NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 11:30 – 14:00 on Wednesday 6th June 2018
Seminar Room, Clinical Education Centre, Southport District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Time
PRELIMINARY BUSINESS			
TB132/18 (V)	**Chair's welcome & noting of apologies** To **note** the apologies for absence **Apologies**: Audley Charles, Annual Leave	**Chair**	**11.30**
TB133/18 (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**	
TB134/18 (D)	**Minutes of the Meeting held on 2nd May 2018** To **approve** the minutes of the Board of Directors	**Chair**	
TB135/18 (D)	**Matters Arising Action Log** To **review** the Action Log and receive relevant updates	**Chair**	
STRATEGIC CONTEXT			
TB136/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**11.40**
QUALITY & SAFETY			
TB137/18 (P)	**Staff Story: Meg Langley (Medical & Surgical Therapy Team Leader): 'Older People's Day'** To **receive** the presentation and **discuss** learning from the above	**Michelle Kitson**	**11.50**
TB138/18 (D)	**Quality & Safety (Q&S) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of QSC**	**12.00**
TB139/18 (D)	**Quality Improvement Plan Progress Update (In response to CQC Report –March 2018)** To **receive** the monthly report	**DoN**	**12.05**

Ref No.	Agenda Item	Lead	Time
TB140/18 (D)	**Freedom to Speak Up Update Report including:** • **Progress Against Action Plan** To **receive** the monthly report	**DoN**	**12.15**
TB141/18 (D)	**End of Life Strategy** To **approve** the strategy	**Dr Karen Groves Consultant, Palliative Medicine**	**12.25**
TB142/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**IMD**	**12.35**
TB143/18 (D)	**Workforce Committee (WFC): Alert Advise & Assure Report** To **receive** a highlight report including any escalated risks from the Committee	**Chair of WFC**	**12.45**
TB144/18 (D)	**Monthly Safer Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**12.50**
PERFORMANCE			
TB145/18 (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**	**13.00**
TB146/18 (D)	**Emergency Care Performance Report Including 4 Hour Access Patient Flow** To **receive** a monthly update report	**COO**	**13.05**
TB147/18 (D)	**Integrated Performance Report (IPR)** To **receive assurance** from the current position in relation to national performance targets and integrated governance	**DoF**	**13.15**
TB148/18 (P)	**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**	**13.25**
GOVERNANCE / WELL LED			
TB149/18 (D)	**Risk Management:** • **Risk Register** To **receive** the monthly report on the Risk Register	**DoN**	**13.35**
TB150/18 (D)	**Items for Approval / Ratification:** • **Uncommitted Revenue Support Loan Approval Taken under Emergency Powers by Chair and CEO on 24 May 2018**	**Chair/CEO**	**13.45**
TB151/18 (V)	**Questions from Members of the Public**	**Public**	**13.50**

Ref No.	Agenda Item	Lead	Time
CONCLUDING BUSINESS			
TB152/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**	**13.55**
TB153/18 (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**	
TB154/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**	**14.00** **CLOSE**
TB155/18 (V)	**Date and time of next meetings** Wednesday ***4th July 2018, 11.30am*** 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 15 May 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	**Pilkington Family Trust** **St Joseph's Hospice** **The World of Glass** **Pilkington Glass Collection**	**Nil**	**Nil**	**Director, St Joseph's Hospice** **Director, Pilkington Family Trust**	**Director, St Joseph's Hospice**	**Nil**	**Nil**	**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**

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COSGROVE Ms Juliette	Director of Nursing, Midwifery & Therapies	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**7 May 2018**
FRASER, Mr Richard	Chairman & Non- Executive Director	**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. Provision of coaching services to Directorate and senior NHS Management personnel**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**
GORRY, Mrs Julie	Non-Executive Director	**Catalyst Choices C.I.C.**	**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 & 4 May 2018**
MAHAJAN Dr Jugnu	Interim Medical Director	**Nil**	**Director of M&M Professional Consultancy Services**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**22 January 2018**
NICHOLLS Mr Silas	Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 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
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**
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**
SINGH, Mr Gurpreet	Non-Executive Director	**Nil**	**Owner: providing practice & GMC work**	**Nil**	**Private practice at Ramsay Health**	**Nil**	**Nil**	**Nil**	**9 April 2018**

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Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 2 May 2018

Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 6 June 2018)

Present

Richard Fraser, Chair
Jim Birrell, Non-Executive Director
David Bricknell, Non-Executive Director
Ged Clarke, Non-Executive Director
Pauline Gibson, NED Designate *
Julie Gorry, Non-Executive Director
Dr Jugnu Mahajan, Interim Medical Director
Gill Murphy, Acting Director of Nursing
Silas Nicholls, Chief Executive
Therese Patten, Chief Operating Officer
Jane Royds, Associate Director of HR*
Gurpreet Singh, Non-Executive Director
Steve Shanahan, Director of Finance

In Attendance

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

Apologies:

None

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
PRELIMINARY BUSINESS		
TB104/18	**Chairman's Welcome and Note of Apologies**	
	Mr Fraser, as Chair, opened the meeting by welcoming the Board members. He welcomed Gurpreet Singh to his first Board as a Non-Executive Director, Mr Lionel Johnson who was presenting the Patient Story and Alice Lanceley from Dr Foster. The Chair thanked Mrs Gorry and Mr Birrell for taking on recent extra responsibilities whilst the Trust was short of the full NEDs quota. The Chair finally thanked Mrs Murphy for her role as Acting Director of Nursing whilst waiting for Ms Cosgrove took up her post as Director of Nursing.	

	There were no apologies to note.	
TB105/18	**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. Dr Bricknell and Mr Singh's interests had been added to the register.	
TB106/18	**Minutes of the Meeting Held On 7h March 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 11 April. **RESOLVED:** The Board **approved** the minutes as an accurate record. The Chair noted that Dr Ruth Chapman had not seen the minutes of the February Board. These minutes to be sent to her.	**CoSec**
TB107/18	**Matters Arising Action Log**	
	The Board considered the following matters arising in turn: **Cultural Review:** the process is ongoing **TB085/18 Monthly Mortality Report:** The outcomes of Dr McManus' review to be brought to June Board **TB095/18 Board Development Programme:** Chairman to feedback at June Board following meeting on 3 May on NHSI's view of bi-monthly boards **TB095/18 Draft Annual Governance Statement:** final draft to be taken to Audit Committee on 23 May.	**ADHR** **MD** **Chair** **CoSec**
STRATEGIC CONTEXT		
TB108/18	**Chief Executive's Report**	
	Mr Nicholls stated that his first month had been a busy, productive one. He highlighted a number of issues relating to: **Urgent Care** Performance against the four-hour standard to discharge, transfer or admit 95% of patients from A&E remained 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 were priorities for the Trust. The aim over the next 12 weeks was to 'cool down' A&E and among the initiatives which would help were:	

	• The successful craning in of an eight-bay Clinical Decision Unit next to Southport A&E on 25 March and its subsequent opening on 30 April. • 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 currently 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 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 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. Mr Nicholls thanked all staff for their hard work. **RESOLVED:** The Board **received** the Report	
QUALITY & SAFETY		
TB109/18	**Patient Story: Mr Lionel Johnson – Patient and Volunteer**	
	The Chair welcomed Mr Johnson as a long-term attendee of the Board, for over 20 years. Mr Johnson thanked the Chair for the kind welcome and gave a background to his life and community involvement. In 1970 he moved to Southport with his family and was at the opening of the new Southport Hospital by the Prince of Wales on 3 May 1989. Mr Johnson's father had died of cancer of the throat, aged 53 and his mother had died of cancer of the pancreas, aged 69 which had galvanised his thought that, '*If I could do anything health-wise, I would do it.'*	

Following National Service, he worked in the entertainment world for 40 years and on occasion arranged for film stars and celebrities to visit hospitals and nursing homes, which had great effect. Following that he worked as Health and Safety Manager for a Blackpool confectionery company and eventually retired.

Volunteer Experience

He undertook over 300 risk assessments for a local care organisation that provided care in private homes, which revealed significant concerns. In 2001 he became a lay member of the Quality Outcomes Framework (QOF) and assessed GP surgeries and pharmacies. This Framework ceased for financial reasons.

He went on to volunteer for the National Blood Service, working with the Tissue Transfer Committee at a time when it was common for 30% of organs to be bacterially infected. Later, he became a lay member of the Senate, working with Geraldine Boocock as Chair, a lay member of the End of Life Strategy Steering Group and the Palliative Care Working Group in which Dr Karen Groves did wonderful work. Mr Johnson also undertook ward assessments.

Along with nurses he attended the Trust's stand on the final day of the Southport Flower Show in 2017. The initiative was well supported and well received by the public with a number of people expressing an interest in nursing.

Mr Johnson had also managed to squeeze into his busy schedule being Vice-Chair of the Churchtown Medical Practice Participation Group, a Homewatch member for 20 years as well as being a Police volunteer in the Enquiry Office. In his voluntary work he has helped shape the future of services and had been a critical friend with his views and observations.

Patient Experience

He had been very fortunate with his own health until recently and had been under the care of Dr Chris Barker, who had been wonderful, helping reduce his pain and improve the quality of his life. Mrs Sanghani had re-constructed his right eyelid and he was amazed at the result.

On January 2nd 2018, he was referred to A&E by his doctor, The chairs were hard and uncomfortable and the corridor particularly draughty and cold at that time of year. There also appeared to be a lack of communication.

Mr Johnson briefly saw Drs Nicolai and Ali before being moved to a

side-room where he could rest on a bed for an hour. In total Mr Johnson spent 10 hours in the department.

At 22:30, he was admitted to Ward 14A.

Before leaving the ward, Mr Johnson witnessed a patient in the opposite bed suffer a very severe panic attack. Five staff went to his aid and Sister Donna Walker was wonderful, with a very calming voice, talking to him, calming him down and helping him breathe naturally.

Whilst the experience in A&E was not the best, the Doctors, Matrons and Nurses did wonderfully and went above and beyond the call of duty. They were fantastic.

Mr Johnson made the following recommendations for A&E:

- Comfortable waiting chairs
- Less draughts entering the room
- More beds available
- Reduce the number of people attending

Information showed that 40% of the public presenting at the department would have been better served elsewhere. Some people don't know there are Walk-in Centres at Litherland and Ormskirk. It would be useful to have one at Hoghton Street to reduce demand on the Southport A&E.

He concluded with a quotation;
'Look to this day.
For yesterday is but a dream
And tomorrow just a vision.
But today well lived
Makes every yesterday a dream of happiness
And every tomorrow a vision of hope'

Following a round of applause, the Chair thanked Mr Johnson for an interesting presentation. His comments would be taken on board and learned from. He observed that communities needed more people like Mr Johnson.

Mr Johnson stated he had probably spent in the region of 15,000 hours on community work.

Mrs Murphy added her formal thanks for Mr Johnson's presentation and work. He was both an advocate and supporter and the team looked forward to his contribution and insight.

