in Condition CoS7(3) does not apply to NHS Trusts.**

The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions.

Southport and Ormskirk Hospital NHS Trust is required to self-certify against two of the original 6 categories of Conditions issued by NHSI and last updated in 2013.

The Trust is required to self-certify against the following two Conditions:

Condition G6- G6 (2) requires NHS Trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

The Trust must answer a series of statements as "***Confirmed***", if Compliant and "***Not Confirmed"*** if Non-compliant". It there is non-compliance, the Trust must explain why and list actions to achieve compliance

Condition FT4 (8)

Despite not being a Foundation Trust NHSI requires the Trust to self-certify against this condition as well which requires that:

- Providers should review whether their governance systems achieve the objectives set out in the licence condition.

- Compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems.

The Board must sign off on the self-certifications by the following deadlines:

- ***Condition G6: 31 May 2018***
- ***Condition FT4: 30 June 2018***

NHS Trusts are no longer required to return their completed licence self-certifications or templates to NHSI; instead, from July 2018, NHSI will contact a select number of NHS Trusts and Foundation Trusts to ask for evidence that they have self-certified. This could be done by either providing the completed templates, if used, or relevant Board minutes and papers recording sign-off.

Appendix 1 below is used as a self-certification against the two conditions.

Recommendations:

The Board is asked to **review** and **approve** the self-certification

Appendix 1 KEY: C=Confirmed NC=Not Confirmed

SELF ASSESSMENT OF COMPLIANCE WITH NHSI PROVIDER LICENSE CONDITIONS G6 and FT4 2017-18						
	License Condition	**Executive Lead**	**Compliance C/NC**	**Narrative**	**Evidence of Assurance**	**Identified Further Actions**
	G6: Systems for Compliance with Licence Related Conditions and Related Obligations *Requires providers to take all reasonable precautions against the risk of failure to comply with the license and other important requirements* 1 a) the Conditions of this Licence, these being: (i) the Trust must be registered with the Care Quality Commission (CQC); and (ii) the directors of the Trust must meet the regulator's fit and proper persons' test. 1 b) any requirements imposed on it under the NHS Acts 1 c) the requirement to have regard to the NHS Constitution in providing	CEO	**C**	The Trust has remained registered with the Care Quality Commission throughout 2016-17 There is a robust Fit and Proper Persons Regulation Policy (FPPR) in place. There were no additional requirements imposed on the Trust under the NHS Acts during 2016/17 The Trust continues to have regard to the provisions contained within the NHS Constitution through the	CQC Registration Certificate Directors' FPPT signed Declaration DBS Certificates Regulation 3 Pre-Employment checks- Personnel File Patient	None

	health care services for the purposes of the NHS **2) Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:** 2a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence		**C**	formulation and adoption of Trust policies and procedures. The NHS Constitution is in line with the Trust's overall values and vision of high quality care for all. The Trust's governance structure reflects the needs of the NHS Constitution and the rights and pledges of patients and staff. The Trust has an approved Risk Management Strategy and approach to identifying, managing and escalating risk. This has recently been brought to the Board for ratification after it was reviewed and updated. Risk registers are maintained by each Clinical Business Unit and Corporate Directorates. Regular review of these enables the escalation of risk that is above acceptable levels to the Executive Team. Risk Registers are reviewed by the Quality and Safety Committee and Finance and Performance Committee on a monthly basis and by the Audit Committee quarterly. The Trust Board reviews the highest risks facing the organisation on a	Experience Group Pledge Group Trust's Statutory Instruments Trust's Prime Policies Risk Management Strategy and Policy Governance Structure Board Assurance Framework Board Reports Audit Committee Reports	

	2b) regular review of whether those processes and systems have been implemented and of their effectiveness.		**C**	monthly basis and where required requests further action to be taken. The Board developed a Board Assurance Framework (BAF) for 2017-18 based on the Trust's refreshed and refined strategic objectives. This is reviewed by the Board on a quarterly basis; and the Board Committees on a monthly basis and at the Audit Committee quarterly. The Audit Committee receives assurance of the effectiveness of the system of internal control The Trust has in place an incident management process which incorporates root cause analysis and lessons learned. There are mechanisms in place to ensure that lessons from any incidents are cascaded throughout the organisation although these are being improved. The Chief Accounting Officer's Annual Governance Statement considers the effectiveness and implementation of the Trust's processes and systems each		

				year. In addition to this the Audit Committee oversees the delivery of the Programme of Internal Audit which focuses on any areas of the control system where independent assurance is required. The Board and its Committees undertake a review of their performance and effectiveness on an annual basis and identifies areas for improvement. Their revised Terms of Reference have suggested that the review should be undertaken twice annually.		
	NHSFT4: Foundation Trust Governance *Enables NHSI to continue oversight of governance of NHS Foundation Trusts.*	Company Secretary	**N/C**	The Trust is not fully compliant with this condition. The CQC Inspection pointed out that there are areas of governance that needed to be improved.		The following are steps needed to improve governance arrangements and achieve compliance. KPMG has been asked by the CEO to undertake a review of the governance structure, delivering recommendations for improvement end of May 2018. The recommendations regarding governance by CQC will be delivered within the agreed timescale.