	RESOLVED: The Board **received** the presentation	
TB110/18	**Quality & Safety Committee - Alert, Advise and Assure (AAA) Highlight Report**	
	Mr Birrell, on behalf of Mrs Gorry, Chair of this Committee, presented the report. • Concerns were raised about the Mortality Operational Group Meeting (MOG), held on 9th April 2018, regarding outlying patients. A Working Group would review the clinical and organisational processes for the management of outliers and report to the MOG. • The CBUs were investigating how to prevent a delay of peripherally inserted central catheter (PICC) lines being placed and improve PICC line provision. Any concerns would be escalated to the Quality & Safety Committee. • There had been a delay in setting up the Hyper-Acute Stroke Service at Aintree Hospital. A meeting with executives and senior managers, which was due to take place with Aintree at the end of March had been cancelled and was being rearranged as a matter of urgency. The Performance Quality Development Strategy was moving in the right direction. **RESOLVED:** The Board **received** the update	
TB111/18	**Quality Improvement Plan Progress Update**	
	Mrs Murphy presented the report Following receipt of the CQC Inspection Report- March 2018 there were: • 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 was a risk identified in the delivery of the two 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 had to date, not been received. Mr Nicholls and Mrs Murphy had recently met with CQC which was assured that the action plan was in place and embedded with safety and quality as priorities. Jo Simpson, Assistant Director of Quality and Dr May Ng, Consultant Paediatrician and Paediatric Endocrinologist, met on 2 May to set timescales for the two SHOULD Do actions from 2016 and this would be updated. **RESOLVED:** The Board **received** the report	**DoN**
TB112/18	**Draft Quality Improvement Strategy**	
	Mrs Murphy presented the report. The Strategy had been further developed since previous discussions at Board in October 2017. The 5 quality priorities had all been reviewed to align with the Quality Improvement Plan: • Preventing harm • Reducing mortality • Safer staffing at all times • Developing the Experience of Care • Delivering Care for You The required outcomes had been identified and timescales agreed, alongside cross-referencing the CQC's Action Plan, to support the organisation to deliver safe high quality care through a journey of continual quality improvement and learning. The Board was asked to consider taking the Strategy forward and Ms Cosgrove, the incoming Director of Nursing would prioritise it if approved. A qualifying amendment would be made to the statement that the Quality & Safety Committee provided the Board with assurance that quality and safety within the organisation was being delivered to the highest level. It was also noted that Quality was the responsibility of all Board members, not just the Director of Nursing. The plan would be supplemented by ensuring that feedback loops were in place, including clinical pathways and action plans to address findings such as mortality and acute kidney injury. Outliers were down and therefore improvement was being realised, however, the AQUA and NHSI findings identified that repeatable, systematic improvement was needed on which to build on this foundation. Mr Nicholls commented that a pro-active approach to achieving a	

	CQC rating of *'Excellent'* was required with focus on doctors, data and managing the Trust's operational actions. **RESOLVED** The Board **received** the report	
TB113/18	**Monthly Mortality Report**	
	Dr Mahajan presented the report. **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 would be published in May and would be reported to the Board in June. **Hospital Standardised Mortality Ratio (HSMR):** The latest available data from Dr Foster for November 2017 showed that the Trust's rolling 12 month position at 113.2 and in-month position at 90.1; significantly below the mean. That had 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. **Structured Judgement Review (SJR):** By the end of May 2018, all junior doctors would be trained on the screening tool and would have begun the process. The main function was to crystallise the 'general feeling' from a case note review into an objective, defensible 'judgement'. This was undertaken through 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. **Reducing Avoidable Mortality** The project began in April 2018 to improve the mortality ratios for the Trust through quality improvement activity. A number of activities on the Care Pathway work stream were identified with a red RAG status but the Board was assured that pace was being put into the system, alongside resources from the PMO Team. Dr Mahajan agreed to re-circulate the duties and responsibilities relating to 'Learning from Deaths'.	**MD**

	Clarification was provided that the Crude Mortality rate in November 2017 had been 21 per 1000 discharges. The Board was assured that reviews take place very soon after death, rapidly supporting cumulative data on emerging trends, if any. **RESOLVED** The Board **received** the update	
TB114/18	**Workforce Committee - Alert, Advise and Assure (AAA) Highlight Report**	
	Mr Clarke, on behalf of Mrs Gibson, Chair of this Committee, presented the report. **Medical Education** HEENW was due to visit the Trust on 21 June 2018 and the University of Liverpool visited 25 April 2018. Whilst progress had been made to evidence improvements in medical education, that had not translated into the trainee experience due to continued service pressures and rota gaps impacting on their ability to attend training and access supervision. **Staff Survey** The staff survey results were disappointing and a concerted effort and plan to address culture and employee experience was needed as a matter of urgency. **Apprenticeships** The Trust had 42 registered apprentices across band 2-7 and in various roles. The Trust had until March 2021 to demonstrate how it would 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 would agree the objectives of a new Apprenticeship Strategy for the Trust. **E&D Lead** Ms Karen Chazen had been appointed and attended the meeting. **RESOLVED:** The Board **received** the report	

TB115/18	**Monthly Safe Staffing Report**	

Mrs Murphy presented the month's report.

The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices, showed the following overall percentage 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

The review of safe staffing in A&E continued with a full assessment of available data and utilisation of the safer nursing care tool/e-roster and would be completed by 4 May and reported to the June Board. Additionally the levels of staffing were reviewed three times daily to maintain safe staffing levels.

DoN

The recruitment and retention of nursing and midwifery staff remained a priority for the Trust and was an on-going challenge. Trust workforce data showed 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.

Discussion took place on mechanisms to recruit roles, including campaigns on vehicles; 'retire and return'; flexible days and support to overcome qualifying obstacles i.e.: Band 3 staff with insufficient Maths and/or English. The sickness and attendance policy was being

	reviewed as the current policy made it difficult to manage. It was reported that many students had been supported; however, a number still believed that the hospital would close and therefore did not view the hospital as a long-term employment option. With the permanent Chief Executive now in place, demonstrating a long-term commitment, it was anticipated that that trend would be reversed. CIP would provide benefits in this regard, examining the over or underspend and the Trust would seek smarter ways of achieving and monitoring this. It was acknowledged that the existing workforce worked very hard and there was potential to fill some volunteer roles for companionship etc. in parallel with general recruitment. Mrs Kitson was reviewing the volunteer and recruitment policy and a position statement of where the Trust was and what it wanted to achieve in relation to volunteers would be brought to the June Board. **RESOLVED:** The Board **received** the report	
TB116/18	**Director of Medical Education Report**	
	Mr Sharma presented the report. The Trust was inspected by the University of Liverpool on 25th April, 2018 and verbal feedback was that there was a culture of teaching with an atmosphere and environment of good clinical staff approach which gave students the best experience. Standards had slipped in recent years. However, with the support of Dr Mahajan, Interim Medical Director and Mrs Farrar, Interim CEO the business case for new staff was approved and is being implemented, which would improve the situation. Further information relating to staff, processes and evidence of appointments was required to be evidenced for Health Education England (NW), (HEE NW) by 25th May with a full inspection of the Trust on 21st June, 2018, in relation to its provision of undergraduate and postgraduate medical education. Mr Singh commented that undergraduates benefited from being linked to a smaller Trust, which provided a better environment. The Trust had always been valued by the University of Liverpool and had been considered the number one choice for 10-15 years, however, in recent years that had not always been the case. Mr Shanahan observed that despite the challenges, a significant volume of under-graduates came to the Trust and the numbers of surgical consultants	

	was greater than some neighbouring hospitals. The relationship with Edge Hill would be further developed now that it had been accredited as a medical school, with support from the Trust from 2020. Mr Nicholls commented that the Trust was committed to providing excellent training, education and experience for under and post graduates. The HEE NW visit of 21st June was scheduled into the appropriate calendars and a presentation was being developed, which would be rehearsed at the Executive Team meeting beforehand. **RESOLVED:** The Board **received** the report	
TB117/18	**Guardian of Safe Working**	
	Dr Ruth Chapman presented the quarterly report. There had been no episodes of Double Bleep Carrying in Paediatrics since 23 January 2018. Despite an almost fully staffed trainee physician work force, the overwhelming workload in Medicine had resulted in trainees working many extra hours and at times senior support had not been available. A briefing paper to address medical and non-medical staffing across Medical wards was presented on 30th April at the Executive Team meeting. Inadequate staffing in Medicine during Bank Holidays was now being addressed which would impact positively on the patient and staff experience. Poor trainee experience would have a negative effect on attracting future trainees. A site assessment was almost complete, including the need to enhance mess facilities. It was envisaged that the latter could be in place a month before the next changeover. Exception Reports were reduced compared with the previous quarter. December and January were difficult months, which had continued into February, however, in the last few weeks that had calmed down as demonstrated by the reduction of Exception Reports. Mr Nicholls added that he was mindful HEE NW could 'pull the plug' on the provision of education and training if it was dissatisfied. It was important that graduates returned to the hospital and the development of mess facilities, including IT and its impact must not be	

	underestimated. Results of the Medical Engagement Survey would be reported to the Workforce Committee in June. The Chair noted Dr Chapman's comment that minutes from the previous quarter report in February 2018 did not reflect the work undertaken. May Board's minutes would be provided to Dr Chapman for approval before finalising. If amendment was required for February Board minutes, an addendum could be added. **RESOLVED:** The Board **received** the report.	**RC** **ICoSec**
PERFORMANCE		
TB118/18	**Finance, Performance & Investment Committee – Alert, Advise and Assure (AAA) Highlight Report**	
	Mr Birrell, as Chair of this Committee, presented the report. • The latest draft 2018/19 Operational Plan forecasted 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 had been identified to date.) • The Trust's 2017/18 deficit was £29.2M before the application of penalties/ sanctions and the Expert Determination assessment, which increased the deficit for 2017/18 to £33.6M. As a consequence of the Expert Determination decision there will be an ongoing discussion about the methodology for charging for patients who are admitted to assessment/clinical decision units rather than inpatient beds. **RESOLVED:** The Board **received** the report.	
TB119/18	**Audit Committee – Alert, Advise and Assure (AAA) Highlight Report**	
	Mr Clarke, as Chair of this Committee, presented the report. The meeting received 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 included: • Internal Audit Annual Plan - 2018/19 • Anti-Fraud Annual Plan-2018-19 • Security Management - Annual Work Plan 2018-19 The Committee also reviewed and approved a number of key documents and Corporate Registers.	

	Mr Clarke was pleased to see progress on General Data Protection Regulations (GDPR) as part of the 2018/19 Internal Audit Plan. **RESOLVED:** The Board **received** the report	
TB120/18	**Emergency Care Performance Report including 4-Hour Access Patient Flow**	
	Ms Patten presented the report. The Trust continued to struggle to deliver against the 4 hour access target. • In March overall performance deteriorated by 1% from 80.9% • The Performance of the Walk In Centre had dropped by 2% since January affecting Trust overall position • There was a marked increase in attendances in March • 12 hour breaches rose to six, compared to February • The Patient Flow Programme had been reset to take all patients off the corridor by the end of June • In April, Trust performance was 85%, with attendances up • The number of ambulance handovers over 30 minutes had risen, which impacted on North West Ambulance Service (NWAS). **Outliers** A significant programme of work was being led by the Mortality Operational Group to better manage outliers. Progress would be reported into Quality and Safety Committee. **Discharges** There had been no significant shift in the state of discharges. Plans were in place to open the Salas area as a permanent discharge lounge with estates work underway to complete before the end of May. Staffing had been discussed with the CCGs on a 12 month basis and substantive posts for Band 4 and Band 7 being advertised. **Improvement Actions** The Chief Operating Officer (COO) had been asked to refocus the work to ensure no patients were waiting on the corridor, with a timescale of three months to achieve. The team was working with EY partners to 'reset' the programme with a reprioritisation of the work programme. 12 beds were now available at Dovehaven Group for use in Delayed Transfers of Care (DTOC), with the Trust paying only for beds used.	

	Work alongside the local authority was taking place, with patients fit for discharge moved from a hospital ward to Dovehaven in the event of complex care packages being finalised and subsequently to their residence. That capacity would be available by the 28 May Bank Holiday weekend. The Board was assured that senior clinicians would monitor those discharged to Dovehaven, with daily meetings and assessment by Medical Discharge Teams (MDTs). Any escalation required, including bed blocking would be directly to the Director of Strategy's Team. Concern was raised that increase of DTOC had previously been criticised by commissioners. It was anticipated that such step down capacity would improve the situation with careful management by MDTs to ensure patients did not re-present at A&E **RESOLVED** The Board **received** the report	
TB121/18	**Integrated Performance Report (IPR)**	
	Mr Shanahan presented the report which highlighted indicators which required discussion by Trust Board, some which required corrective actions to be taken. A brief narrative had been provided to give assurance that corrective measures were in place. Indicators within the Integrated Performance Report formed part of the Trust's new performance management framework and were discussed with the relevant teams in monthly performance forum meetings. Mr Shanahan circulated a draft dashboard. It was agreed that the format could be adapted for specific metrics and made clearer, however, oversight of the whole, complex business needed to be visible. It was envisaged the report would obviate a number of Board Reports. The following was noted: C-Diff was rated as **Red,** however, as the rate was better than the target it should have been rated **Green.** 62 day GP referral to treatment was rated as **Red**, following a good previous quarter's performance due in part to diagnostic issues, which were now back on target. Transient Ischaemic Attack (TIA) narrative was insufficient and an update was to be provided.	**COO/MD**

	RESOLVED The Board **received** the report	
TB122/18	**Director of Finance Report**	
	Mr Shanahan presented this report. **Current financial position at Month 12** • Deficit at the end of the year was £33.6m; £15.5m worse than planned • The final position included provision for sanctions (the full value of which was not applied by Southport & Formby CCG and the outcome of the Expert Determination) • Before taking account of those provisions the Trust deficit would have been £29.2m as per revised 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 represented an under-spend against the External Financing Limit (EFL) of £75k; Trusts were not permitted to over-spend against its EFL • The Capital Resource Limit (CRL) of £6.048m was under spent by £7,000 Expert Determination had been accepted. The Trust will be arranging Executive to Executive meetings with its two main Commissioners on a monthly basis to strengthen the relationships. Discussions would include de-risking the Trust's and the CCG position based on the finances available and how to move forward strategically. **RESOLVED:** The Board **received** the report	
TB123/18	**Financial Plan 2018/19, including 5 Year Capital Plan**	
	Mr Shanahan presented the report. **Financial Plan** • 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 was required to submit the final Operational Plan at midday on Monday 30 April 2018. • The financial plan for 2018/19 submitted as part of this process had increased from £33.3m to £35.8m; • A Cost Improvement Programme (CIP) of £7m (c3.5% of total expenditure) remained 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 were: • 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. **Capital Plan** • Recalculation of the 18/19 capital resource limit had reduced the value of the 18/19 plan by £10k. • The Plan was amended to include estates improvement work to create a discharge lounge and isolation works in the Spinal Injuries Unit. • Annual capital spend was consistently between £4m and £4.2m per annum (excluding donations and managed service contracts). • The revised plan was agreed at Capital Investment Group and had been to Finance, Performance and Investment Committee prior to requesting final Board approval. **RESOLVED** The Board **approved** the reports	
GOVERNANCE/WELL LED		
TB124/18	**Risk Management**	
	Board Assurance Framework Mr Charles presented the report. The entire BAF was now on Datix and a monitoring and reporting framework via the electronic risk management system was being developed with the help of Business Intelligence. Placing the BAF on Datix provided a one-stop-shop through which Risk Owners received alerts about the update of their risks, controls, assurances and action plan and help them manage their risks. Although risk areas had received assurances and additional controls were put in place, the risks scores remained unchanged as the changes were not significant enough to warrant a reduction of risk scores. **Risk Register** Mrs Murphy presented the report. Since the previous Board, no new risks had been added to the risk register. Four risks had been removed, details as follows: • 1760 – Equality & Diversity Lead – risk downgraded to high following recruitment process. Risk will be closed when E&D Lead in post.	

	• 1368 – Safe Staffing – risk downgraded to high due to Trust achieving compliance with safe staffing levels. • 1701 – Failure of equipment, central monitoring suite ITU/HDU/CCU – risk downgraded to high following purchase of new equipment. Risk will be closed once equipment had been installed. • 1624 – Lack of evidence of professional curiosity – risk downgraded to high due to further training, communication and change to risk assessments. Discussion took place about the Board's focus, consideration of how this would be presented in the future with the emphasis on assurance rather than risk. **RESOLVED** The Board **approved** the reports	
TB125/18	**Trust Compliance with Provider Licence**	
	Mr Charles presented the updated report to the Board who stated that there was substantial evidence to suggest that the Trust was compliant with **Condition G6** which required NHS Trusts to have processes and systems that: • identified risks to compliance • take reasonable mitigating actions to prevent those risks and a failure to prevent them from occurring The report also asserted the Trust was not compliant with **Condition FT 4**: which required that: • Providers should review whether their governance systems achieved 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 with Condition FT4 was included detailing the steps needed to improve governance and achieve compliance. That was complemented by a Rapid Governance Review being undertaken by EY. **RESOLVED** The Board **reviewed** and **approved** the report	
TB126/18	**Items for Approval/Ratification**	
	There were no items for approval/ratification.	
TB127/18	**Questions From Members of the Public**	
	There were no questions raised.	

CONCLUDING BUSINESS		
TB128/18	**Any Other Business**	
	There was no other business	
TB129/18	**Items for the Risk Register/Changes to the BAF**	
	There were no items or changes.	
TB130/18	**Message from the Board**	
	There was no message from the Board.	
TB131/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 6 June, 11:30am **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 6 June 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	**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 July Board.**	**AMBER**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 6 June 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. **Update: to go to MOG in July**.	**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**
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**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 6 June 2018

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
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**
MAY 2018	**TB113/18 Monthly Mortality Report**	**MD MAY 2018**	Dr Mahajan agreed to re-circulate the duties and responsibilities relating to 'Learning from Deaths'.		**AMBER**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 6 June 2018

BRAG Status Key

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Green	Progressing on schedule
Blue	Completed

COMPLETED ACTIONS

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
JUNE 2017	**TB116/17 Staff Engagement Plan**	**ADHR June 2018**	OD Plan to be brought to the Board after discussion with the CEO.	On June Board	**BLUE**
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. **Updates on June Board**	**BLUE**
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.	**Finalised, signed and provided to NHSI 25 May 2018**.	**BLUE**
MAY 2018	**TB106/18 Minutes of the Meeting Held on 7h March 2018**	**CoSec JUN 2018**	The Chair noted that Dr Ruth Chapman had not seen the minutes of the February Board. These minutes to be sent to her.	**Minutes from February and draft of May sent to Dr Chapman 24 May 2018.**	**BLUE**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 6 June 2018

DATE	AGENDA ITEM	LEAD & TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
MAY 2018	**TB111/18 Quality Improvement Plan Progress Update**	**DoN MAY 2018**	Jo Simpson, Assistant Director of Quality and Dr May Ng, Consultant Paediatrician and Paediatric Endocrinologist, met on 2 May to set timescales for the two SHOULD Do CQC actions from 2016 and the plan updated.	**Performance is steadily improving; completion date for both actions will be December 2018.**	**BLUE**
MAY 2018	**TB115/18 Monthly Safe Staffing Report**	**DoN MAY 2018**	A full assessment of available data and utilisation of the safer nursing care tool/e-roster and would be completed by 4 May and reported to the June Board.	**Update to June Board.**	**BLUE**
MAY 2018	**TB121/18 Integrated Performance Report (IPR)**	**COO/MD MAY 2018**	Transient Ischaemic Attack (TIA) narrative was insufficient and an update was to be provided.	**Updated. Included in June Board report.**	**BLUE**

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

6 June 2018

Agenda Item	TB136/18	Report Title	Chief Executive's report
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Silas Nicholls, Chief Executive		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

- Board appointments
- Super Week embeds operational change for benefit patients
- Transforming hospital services
- Financial performance
- MP support Dementia Action Week

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

CHIEF EXECUTIVE'S REPORT TO PUBLIC BOARD – MAY 2018

I was delighted to welcome **Juliette Cosgrove** this month as Director of Nursing, Midwifery and Therapies. 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.

I was also pleased to announce **Therese Patten** is moving to a new role, Director of Strategy, which will help the Trust gain greater control over this important agenda. Her appointment will also help reduce our reliance on expensive external support.

Her responsibilities as Chief Operating Officer move to **Steve Christian**, Regional Director of Improvement at NHS Improvement, who joins us on secondment for three months while the Trust recruits to the post.

Steve, who lives locally and is a former Trust operational manager, brings a wealth of experience and recently led the Action on A&E programme across the North of England.

I have accepted the resignation of Rob Gillies as Executive Medical Director. He was excluded from work last August following an independent review of culture at the Trust. We will shortly begin the process of recruiting a successor. In the meantime, **Dr Jugnu Mahajan** has agreed to continue as interim Medical Director.

Super Week embeds operational changes to benefit patients

When I first joined the Trust in April, I was determined that we should bring together the best of our teams to improve the quality of our services and the experience we offer to our patients.

This is so important to the emergency care we offer and the experience that our patients have in A&E and across the Trust.

That effort came together in "Super Week" on the fourth week of May. It was the week when we began embedding operational changes to how we move patients through the hospital from A&E to discharge. Super Week was driven by three big promises to patients:

- Stopping 12-hour waits in A&E
- Ending the practice of giving patients care in corridors
- Improving performance against the national standard to treat, transfer or admit 95% of patients attending A&E within four hours

I was delighted by the efforts of all involved to ensure we made progress towards these three areas of improvement. Staff worked with system partners and external support to ensure our key aims were achieved.

Despite our highest attendances ever at Southport hospital A&E on Sunday and Monday at the start of Super Week, staff were able to turnaround and achieve significant results:

- By 27th May, the end of Super Week, overall performance against the four-hour standard for the month was 89.58% - the best performance this year
- No 12-hour waits have been recorded since April. Operational grip and control in site management and wards continues to drive a safe and calm approach to managing our urgent care pathways
- A decreasing number of patients treated on the A&E corridor and for a shorter time

These achievements have been supported by:

- The opening of the new Clinical Decision Unit on 30 April
- A temporary discharge and transfer lounge on Ward 7b ahead of a permanent home opening in the former Salus Centre in June
- The purchase by the Trust of 14 local care home beds to support the transition of patients who are medically fit to leave the hospital

Further work begins in A&E on 14 June which will see an increase in clinical assessment space for triage and four more cubicles for ambulance patients, further improving patient experience, privacy and dignity.

Transforming hospital services
Our patients demand the best care and they deserve the best care. That's why we're examining how we can improve our services to change care for the better.

I was very pleased to hear staff and partners thinking "out of the box" at a clinical leaders' workshop this month about how we can best meet the needs of patients in the future.

The workshop was part of the Trust's Care for You programme which aims to transform our hospital services. All available evidence is being considered before a new model for our hospital can take shape. Key to making any proposals are the views of our nurses, doctors and therapists who know patients' needs best.

If the changes proposed are significant, they will be subject to appropriate public engagement and consultation.

Financial performance
The Trust is forecasting a deficit for 2018/19 of £28.8m. April saw a lower overspend than expected – £2.62m against a planned £2.8m. This was supported by an underspend on agency staff of more than £110,000.

MP supports Dementia Action Week
Southport has one of the oldest populations in the UK, so we had particular interest in Dementia Action Week (21-27 May).

Key among the activity was the launch of a booklet with advice on countering loneliness. It was developed with the help of our Patient Experience Group, and member Terry Durrance in particular.

The booklet will be available to patients leaving hospital and Southport MP Damien Moore came along to support the launch event.

New on the menu from our Southport catering team was a hot and cold finger food menu for patients who have a diagnosis of dementia, and may benefit from a meal which does not require a knife and fork to eat.

Michelle Kitson, Matron for Patient Experience, also worked with Liverpool's Open Eye Gallery and Merseycare NHS Foundation Trust to secure a display of images, Life Beyond Diagnosis, for display at Southport hospital. The images aim to break the stigma associated with dementia and reflect people's lives as individuals, not as a condition.

May was a month of celebrations …

- Nearly 100 staff and colleagues attended the launch of our Nursing and Midwifery Leadership programme on Tuesday in the Clinical Education Centre at Southport on May 8
- Celebrations for International Nurses Day on 12 May included a draw for staff with many of the prizes gifted by local businesses
- Dr May Ng, Consultant Paediatrician and Paediatric Endocrinologist, was elected to Diabetes UK Council of Healthcare Professionals
- We learned Prof Adnan Saithna, Consultant in Orthopaedics, had received a joint international award, Excellence in Knee Surgery, at the 17th Annual Brazilian Knee Surgery Congress to improve the diagnosis and treatment of sports injuries of the knee
- Finally, the catering team at Ormskirk hospital retained their five star rating in food hygiene following an inspection by the local environmental health team

ALERT ADVISE ASSURE (AAA) HIGHLIGHT REPORT

Committee/Group Meeting date:	Quality & Safety Committee May 29th, 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)

- Some sub-committees are struggling to get full attendance at their meetings due to work pressures. It is hoped that this issue will be addressed as part of the Governance Review that is currently underway.
- The 2017/18 Quality Accounts are not yet complete so it is likely that they will need to be signed off at the QSC meeting in June.

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 Mortality Operational Group has reviewed outliers across the Trust and will be recommending to the Clinical Effectiveness Committee that improvements be made to both streaming arrangements and the allocation of clinical responsibilities for outliers.
- The Clinical Effectiveness Committee has approved the Acute Kidney Injury Pathway.
- QSC intends to review how clinical metrics are considered at the Committee in order to optimise the level of assurance that can be drawn from the data. This is likely to mean that a smaller number of indicators will be reviewed but in greater depth.

ASSURE

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

- The Trust has made good progress in improving End of Life Care services and has a clear plan for further development over coming months
- The Safeguarding Annual Report outlined how services have been improved over the last 12 months. This position is underlined by the CQC recognising in its March 2018 Inspection Report that the culture of safeguarding has been embedded into the Trust.
- Following the training of a critical mass of Consultants, it is anticipated that Structure Judgement Reviews will commence in July

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

It was felt that the operational risks overseen by the Committee were appropriately scored.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 June 2018

Agenda Item	**TB13918**	**Report Title**	**Quality Improvement Plan Progress Update**
Executive Lead	Juliette Cosgrove, Director Nursing, Midwifery, Therapies and Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Approve ✓To Assure ☐ For Information		☐ To Note ☐ To Receive

Executive Summary

This 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.

Of the 97 actions in the improvement plan, there are

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

Following a review of the current Improvement Plan by the newly appointed Director of Nursing, it has been decided that the plan will be delivered through discreet single actions or larger Improvement Projects, the RAG rating tool has also been reviewed and updated.

Of the 97 improvement actions, 96 are currently rated amber (on track to deliver) and one is blue (delivered and sustained) based on current review and progress.

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

It is recommended that the Board notes the progress and any risks identified in this report.

Strategic Objective(s) and Principal Risks(s)

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

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

✓**SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*
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✓**SO5** Ensure staff feel valued in a culture of open and honest communication	*Failure to attract and retain staff*
✓**SO6** Establish a stable, compassionate leadership team	*Inability to provide direction and leadership*

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

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

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

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

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

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

The Board are asked to review the Quality Improvement Plan update and be assured there are systems, processes and escalation plans in place, when required, to deliver the CQC recommendations.

Previously Presented at:

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

Southport and Ormskirk Hospital NHS Trust

QUALITY IMPROVEMENT PLAN UPDATE

1. PURPOSE OF REPORT

This paper provides the 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 21 May 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.

Trust Ratings

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Good ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Inadequate ↓ Mar 2018	Requires Improvement ↔ Mar 2018

Ratings for Southport and Formby District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Requires Improvement ↓ Mar 2018	Requires Improvement ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Requires Improvement ↔ Mar 2018
Medical care (including older people's care)	Requires Improvement ↔	Requires Improvement ↔	Good ↔	Requires Improvement ↔	Inadequate ↓	Requires Improvement ↔
Surgery	Requires Improvement ↑ Mar 2018	Requires Improvement ↔ Mar 2018	Good ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Inadequate ↔ Mar 2018	Requires Improvement ↔ Mar 2018
Critical care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires Improvement Nov 2016	Good Nov 2016	Good Nov 2016
Outpatients	Requires Improvement Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Spinal injuries	Requires Improvement ↓ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Requires Improvement ↔ Mar 2018
Overall*	Requires Improvement ↑ Mar 2018	Requires Improvement ↔ Mar 2018	Good ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Inadequate ↓ Mar 2018	Requires Improvement ↔ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Ormskirk District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018
Surgery	Requires Improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Requires Improvement ↔ Mar 2018
Maternity	Requires Improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires Improvement Mar 2018	Requires Improvement Mar 2018
Services for children and young people	Good Nov 2016	Requires Improvement Nov 2016	Good Nov 2016	Requires Improvement Nov 2016	Good Nov 2016	Requires Improvement Nov 2016
Outpatients	Good Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Requires Improvement ↔ Mar 2018	Requires Improvement ↔ Mar 2018	Good ↔ Mar 2018	Good ↑ Mar 2018	Requires Improvement ↔ Mar 2018	Requires Improvement ↔ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

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.

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

Of the 97 actions in the improvement plan, there are

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

Generic themes for all 2017 actions are:

- Access & Flow (6)
- Clinical Care (24)
- Environment (11)
- Equipment (4)
- Governance (8)
- Infection Prevention Control (5)
- Medicines (6)
- Leadership / Strategy (2)
- Records / Documentation (16)
- Training / Appraisals (9)
- Patient Experience / Engagement (6)

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

4. TRUST APPROACH

Following a review of the current Improvement Plan by Juliette Cosgrove, the newly appointed Director of Nursing, it has been decided that the plan will be delivered through discreet single actions or larger Improvement Projects, some of which are already established, whilst others are in the process of being set up and will be in place by the end of Quarter 1.

Improvement Projects are listed in the table below:

Improvement Project	Lead	Accountable Committee / Group
Environment and Cleanliness	Head of Estates / Head of Facilities	FP&I / IPC Committee
Access and Flow	COO	FP&I / Quality & Safety
Governance • Governance Structure • Risk registers • Duty of Candour	Company Secretary / Deputy Director of Nursing	Quality & Safety Committee
Clinical Care	TBC	Quality & Safety Committee
• Deteriorating Patient	Associate Medical Director for Patient Safety	Mortality Operational Group (MOG)
• Infection Prevention Control (IPC)	Head of IPC	IPC Committee
• Medicines Management	Chief Pharmacist	Drugs and Therapeutics Committee
• Family and Friends Test (FFT)	Deputy Director of Nursing	Patient Experience Group
• Accuracy and Security of Patient Documentation	TBC	Nursing Documentation Group / Information Governance
• Mandatory Training / Competencies of Clinical Staff	Head of Education and Training / Clinical Leads	Workforce Committee

The RAG rating tool has also been reviewed, and the Trust will adopt the following RAG process to monitor progress and assurance against compliance.

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

The 'Quality Improvement Delivery Group' (QID) has been established as a sub-group of the Quality and Safety Committee to monitor delivery against the revised CQC Action Plan, the group meets fortnightly, Terms of Reference include:

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

5. PROGRESS TO DATE

A high level update on progress can be found below, of the 97 improvement actions, 96 are currently rated amber (on track to deliver) and one is blue (delivered and sustained) based on current review and progress. Following discussions with Executive Leads five improvement actions have been identified to move to green (Action Completed), they will be presented to Quality & Safety Committee in June 2018 to support status.

A detailed critical analysis of progress, key issues and risks to delivery will be provided for the next Quality and Safety committee meeting, then reported through to Board by exception.

Delivered and Sustained	1
Action Completed	0
On track to deliver	96
No progress / Not progressing to Plan	0

6. CONCLUSION AND NEXT STEPS

The Trust have identified that one action is complete and embedded (The provider must ensure oxygen and suction are available in all bed spaces – all wards and bed spaces have piped oxygen and suction, to maintain compliance the Trust will continue review the prescribing and administration of oxygen). To

date 96 actions are on track to deliver, any risks to delivery for escalation will be highlighted within this report.

7. RECOMMENDATIONS

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

Jo Simpson

Assistant Director of Quality

PUBLIC TRUST BOARD
6th June 2018

Agenda Item	**TB140/18**	**Report Title**	**Freedom to Speak Up (FTSU) Annual Report**
Executive Lead	Juliette Cosgrove, Director of Nursing Midwifery and Therapies		
Lead Officer	Gill Murphy, Deputy Director Nursing Midwifery and Therapies		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ☐ For Information	☐ To Note ✓ To Receive	

Executive Summary

The purpose of this annual report is to update the committee on concerns raised to the Freedom to Speak up Guardian, to confirm actions completed to date against the National Guardian office (NGO) recommendations and confirm actions planned for the coming year.

Key points for information:
Following the NGO review in September 2017 the Trust has an established action plan which has been approved by both the Trust board and NHSI. The Trust sees the review and current action plan as a key priority and key achievements of this action plan include the following:

1. The appointment of a permanent freedom to speak up guardian.
2. The development of a policy and initial communications strategy.
3. The appointment of an equality and diversity lead.
4.

In addition to the annual report, further actions have taken place.

The quarterly review meeting with CQC, NHSI and NGO took place on 29th May 2018, with positive feedback on progress made to date.
The cultural review across our consultant workforce has commenced, with preliminary data from the survey shared with the Medical Director.

In May 2018 NHSI released *Guidance For Boards On Freedom To Speak Up In NHS Trusts And Foundation Trusts.* This guide sets out NHSI's expectations of boards in relation to FTSU and to create a culture responsive to feedback and focused on learning and continual improvement. Part of this guidance includes the completion of a board self-review tool, which in turn should support the development of an action plan. The Company Secretary is arranging time through a board development session to complete this self-assessment tool by August 2018.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

xCompliance xEngagement and Communication ☐ Finance	☐ Legal ☐ Quality & Safety xRisk xWorkforce

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

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

To continue to implement actions with monthly update meetings with Non-executive, Executive leads and FTSU guardian

Previously Presented at:

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

National Guardian
Freedom to Speak Up

Freedom to Speak up Guardian Annual Report 2017-18

Purpose of the Report

To update the committee on concerns raised to the Freedom to Speak up Guardian, to confirm actions completed to date against the action plan and confirm actions planned for the coming year.

Key points for information

Following the National Guardians office review in September 2017 the Trust has an established action plan which has been approved by both the Trust board and NHSI.

The Trust sees the review and current action plan as a key priority and key achievements of this action plan include the following

1. The appointment of a permanent freedom to speak up guardian.
2. The development of a policy and initial communications strategy.
3. The development of a job description for an equality and diversity lead. (This post has been advertised and interview date set).

Background

The committee is aware that in September 2017 the National Guardian's Office conducted a review of the "speaking up" processes, policies and culture at the Trust. This review was established due to information received regarding the Trusts process for supporting staff who raise concerns. It was felt that the current systems and processes where not in accordance with best practice.

In particular, the National Guardian's Office had received information which indicated that a bullying and discriminatory culture existed across the trust.

The purpose of the review was to evidence where the "speaking up" process, policies and culture did not meet with best practice and to make recommendations to remedy this. The Trust has fully supported the review and provided all necessary information for its completion

Findings

The review found evidence that the culture, policies and procedures of the Trust did not always support workers to speak up. There was also evidence of a reported bullying culture felt by staff within the Trust.

Many workers who spoke to the National Guardian's Office during the review expressed a belief that the Trust did not take their views or concerns seriously.

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

Response
An action plan was developed to support the 22 recommendations for the Trust.

This plan was approved at Trust board on the 7th February 201 and has also had approval from NHSI. In addition quarterly updates of progress against the plan and the review recommendations are made to NHSI.

The Trust had appointed a temporary "freedom to speak up" guardian in April 2017 to work through the required actions and support staff in raising concerns. A key recommendation, however, was to develop a job description and appoint a permanent guardian.

The trust has also identified the Director of Nursing as the executive lead and appointed a Non –executive lead, for Freedom to Speak Up.

Establishing the role
In April 2018 the Trust appointed a permanent "Freedom to Speak Up" Guardian (FTSU).

Staff appear to have responded positively to the appointment of the (FTSU) Guardian. Data also indicates that since the appointment (12 months) an increasing number of concerns, 16 have been raised in total (Appendix 1)

This information suggests that staff may be more comfortable in raising concerns with the Freedom To Speak up Guardian rather than their line manager. An analysis of this data has not yet identified any trends regarding the nature of concerns being raised at present; however following the case review it is clear that the culture requires immediate attention

The (FTSU) Guardian service appears to be utilised by all staff groups within the Trust, with no individual or stand-out groups of staff raising specific concerns at this stage.

It is pleasing to report that the majority of concerns were reportedly raised in an open manner, suggesting a changing environment where staff felt more confident to speak up about concerns.

There were however a smaller number of concerns which were raised in an anonymous or confidential manner. This suggests that further on-going support is needed to build a more open culture in relation to raising concerns.

A key focus of the Freedom to Speak Up Guardian, has been to develop a communication strategy, supported by the Trust's Communication Team.

This initiative has included using posters, pay slip inserts and the further development of the Trusts internet site. Information about the role of the Freedom to Speak Up Guardian is now included within the New Starter and Junior Doctor Induction.

In addition, a personalised approach has been taken to introducing the role to staff through regular attendance at team meetings, department walk arounds and senior management meetings.

The Guardian has also attended national meetings and training events and is supported by the Deputy Director of Nursing, and Associate Director of HR in delivering the agreed action plan.

Summary
The key and immediate actions made were to appoint a permanent (FTSU) guardian and develop and publish the supporting policy. Both of these actions have been achieved within the agreed timeframe.

The next step is to ensure that the role and service is fully embedded across the Trust and to communicate the policy and service to our staff.

We will ensure that all of our staff are fully aware of how to raise concerns and ensure that they are supported in doing so with further work planned including a full evaluation.

Another key recommendation was to develop an Equality and diversity role for the Trust. The Job description has been developed, the post has been advertised and an interview date set.

A further recommendation was to utilise good practice and learning from other Trusts and we are in the process of learning lessons from other systems. In addition following our review, a number of other Trusts have made contact with us to share our learning in terms of the role, recommendations, action plan and strategy. This is a really positive outcome and we are happy to share the lessons we have learned as part of this process.

Next Steps
The Freedom to Speak Up Guardian will be taking a more targeted approach based on data and the staff survey results to ensure support is targeted on areas of most need.

The key areas within the action plan that need to be delivered are around the visibility of the executive team. The FTSU guardian is working closely with the Deputy Director of Nursing and the Associate Director of HR to develop a timetable to support this

Work is about to commence in support of a cultural review, as well as a review of all related policies, this will commence in May/June 2018.

There a several actions that are slightly behind the agreed time frames for completion. These actions are related to audit processes, surveys and case reviews; the team has a meeting in the diary (April 2018) to immediately address these actions.

Recommendations
The committee is asked to receive and note the information within this report.

Appendix 1 FTSU Concerns raised 2017/18

Date	Number	Theme	Outcome
Jun-17		Concern in relation to Patient Safety.	Decided to pursue externally to the organisation. Closed.
Not Dated		Car parking fees.	Investigated and appropriate action taken.
Quarter 2 (MA appointed to Role 1.9.17)			
Sep-17	FTSU 01	Palliative care and poor communication with family	Discussion with matron responsible for ward. Datix written, learning points and commination issues noted. Closed.
Sep-17	FTSU 02	Supervisory support to staff during manager's absence.	Escalated to senior manager, prompt response. Closed.
Sep-17	FTSU 03	Treatment of Mental Health patient in A&E	Issue raised by family friend / hospital volunteer. Permission requested from family to escalate. Not granted as they were taking up with MP.
Sep-17	FTSU 04	Member of staff feeling isolated during a HR investigation	Support offered, process talked though, issue fed to HR. Closed.
Quarter 3			
Oct-17	FTSU 04	Lack of support following suspension and investigation	Support offered, process talked though, issue fed to HR. Closed.
Nov-17	FTSU 05	Staff support following patient restraint	Did not want FTSUG to pursue. Closed.
Nov-17	FTSU 06	Issue raised about patient experience and safety at ODGH as patients were being moved every night from ward to ward.	This was a short term measure before ward amalgamation. Closed.
Nov-17	FTSU 07	Parents given wrong information about the date of the "baby service" following pregnancy loss.	Spoke to pathology manager. Information was corrected and parents went to the right service. Paperwork updated to prevent "near miss" happening again. Closed.

Quarter 4			
Jan-18	FTSU 08	Significant concerns raised about HR investigation process	Full investigation and response from HR about to be issued. Ongoing.
Jan-18	FTSU 09	Use of inappropriate covert information	Agreed policy to be followed. Closed
Jan-18	FTSU 10	Concern from temporary staff member that a job offer was withdrawn due to previous whistleblowing in another organisation.	Assurance from HR that offer withdrawn for other policy reasons. Closed.
Mar-18	FTSU 11	Concern about ward whiteboards not being updated in timely manner	New system to be in place over next few months. Ongoing.
Mar-18	FTSU 12	Concern about care of a patient on the Spinal Unit.	Meeting set up with DDN. Family decided to go down complaint route. Closed

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 June 2018

Agenda Item	**TB141/18**	**Report Title**	**End of Life Strategy 2017 - 2019**
Executive Lead	Juliette Cosgrove, Director of Nursing		
Lead Officer	Dr Karen Groves, Consultant Palliative Care		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure ✓ For Information	✓ To Note ☐ To Receive	

Executive Summary

Southport and Ormskirk NHS Trust (S&O) believes that end of life care is important to patients, families and health professionals.

An End of Life Strategy Steering Group, which meets monthly, resulted from the publication of the End of Life Care Strategy and draws together all those interested in, or responsible for, End of Life Care. This feeds into the Trust Quality Committee and West Lancashire, Southport & Formby Supportive & Palliative Care & End of Life Integrated Clinical Network, which is a subgroup of the Cheshire & Merseyside Palliative and End of Life Care Clinical Network Group.

The Trust has taken part in all that National End of Life Programmes for Acute Trusts and is currently one of ten Trusts selected to take part in the national 'Building on the Best' Programme.

The Committee is asked to note the Strategy, which is based on national & local strategy & guidance.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

The Board of Directors is asked to formally approve the strategy

Previously Presented at:

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

Southport and Ormskirk NHS Trust
Supportive, Palliative & End of Life Care Strategy 2017-19

1. BACKGROUND

1.1 Southport and Ormskirk NHS Trust (S&O) believes that end of life care is important to patients, families and health professionals. Supportive, Palliative and End of Life Care relates to the care and co-ordination required for those with far advanced and progressive disease, whether or not they are undergoing treatment; those with symptom control and psychological needs requiring specialist palliative care services; and those approaching the end of life. At various times they may incorporate **Supportive, Palliative and Bereavement Care** in addition to **Care of the Dying**.

1.2 The National End of Life Care Strategy 2008[i] outlined the difficulties which existed prior to the strategy and suggested a way forward which included

- raising public awareness of death and dying;
- recognising end of life processes which include the last year of life and the first year of bereavement for commissioning services;
- education of health and other professionals in communication skills, advance care planning, assessment and care, and symptom control;
- measurement of outcomes by using the subsequently developed quality markers

1.3 Since then there has been a plethora of documents, starting with the Neuberger Review[ii] of the impact of the Liverpool Care Pathway, and its response from the Leadership Alliance for the Care of Dying People – One Chance to get it Right[iii], outlining the Priorities for Care of the Dying, both of which have changed the face of end of life care.

1.4 The voice of the public has been heard loud and clear in the National Council for Palliative Care's, 'Every Moment Counts'[iv] and 'What's Important To Me'[v]

1.5 More recently the Ambitions for Palliative & End of Life Care[vi], the NICE Guidance (NG31)[vii] and Nice Quality Standards (QS13 & QS144)[viiiix] for end of life care and the the care of dying adults in the last days of life, have given further clarity on the way forward in this area.

1.5 Approximately half of the deaths of West Lancs, Southport and Formby residents occur within an acute hospital setting and over 80% of these occur within Southport and Ormskirk hospitals. (ONS data).[x] Nationally two thirds of those who are terminally ill would choose to be cared for and to die at home where possible and, locally, preferred place of care figures show that home is the PPC for over 80% of those asked.[xi]

1.6 Southport and Ormskirk NHS Trust believes that end of life care should take place, where ever possible, in the patient's own home (which may be a care home) if that is their wish, and that, wherever care and dying occurs, staff should be educated to understand how to ensure that this is the best possible experience in the circumstances for the patient, family and health professionals.

1.7 An End of Life Strategy Steering Group, which meets monthly, resulted from the publication of the End of Life Care Strategy (2008) and draws together all those interested in, or responsible for, End of Life Care. This feeds into the Trust Quality Committee and West Lancs, Southport & Formby Supportive & Palliative Care & End of Life Integrated Clinical Network, which is a subgroup of the Cheshire & Merseyside Palliative and End of Life Care Clinical Network Group.

1.8 Southport & Ormskirk Hospitals NHS Trust works closely with Queenscourt Hospice, who have always worked closely to ensure the provision of a seamless integrated supportive and palliative care service and to whom NHS Specialist Palliative Care Services are currently subcontracted from the providers (Lancashire Care Foundation Trust and Virgin Care)

commissioned by the Clinical Commissioning groups (Southport & Formby CCG and West Lancashire CCG). Members of the Palliative Care Services have honorary contracts and in-reach to the Trust.

1.9 Southport and Ormskirk NHS Trust ensures that every with palliative care needs and / or approaching the end of life has a holistic assessment of current and future; personal and clinical; physical, spiritual, psychological, and social needs, and that those important to them also have their holistic (especially communication) needs assessed.

1.10 The Trust has a planned approach to end of life care which addresses the identified physical, psychological, spiritual and social needs of patients and those important to them, its own staff, and the organisation, and ensures that appropriate decisions about treatment at the end of life care are made in a timely manner.[1]

1.11 The 'Route to Success' for end of life care, in Southport & Ormskirk NHS Trust, is made up of many 'roads'.[xii] Each of these individual 'roads' has been developed to create the network required, which, combined with appropriate staff attitudes, skills and confidence, makes excellent end of life care a real possibility.

1.12 The Trust has taken part in all that National End of Life Programmes for Acute Trusts and is currently one of ten Trusts selected to take part in the national 'Building on the Best' Programme.[xiii]

2. END OF LIFE ENABLERS

2.1 Southport and Ormskirk NHS Trust hospital adopts well established and effective processes for planning and accomplishing compassionate end of life care for patients and carers by wholeheartedly embracing use of the already available national End of Life Enablers:

- **Future Care Planning** (including Advance Care Planning (ACP))
- **Co-ordination of Care** (using the Gold Standards Framework (GSF))
- **Dealing with Uncertainty** (based on individual elements of the AMBER Care Bundle)
- **Care of those thought likely to be Dying** (by developing an individual plan for care with patient and family)
- **Respecting Patient Choices** with a locally developed, effective Rapid End of Life Transfer process.

2.2 Future Care Planning

2.2.1 Future Care Planning includes:

- **Anticipatory Clinical Management Planning** (both with patients who have capacity and in the 'best interests' of those who lack capacity)
- **Advance Care Planning -** the newest of the End of Life Enablers – encourages individuals to make their personal wishes and preferences known and, if they wish, documented. An education process and a procedure with its own documentation, recording and audit has been developed before widespread use can be expected.[2]

2.2.2 S&O has worked with the West Lancs, Southport & Formby Supportive & Palliative Care Services (WLS&FSPCS) to develop this documentation and process across all health care settings and provide accompanying education.

[1] CLIN CORP 02 Treatment Decisions at the End of Life
[2] CLIN CORP 05. Advance Care Planning (including Advance Decisions to Refuse Treatment)

2.2.3 A Do Not Attempt Cardiopulmonary Resuscitation Policy is in place to ensure that inappropriate resuscitation attempts are not undertaken in situations where patients are dying and a positive outcome to such a resuscitation attempt could not reasonably be expected.[3] A DNACPR order which is made in the community or hospital setting, is now transferrable with the patient across boundaries for the benefit of the patient.

2.3 Co-ordination of Care for those approaching the End of Life[4,5]

2.3.1. S&O was the first whole hospital to be involved in the **Gold Standards Framework (GSF)** Acute Hospitals pilot in 2010 and to roll out the principles across the trust. The vocabulary of GSF has helped with cross boundary communication about this group of patients.

2.3.2 Southport and Ormskirk NHS Trust is committed to **identify those approaching the end of life in a timely manner** (NICE QS13:1)[xxi] and coordinates the care of those patients at the end of life by use of the Gold Standards Framework which incorporates **C**oordination, **C**ommunication, **C**are of the carers, **C**ommitment to education, **C**ontinuity of care, **C**ontrol of symptoms and **C**are of the dying.

2.3.3. **People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment**. (NICE QS13:3)[xxi]

2.3.4 People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment. (NICE QS13:4)[xxi]

2.3.5 **People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible.** (NICE QS13:5)[xxi]

2.3.6 With the improved identification of those in the last year of life, assessment of their needs, co-ordination of their care, communication and flagging on electronic systems (in preparation for a cross boundary electronic palliative care co-ordination system), and discharge as soon as feasible to their preferred place of care, then the aim is to reduce admissions, ensure an effective short stay where essential and increase transfers to the preferred place of care.

2.3.7 **People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.** (NICE QS13:8)[xxi]

2.4 Dealing with Uncertainty

[3] CLIN CORP 09 Cross Boundary Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
[4] CLIN CORP XX Co-ordination of Care for those who may be Approaching the End of Life
[5] CARE PLAN 024/046 Co-ordination of GSF Patients Care Plan

2.4.1 **People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences**. (NICE QS13:9)[xxi]

2.4.2 Where patients, recognised to have a poor prognosis of a small number of months, are admitted to hospital acutely ill, it is crucial that the conversations between clinical staff and patient and family acknowledge the seriousness of the underlying illness and the impact that this may have on recovery from an episode of acute illness. It is easy, in the emergency situation for staff to concentrate, quite rightly, on treatment of the acute, and possibly reversible, presenting condition initially. Staff will, however, have at the back of their minds, that the underlying condition may prevent recovery from this acute episode and will not be surprised if acute treatment does not have the desired effect.

2.4.2 Patients and families pick up on the active treatment that is being undertaken for the acute condition but may not be aware that the underlying condition has an impact on recovery from the treatment of this, and may be swept along by the shorthand clinical communication which occurs in the urgent situation.

2.4.3 It is vital that staff take the time to explain uncertainty of recovery and that, although treatment is being undertaken to attempt to reverse the acute illness, the underlying condition may prevent this from happening and deterioration may continue to occur. They are likely to need to be overt and explicit about the fact that the patient may be 'sick enough / ill enough to die'

2.4.4 Patients and families should be clear that, treatment will be reviewed on a daily basis and if it is not proving effective then change to a different plan for care may need to be implemented depending on the clinical situation and the expectations for recovery or deterioration at that time. They should also understand that treatment which is working will not be withdrawn but that treatment which is ineffective or even proving harmful will be changed to treatments which are helpful and beneficial.

2.5. Care of those thought likely to be Dying[6]

2.5.1 Where a patient appears likely to be dying, it is imperative that good communication occurs between clinical staff and patient, those important to the patient and other staff, so that everyone is clear what is expected and can prepare and act accordingly.

2.5.2 **Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering.** (NICE QS144:1)[xxii]

2.5.3 **Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan.** (NICE QS144:2)[xxii]

2.5.4 Having excluded reversible causes for deterioration, had appropriate conversations with patient and family, the multiprofessional team will then develop an individual plan for the care of those thought likely to be dying which includes physical, spiritual, psychological and social needs and pays particular attention to eating and drinking, which will be reviewed and updated daily by the mutliprofessional team.

[6] CLIN CORP 77A Care of those thought likely to be Dying

2.5.5 **Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.** (NICE QS144:3)[xxii]

2.5.6 **Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options.** (NICE QS144:4)[xxii]

2.5.7 The multiprofessional team will also keep the patient and those important to the patient updated on a daily basis, ensuring their understanding and answering any questions and addressing any needs they may have.

2.6. Respecting Patient Choices

2.6.1 Where irreversible deterioration in clinical condition occurs, if it is clear that the patient is likely to be dying and the preferred place of care is home (or care home), those caring for the patient and family will make every attempt to get the patient home (or to their care home).

2.6.2 Collaboration between North West Ambulance Service, the Pharmacy Department, the Community Equipment Services, Discharge Planning and others has made it possible to develop a local **Rapid End of Life Transfer** process to take place within a couple of hours of the decision to transfer.[7]

2.6.3 In the unlikely event that a NWAS ambulance is unable to meet the time frame specified, the bed manager has authority to book a private ambulance to ensure that transfer goes ahead in a timely fashion.

3. COMMUNICATION

3.1. The Trust has, and continues to, demonstrate its commitment to good communication, which it acknowledges lies at the heart of best, compassionate end of life care. **People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences** (NICE QS13:2)[xxi]

3.2. Communication in this way should raise the level of patient, family and staff satisfaction and reduce staff stress at handling difficult situations.

3.3 Advanced Communication Skills Training

3.3.1 'Connected', the National Advanced Communication Skills Training (ACST), compulsory for senior clinicians working with cancer MDTs, has not only been available for those eligible, but the Trust has made it, expected for all ward managers to undertake the course so that a critical mass of senior staff have the skills to effect change in communication within the organisation.[xiv] Although the free 'Connected' programme has ceased, Advanced Communication Skills Training is still available from the Terence Burgess Education Centre.

3.4 Core Communication Skills Training

[7] CLIN CORP YY Rapid End of Life Transfer Policy

3.4.1 Those who are not senior clinicians may not have such an opportunity and yet need to be communicating in a manner congruent with the style encouraged by the ACST.

3.4.2 The 'Simple Skills Secrets'[xv] programme gives staff at all grades and in all professional and none professional roles, a means of responding to patients and families concerns, which gives patient and family a sense of having been listened to, having had an opportunity to voice their concerns and leaves them with a plan for addressing them. This programme is being rolled out across the Trust and formal evaluation of its effectiveness has been undertaken.

3.5. Intermediate Communication Skills

An Intermediate Communication Skills programme is available for staff requiring more than core training as a stepping stone towards advanced.

3.6. Cross Boundary Communication

The development of electronic, faxed and carried, improved documentation about end of life care and systems for its transfer, will ensure that these patients are identified, recognised, dealt with appropriately and returned to their preferred place of care without unnecessary delay.

3.7 Communication about difficult topics

Communication about difficult questions (e.g. 'Am I dying'), situations (e.g. Resuscitation decision making) and processes (e.g. Future Care Planning) may require a more focused approach to training. These situations are dealt with individually, with targeted training, or a part of a larger scale rollout.

4. SPIRITUAL SUPPORT

4.1 The Trust has a Spiritual Support Policy[8] in line with the Cheshire & Merseyside Palliative & End of Life Care Network Spiritual Care Policy[xvi].

4.2 **People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.** (NICE QS13:6)[xxi]

4.3 Staff are encouraged, competent and confident to assess spiritual and religious needs of patients and families, and provide, signpost or access appropriate spiritual/religious support.[9]

4.4 Staff training in raising spiritual awareness is available during induction and afterwards. The aim is that at least one member of staff from each ward and neighbourhood has undertaken the 'Opening the Spiritual Gate' awareness raising training.[xvii]

4.5 Staff policies reflect the Trust's concern for the spiritual welfare and nurturing of its own staff.

[8] CORP 104 Spiritual Care Policy
[9] CARE PLAN 100 Spiritual Care Plan

4.6 The Trust provides a spiritual and religious support service (including chaplaincy) and quiet, prayerful space, faith equipment and ablution facilities, which meet the needs of patients, families and staff of all religious beliefs and none.

4.7 The Trust has a chaplaincy lead and team, responsible for the spiritual welfare and pastoral support of patients, families and staff.

5. CARER SUPPORT

5.1 Care and communication extends to those important to the patient, and the multiprofessional team caring for the patient have responsibilities for assessing and addressing the needs of those important to the patient (the 'family'), particularly of those who may be dying.[10]

5.2 The communication needs of those important to the patient still need to be met, even when the patient has refused consent for them to be given personal or clinical information. The staff should employ their communication skills to meet the communication needs of the 'family' without breaking confidentiality and should ask for help if this is a challenge.

5.2 **Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.** (NICE QS13:7)[xxi]

5. BEREAVEMENT

5.1 **The body of a person who has died is cared for in a culturally sensitive and dignified manner.** (NICE QS13:12)[xxi]

5.2 S&O has established processes and procedures for care after death[11], verification of death by trained nurses,[12] and the immediate care of the grieving family, is undertaken by staff caring for the patient.

5.3 **Families and carers of people who have died receive timely verification and certification of the death.** (NICE QS13:13)[xxi]

5.4 People closely affected by a death are communicated with in a sensitive way and are offered immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences. (NICE QS13:14)[xxi]

5.5 The bereavement team in mortuary services continue that support whilst they guide the family through the necessary procedures.

5.6 Procedures for viewing the body of the person who has died, the very sensitive nature of the interaction, the importance of the environment in which this is done and ambiance of the viewing room reflects this support.

5.7 Bereavement training is undertaken through a collaboration between palliative care services, mortuary & bereavement services and chaplaincy e.g. for midwives supporting parents facing loss

[10] CARE PLAN 092 Carer's Care Plan
[11] CLIN CORP 77B Care after Death Policy
[12] CLIN CORP 68 Verification of Death by Registered Nurses

5.8 Remembering is promoted through the baby garden, baby loss services and an annual bereavement service for all those who have suffered bereavement related to care in the care of the Trust.

7. EDUCATION

7.1 Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.

7.2 **End of Life Education is provided to all staff regardless of role or qualification since all come into contact with patients in the last year of life, their families and bereaved relatives. An educational needs assessment informs the content and form of the educational programme, which is in line with the national and network curricula.** (NICE QS13:15)[xxi]

7.3 e-elearning

7.3.1 The National e-elca online learning programme is available to staff who have access to the National Learning Management System and it is the intention of the Trust that all staff should be able to access this easily and wherever they are.

7.3.2. This national education consists of communication skills, advance care planning, assessment, symptom management, care planning, spiritual care and bereavement.

7.3.3 Cheshire & Merseyside Palliative & End of Life Care Network has converted the 'Opening the Spiritual Gate' programme to e-learning to make it accessible for all staff.

7.4 Face to face

7.4.1 End of Life and Palliative Care Education is available on the ward from the Supportive & Palliative Care Services, the Transform Team and at the Terence Burgess Education Centre at Queenscourt.

7.4.2 Staff are encouraged and supported to undertake as much of this education as is possible.

7.4.3 Specifically senior ward nurses and all qualified district nurses undertake the 6 day Palliative Care Education Programme created as a result of NHS Cancer Plan (2000)[xviii] requirements.

7.5 Educational resources

7.5.1 Each ward, neighbourhood and department has
- a copy of each of four folders with a presentation and materials about each of the key enablers
- a set of drawers in which all related documentation is kept.

7.5.2 There is an End of Life section on the intranet where details about all end of life care processes, documentation, support and education is outlined.

8. PALLIATIVE & END OF LIFE WORKFORCE

8.1 **Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.** (NICE QS13:16)[xxi]

8.2 General level palliative care

8.2.1 Every member of staff, clinical or non clinical, registered or non registered, is important in the overall care and support of those approaching the end of life, their families and staff caring for them. The Trust recognises that it is therefore imperative, that all staff and volunteers understand end of life care, the importance of the wishes and preferences of the individual, and the support needed for families and those important to the patient.

8.3 Transform Team

8.3.1 Originally funded from a variety of sources, Southport & Formby CCG now funds a Transform Team to work across hospital, community and care homes to support those who are recognised to be approaching the end of life and who are (or should be) GSF registered, and those who are likely to be dying and their families in Southport & Formby.

8.3.2 The Transform Team educates, empowers and supports staff, patients and families to improve the experience and efficiency of care at a time where every day counts.

8.4 Specialist Palliative Care Services

8.4.1 **People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.** (NICE QS13:10)[xxi]

8.4.2 Integrated Supportive & Specialist Palliative Care Services (SSPCS) support patients with specialist palliative care needs, and their families, at home, in hospital, and in care homes, and health professionals caring for them, 9am-5pm seven days a week.

8.4.3 Queenscourt Hospice offers additional 24 hour medical advice to health professionals working in the Trust.

8.4.4 The SSPCS consists of a full range of members according to Specialist Palliative Care Peer Review[xix] and NHS England Specialist Level Palliative Care Commissioning requirements[xx] and NICE Quality Statement 16: Workforce planning (NICE QS13:16)[xxi].

8.4.5 The SSPCS link to the Cancer Site Specific and non malignant MDTs.

8.4.6 Consultant led Specialist Palliative Care Services provide symptom management, psychological, spiritual and emotional support to patients and families and education to those clinical staff caring for them.[13]

9. PALLIATIVE & END OF LIFE CARE AUDIT PROGRAMME

[13] CARE PLAN 095 Pain Management in Palliative Care

9.1 S&O has taken part in five biennial National Care of the Dying Audits and the results are the substrate for biennial action plans constantly trying to improve end of life care within the area.

9.2 A series of End of Life audits is undertaken by most wards, departments and individuals, to inform.the process of developing end of life care. This culminates in a Celebrating Success Audit mini conference held in the Clinical Education Centre each December at which the work of individual staff members is presented and prizes awarded.

9.3 Continuous audits of all deaths, particularly those where an individual plan for the care of those thought likely to be dying, is ongoing.

9.4 Supportive & Palliative Care Services meet four times a year to present audits of the integrated SPCS.

9.5 Staff are encouraged to present & publish work relating to Supportive, Palliative & End of Life Care in the Trust and local area as articles, posters or oral presentations.

10. QUALITY STANDARDS

10.1 Supportive, Palliative and End of Life Care services work to standards included in the NICE Supportive & Palliative Care Guidance 2004[xxii], End of Life Care Strategy 2008[i], One Chance to get it Right 2014[iii], Ambitions for End of Life Care 2015[vi], and individual NICE guidance regarding topics such as opioids for pain management[xxiii] etc.

10.2 The National Institute for Clinical Excellence End of Life Care Standards QS13 (last updated 2017) and QS144 Care of Dying Adults in the last days of life are used to measure the quality of end of life care within the Trust.[xxiv] [xxv]

11. CODING

11.1.1 The process of clinical coding includes coding Z51.5 against those patients who have received a holistic assessed by members of the Specialist Palliative Care Services whilst in hospital.

11.2 Ensuring that this coding is complete is vital to accurate hospital mortality statistics. Internal and external audits of coding have taken place to ensure that data is captured accurately.

12. DEATH DATA

12.1 Place of Death Data is requested from the Office of National Statistics for residents of West Lancs, Southport & Formby each year.

12.2 In addition to this hospital death data is collected and interrogated to determine helpful and unhelpful trends.

13. PATIENT & 'FAMILY' SATISFACTION

13.1 Patient and family satisfaction should be sought in the usual ways e.g. Friends and Family Test. However there may be occasions where this is not possible and staff will record realtime and written comments made by patients and families.

13.2 Feedback will be sought at the same time as the bereavement telephone call where the Transform or Specialist Palliative Care Services have been involved and the patient has died and by the Bereavement Service at the time of collection of the certificate and patient property.

13.3 End of Life complaints, compliments and incidents are collected, investigated and themed. These are discussed at the End of Life Strategy meeting. The lessons learned inform education around end of life care and assist in monitoring change.

14. EXECUTIVE SUPPORT

14.1 Interest in the quality of End of Life Care is evident throughout the hierarchy within the Trust.

14.2 The Executive Lead for End of Life Care is the Director of Nursing

14.3 There is an appointed Non Executive Lead for End of Life Care who oversees End of Life Care within the Trust from a Board point of view

14.4 The Clinical Lead for Palliative and End of Life Care is the Lead Consultant in Palliative Medicine.

14.5 Although End of Life Care has high level appreciation, it is equally important to the ward staff and teams at every level, who are keen to ensure that every patient and family experience is as good as it possibly can be at this very important and highly emotional time in life for patients and those important to them.

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A. Introduction

Southport and Ormskirk NHS hospital sits on the North West Coast of England. Southport is a seaside town and has long been a popular destination for retirement, whilst Ormskirk is a market town which hosts a large rural area. The hospital provides secondary care for the residents of West Lancashire, Southport and Formby, which has a total population of 235,000.

The case study is set against a backdrop of the national picture for palliative and end of life care. This picture highlights that 1% of the national population dies each year and 56% of those deaths occur within a hospital setting. However statistics demonstrate that 60-70% of the population would choose to die at home.

Clarke et al (2014) evidenced, that on any given day in a hospital setting, a third of inpatients will die at sometime within the next year. With this information and the support of the Building on the Best programme, the Transform Team at Queenscourt Hospice have set about to educate, empower and support patients, families and health professionals to continually improve and deliver excellence in palliative and end of life care within Southport and Ormskirk NHS Hospital. The team consists of supportive and specialist palliative care services from palliative medicine and nursing. Utilising a multitude of resources, and pushing the boundaries of creativity and flexibility in education, empowerment and support to patients, families and staff, the aim is to improve end of life care.

The focus of the Building on the Best programme within Southport and Ormskirk Hospital has been to improve practice across all four work streams of symptom control, shared decision making, cross boundary communication and out patients department. As an integrated service working cross boundary, it was important that all these areas were addressed to improve the service as a whole and meet with the six ambitions for end of life care (NHS, 2015). The four work streams, at any one time, can impact on one another and therefore could not be improved in isolation, for example advance care planning impacts on all 4 streams

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B. Overview

- West Lancashire, Southport and Formby has a total population of 235,000
- Locally, 1.2% of the local population die each year, which is higher than the national average of 1%
- The area has a higher than average elderly population.
- The patients currently known to the palliative and end of life services in hospital have an age range of 31-108 with the average age of 80
- There are 100 care homes in the local area with 3500 beds
- Southport and Ormskirk Hospital is based across 2 sites which have a combined total of 497 beds (455 general and acute, 27 maternity beds and 15 critical care)
- 44% deaths within the local area (WL, S&F) occurred in hospital in 2016 (ONS), of these 80% were within Southport and Ormskirk Hospital (20% in hospitals elsewhere)
- 12% of those who die in S&O hospital are admitted from a care home
- 89% of those who die in S&O hospital do so following an emergency admission.

The graph of WL, S&F deaths is shown below, demonstrating the upturn in numbers of deaths across the whole area.

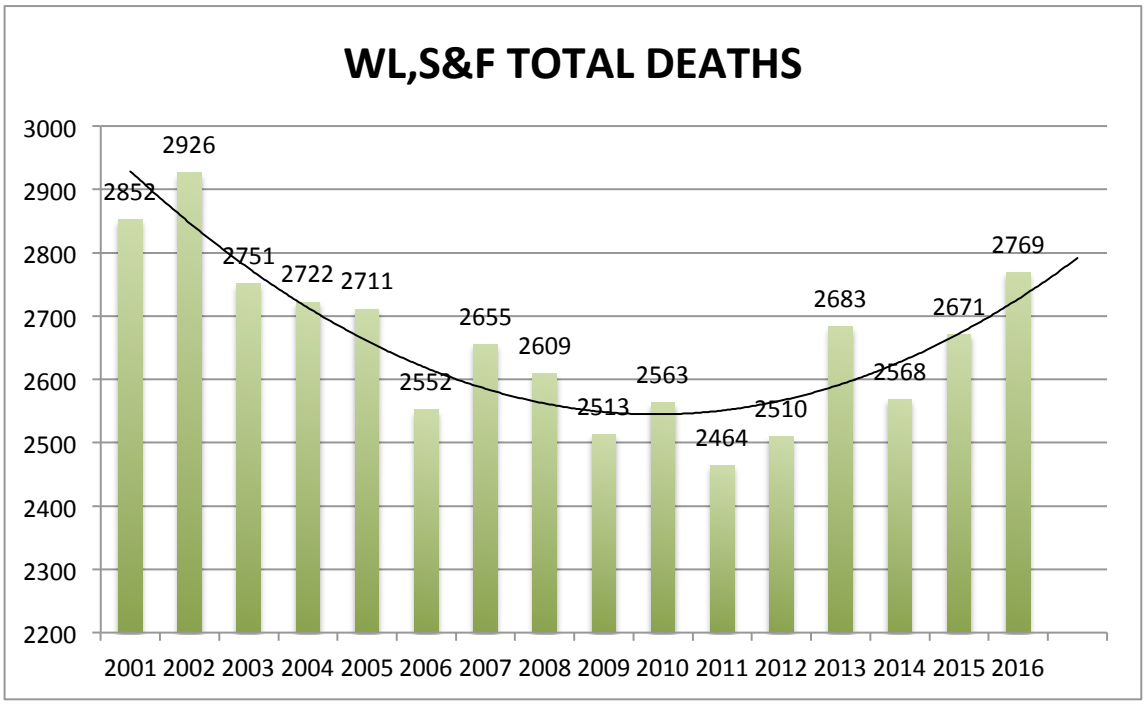

Figure 1: West Lancs, Southport & Formby all deaths from all causes 2001-2016 (ONS)

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C. Impact

Data for improvement

		2015/16	2016/17	2017/18
All known hospital EoL patients (SPCS, GSF & Transform)	↑	1052	1124	1364
GSF registered	↑	936	963	1274
Care Home residents	↑	288	285	371
Transform only	↑	658	724	984

Figure 2: Hospital data regarding known EoL patients before & during period of BoB

These figures mean that over the period of the BotB project there has been a:-

- 30% increase in patients known to the Supportive and Specialist Palliative Care Services (SSPCS);
- 36% increase in the number of hospital patients known to be GSF registered;
- 29% increase in the number of patients known to SSPCS who come from care homes;
- 50% increase in the number of patients known to the Transform Team

No of hospital patients		2015/16	2016/17	2017/18
GSF registration prompted by hospital	↑	302	425	764
Had conversation about REoLT (Rapid End of Life Transfer)	=	417	350	410
Had successful REoLT	↑	80	99	114
No. deaths in hospital	=	857	935	950
Individual Plan for Care of those thought likely to be Dying developed with patient & family	↑	41%	49%	56%
Hospital deaths achieved PPC (Preferred Place of Care)		37%	41%	64%

Figure 3: Hospital data regarding key enablers before & during period of BoB

These figures mean that over the period of the BotB project there has been a:-

- 153% increase in the number of GSF registrations prompted by the hospital services;
- a small decrease in the number of patients having a conversation about REoLT but an increase of 43% actually achieving REoLT;
- an increase of 11% of deaths in hospital over the two years;
- an increase of 15% of deaths having an individual plan for the care of those thought likely to be dying (now 56%) being developed with them and their family to support their care according to the new priorities for care of the dying;
- 64% of those dying in hospital achieving their documented preferred place of care – an increase of 27%.

If the number of people who had a successful REoLT, had died in hospital – this would have increased the hospital deaths in 2017/18 to 1064 people dying in hospital compared to 950 actual.

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D. Areas

1. SHARED DECISION MAKING

Consultant geriatrician has been developing Anticipatory Clinical Management Plans (ACMP) with frail elderly patients and their families (average age 84 years; average number comorbidities = 6; 65% suffered from dementia; 91% had no known malignancy; average time ACMP to death = 59 days). This has proved to significantly lower readmission rates.

- 16% of patients with ACMP readmitted (national average (40-70%)
- 97% died in PPC

On initial assessment of GSF registered patients admitted to hospital, discussion takes place regarding wishes and preferences for the future.

Here is an example case study of a patient with whom shared decision making was documented and communicated through an ACMP cross boundary with multiple health professionals who were supporting this patients care in the community **(see figure 4)**

EXAMPLE ACMP

- 67 year old man with diagnosis of gastric cancer
- Admitted generally unwell found to be anaemic
- Angry and upset at emergency admission via Accident & Emergency Department. Felt it was chaotic and distressing
- Requested management plan to avoid similar situation
- ACMP developed for future monitoring of symptoms, indications for blood tests and appropriateness of transfusion
- Shared cross boundary with plan clearing stating who was responsible for each part of plan

Figure 4: Example of Anticipatory Clinical Management Plan

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2. SYMPTOM MANAGEMENT

a) Opioid administration timing

To improve the timing of modified release opioid administration timing on the wards, all wards signed up to pain pledge and identified the best time to administer modified release (MR) opioids, which reflected the ward routines. An audit was carried out to identify the regularity of MR opioid administration to palliative patients, to optimise pain control and against the standard that all prescribed MR opioids should be given -/+ 30mins of prescribed time. 2 cycles of audit were carried out. An action plan has been implemented following each cycle and the audit results have been delivered at senior nurse, pharmacy and medical education meetings. The results demonstrated some overall improvement and a significant improvement when wards utilised the preferred prescribing times.

The results, although not as close to standards as hoped for are nevertheless improved for the most part, and are as follows **(Figure 5)**

Figure 5: MR Opioid Administration Audit Results

MR Opioid Administration Audit

- MR opioid given within 30 minutes of prescribed time
  - 1st cycle 6.6%
  - 2nd cycle 9.1% ↑
- Doses MR opioid given more than 30 minutes late
  - 1st cycle 88.3%
  - 2nd cycle 80.8% ↓
- Doses MR opioid given more than 30 minutes early
  - 1st cycle 1.4%
  - 2nd cycle 4.8% ↑
- Average time doses given
  - 1st cycle 2 hours 10 minutes late
  - 2nd cycle 2 hours late ↓
  - Range 6 hours early to 6 hours 10 minutes late
- However, given within 2 hours of time prescribed
  - 1st cycle 45.1%
  - 2nd cycle 60.0% ↑

oves April 2018

Using ward's preferred prescription times rather than actual prescribed ones, gives a different picture

MR Opioid Administration Audit
(Ward Preferred Prescription Times)

- Given within 30 mins of ward's preferred prescription time for administration = 37.4% ↑
- Given within 2 hours of preferred time = 92.9% ↑

Figure 6: MR Opioid Administration Audit against ward preferred Prescription Times

b) Safe & effective delivery of continuous subcutaneous infusions

An audit of recording of syringe pump checks according to standards was undertaken and a new checklist designed to improve the safety and monitoring of the delivery of continuous subcutaneous infusions. **(Figure 7)**

Syringe Pump Checklist Audit

- Rate set recorded
  - 1st cycle 99% : 2nd cycle 99%
- Syringe brand match recorded
  - 1st cycle 0% : 2nd cycle 99%
- Syringe volume recorded
  - 1st cycle 23% : 2nd cycle 98%
- 'Lock on' recorded
  - 1st cycle 77% : 2nd cycle 100%
- 'Volume to be infused (VBTI)' recorded
  - 1st cycle 99% : 2nd cycle 99%
- Battery life recorded
  - 1st cycle 100% : 2nd cycle 99%
- Clarity of fluid in syringe recorded
  - 1st cycle 100% : 2nd cycle 100%
- Subcutaneous site state recorded
  - 1st cycle 100% : 2nd cycle 100%

Figure 7: Syringe Pump Checklist Audit

Included in this audit was how frequently and effectively syringe pump safety checks are carried out for the McKinley T34 Syringe Pump in Southport hospital. Results; The Trust Standard for syringe pump checklist is to be completed is every 4 hours (or 6 checks per 24 hours). Average number of checks was 3.3 checks per 24 hours in cycle 2 compared to 3 checks per 24 hours on previous cycle. An action plan has been developed and implemented. Transform are supporting the wards to ensure correct checklist is utilised and monitoring checklists for patients who have a continuous subcutaneous infusion insitu. The audit results have been delivered at senior nurse meetings

c) Symptom management of those thought likely to be dying

Continuous audit of symptom control in those thought likely to be dying is undertaken. Symptom management in 2015/16 is compared with symptom management in 2017/18 below **(Figure 8)**

Symptom Control at the End of Life Audit

Symptom control	2015/16	2017/18
Pain free/controlled	75%	81%
Agitation free/controlled	73%	78%
Respiratory Tract Secretions free/controlled	74%	81%
Nausea & vomiting free/controlled	77%	74%

Figure 8: Data for symptom control in last 24hrs for patients dying in hospital with an individual plan for the care of those thought likely to be dying developed

d) Ward Pain Management

CQC report in 2016 identified that pain management on hospital wards required improvement. Areas identified as good included:

- Availability of opioid leaflets
- Patients said they were asked about pain regularly
- Good documentation of pain assessment for the dying

However there were said to be:

- No formal pain tools observed

- Pain care plans not seen
- Staff unaware of formal tool for assessing pain in dementia

In response to this were developed new:

- Trust Wide Core Care Plan (095) for Pain Management in Palliative Patients
- Palliative Care Pain Monitoring Chart, which included
    - Abbey Pain Scale for assessment of patient with cognitive impairment
    - Pain Assessment Chart for patient completion.

This was supported by a Hospital Palliative CNS teaching package on iPads delivered at planned sessions and opportunistically to 132 ward staff.

e) Access to analgesia when required

The hospital policy was amended to remove Oramorph from controlled drug status, to allow its administration by 1 nurse rather than 2 nurses, to ensure the patient received medication in a timely manner once requested

3. CROSS BOUNDARY COMMUNICATION

a) GSF Registrations

Recognition of those approaching the end of life (months to year) should result in Gold Standards Framework (GSF) registrations prompted by the hospital. These have increased from 302 in 2015/16 to 713 for the first 11 months of 2017/18 (projected annual 778). The first GSF registration from OP was Dec 16 and since then they have prompted GSF registration for 38 people.

b) Rapid End of Life Transfers (REoLT)

New Rapid End of Life Transfer carbonated booklets have been produced and placed in every clinical setting as part of end of life documentation. Each REoLT checklist is followed up after the transfer and delays in equipment, transport, care or any other aspect of process an incident form is completed and reported to the Clinical Commissioning Groups (CCG) / End of Life (EoL) Strategy Group and senior hospital management. The process is increasingly completed independently by ward staff and becoming embedded into discharge process. Above results evidence the ongoing increase in the number of REoLT conversations and transfers. There has been a 43% increase in successful REoLTs over the two year period of BotB.

c) Respiratory Ward Collaboration

Meeting twice weekly with Respiratory Consultants for board rounds, as the respiratory team had recognised the need for a change in practice, was achieved through clear identification of ward patients who were GSF registered and had a documented PPC. Discussion on board includes:

- patient/family conversations
- scope for ACMP
- discharge plans

The GREAT acronym (G GP end of life register; R Resuscitation status; E end of life medications; A advance care planning; T Treatment escalation plans) was used as a framework for discussions

Transform working on board rounds with senior medical and nursing staff to identify patients who were not appropriate for hospital readmission due to the recognition of approaching end of life. This was supported through the development of ACMP. Below is a case study example following a best interest decision meeting with a family for a patient with a diagnosis of advanced dementia who had no capacity to make decisions.

EXAMPLE ACMP

- 85 year man lived in a care home
- Diagnosed with advanced dementia, lacked capacity to make decisions
- Family conversation documented – CPPC was care home - did not want Dad readmitting to hospital
- ACMP developed in event of further chest infection
- Patient discharged back to care home following day with anticipatory EoL medications
- Resuscitation decision made - uDNACPR in situ
- ACMP in medical records shared cross boundary
- Patient died 8 days later supported by an individual plan for the care of those thought likely to be dying, in the care home, with family present

Figure 9: Example Anticipatory Clinical Management Plan and outcome

4. OUTPATIENTS

a) Recognition of End of Life

Since delivering EoL education to staff there have been 38 patients recognised to be in the last year of life and registered GSF. This is the first year any patients have been registered GSF from outpatients

b) Education: End of Life Skillset Challenge

Despite having difficulty in releasing staff, all nursing staff in Outpatients department have now completed the bronze level of the Skill Set Challenge

c) Hello my name is ....

'Hello my name is……' campaign launched. All outpatient staff who completed training now wear badges with logo and greet patients appropriately

d) Who would know

Updating of 'Who would know' posters in outpatients department to raise awareness of future care planning.

e) Raising staff interest in being involved

Haematology and Acute Oncology Clinical Nurse Specialists have expressed wish to be involved in recording and sharing Advance Care Planning. Audits to be undertaken

E. Other aspects

1. Patients and carers

- Development of:
  - GSF registered Patient Care Plans
  - Carers Care Plans
  - Policy for the Co-ordination of Care of those approaching the End of Life (GSF Registered)
- Completed care plans are put in the nursing notes of all GSF registered patients. Carers care plan also include carer assessment trigger tool for use by ward staff to prompt further in-depth assessment of need
- Families of those patients recognised as likely to be dying have 24 hour access to **Oasis Room** where they may wish to stay overnight or use for breaks throughout time in hospital.
- Family hospital **facilities leaflet** developed and **hotel style folders** produced in each Oasis room, with information regarding available services and facilities within the hospital
- Local schools and Girl Guide groups have been hand making individual **syringe pump bag covers** and **carer's comfort packs**, which are labelled with 'made for you by [child's first name]'. Positive feedback received from families on receipt of these.
- Queenscourt Outside Volunteers being rolled out in the hospital. The trained volunteers will sit with patients who have been recognised as likely to be dying (and are alone), and help support their families (if there are any), who may spend long periods of time alone in a hospital environment.
- Bereavement telephone calls made to next of kin following the death of all patients known to be GSF registered, to offer condolences and offer family members opportunity to feedback regarding the patient and family care and experience at end of life. Feedback mechanisms in place to inform ward of positive feedback and incident forms completed for investigation if concerns raised.

Building on the best

NHS Southport and Ormskirk Hospital NHS Trust

2. Staff

a) End of Life Skillset Challenge

End of Life Skill Set challenge re-launched across both hospital sites with keen interest and uptake from staff. It is an education programme which delivers teaching and supports professional development around end of life and palliative care which includes communication skills, end of life key enablers, spirituality and audit for change management. Bronze, Silver and Gold award for completion of end of life education and audit programme as detailed below.

BRONZE LEVEL
Training Required (all face to face sessions – Transform + Core Communication Skills half day)
Introduction to **Co-ordination of Care** (Use of the Gold Standard Framework)
Introduction to **Future Care Planning** (Advance Care Planning / Anticipatory Clinical Management Planning)
Introduction to **Dealing with Uncertainty** at the End of Life.
Introduction to **Respecting Patient Choice** (Rapid End of Life Transfers)
Introduction to **Care for the Dying** Patient (Priorities for Care of the Dying)
Introduction to **Family Support** (Genogram Training, Carer Assessment, Bereavement Support)
Core Communication Skills: Simple skills secrets *(1/2 day workshop)*

SILVER LEVEL
Training Required (depends upon role and seniority)
Overview of **Palliative & End of Life Care** (RGN 6 days / HCA 2 days / doctors 6 sessions/AHP designed)
Overview of **Future Care Planning** (1 day Advance Care Planning / Anticipatory Clinical Management Planning)
Overview of **Spiritual Care** (Clinical – Opening the Spiritual Gate F2F or online / Non clinical e-elca modules)
Eating & Drinking for the Dying Patient (Clinical – ½ day / non clinical e-elca)
Communication Skills: (Clinical – intermediate or advanced according to role / non clinical intermediate if role appropriate)
Bereavement Care (Mortuary Awareness Session / Verification of Death if appropriate to role)
Reflective Practice (Reflective Case Study / Reflection on End of Life Care in Place of Work)

GOLD LEVEL
Training Required (depends upon role and seniority)
Communication Skills: (Clinical - all band 6 and above to undertake advanced communication skills training)
Clinical Audit (identify and agree audit relating to end of life care / register audit with the end of life audit programme and develop an audit plan with agreed audit standards / undertake 2 cycles of audit, with an action plan developed and intervention implemented between cycles / present audit at the annual Celebrating Success Conference and appropriate departmental audit meeting)

In the last 2 years **90 hospital staff** have completed **bronze level** and **2** have completed **gold**. Several are still undertaking audits to reach gold, having completed silver prior to the BotB programme starting.

b) Other End of Life Education

There is ongoing multi-professional education for end of life key enablers and palliative care.

New HENW funded & North West Coast Learning Collaborative developed, Advance Care Planning education package launched in July 2017 which aims to educate 800 health professionals over 2 years in each of 9 areas of the North West, one of which is WL, S&F.

Education Topic	Number of hospital staff attended
Care of the Dying (Priorities for Care of the Dying)	**289**
Co-ordination of Care (Gold Standards Framework)	**275**
Respecting Patient Choice (Rapid End of Life Transfer)	**246**
Dealing with Uncertainty (at the End of Life)	**91**
Future Care Planning (Advance Care Planning/Anticipatory Clinical Management Planning)	**247**
Family Support (Genograms / Carer Assessment / Bereavement Care)	**172**
Pain Management (Assessment / Monitoring / Management)	**132**

3. Systems

- Every patient registered GSF who is admitted into hospital is **seen within 24 hours by the Transform Team**, to give opportunity to support the delivery of care and support patient and family
- **Live dashboard** for the daily identification of GSF patients in the hospital. Flags patients who are known to be GSF registered, living in a care home or known to Specialist Palliative Care Services
- **Daily helicopter meeting** between Transform Team, Hospital Palliative CNS, Palliative medicine and admin staff. This provides opportunity to be proactive in a more timely manner, ensure the most appropriate professional visits the patient and avoids duplication
- Every clinical area has an set of **End of Life drawers** with all the required documentation to implement the EoL key enablers, kept up to date by Transform admin staff
- **Every ward visited every day** to ascertain if any patients eligible for GSF registration, any patients rapidly deteriorating or staff have concerns about, or any patients that have been recognised as dying

and have an individual plan for care for those thought likely to be dying developed with them and their family, to give opportunity for Transform to support ward staff in care delivery

- **Identify GSF registered patient who attend A+E but avoid hospital admission**. Reason for admission informed to community palliative CNS (if patient known to them) and Transform Care Home Facilitator to give opportunity to implement ACP and ACMP to try to prevent inappropriate hospital admissions in the future
- New **central point of access** for all specialist and supportive palliative care services. New **admin support** available 7 days a week
- Ongoing data collection of **time taken** for GSF patients medically optimised for discharge to hospital discharge date
- **Deteriorating Patient Hub** development planned resulting in redesign of hospital wards and request to lead **Future Care Planning Workstream** with Trust support.
- Ongoing recruitment of **volunteers** to support care of the dying
- All **audit results are being presented** to multi-professional staff groups as part of ongoing action plans
- Monthly teaching in Trust New Starters **Induction Programme** to inform of Specialist and Supportive Palliative Care services within the hospital and to give and overview of EoL key enablers and documentation

F. Challenges and solutions

1. Organisational Challenges at senior level

- The integrated care organisation that was S&O NHS Trust was split into 3 separate organisations, with the tendering of Community Services out to external agencies
- Continuous interim leadership in all senior roles for 2 years, with 7 interim Chief Executives over this time, impact is reflected in CQC report Mar 2018 (2 CQC inspections within 2 years)
- Information technology systems within the organisation and surrounding areas are individual and incompatible
- Despite a national and international recruitment drive there are a large number of nursing vacancies within the Trust
- Uncertainty about continued funding for Transform Team past March 2018

2. Organisational Challenges at Hospital level

- Insufficient timely recognition of those patients approaching end of life
- Lack of resources, particularly staff time, for receiving end of life education
- Communication with primary care from the hospital is not always completed in a timely manner
- Assessment and patient management not standardised across all wards. Differing ward round proformata, which may or may not include consideration of end of life key enablers
- Conversations about future care not always being recorded or shared
- Implementation, recording and sharing of advance care planning in all settings across the hospital variable
- Missed opportunities and staff feeling "it's not my role.....someone else should do that"
- Lack of continuity of senior leadership and vision to drive the implementation of the end of life care as a Trust priority
- Increasing workload with reduced resources
- Acting DoN currently in post, substantive post awaited; Interim CEO in post, substantive post appointed but awaited; Interim Medical Director in post

3. Solutions, Interventions and Support

- Substantive Chief Executive to commence in post April 2018
- Non Executive Director with responsibility for EoL Care in post since August - positive force for good
- Willing and enthusiastic frontline staff who want to do their best for patients and families
- Cross boundary systems (processes, policies, procedures, documentation, integrated services, joint working)
- Ongoing meetings, audit and education for end of life care in community services to maintain integration and standardisation of care for palliative patients no matter where they are cared for
- Opportunistic teaching and education, alongside formal teaching and study days
- Working group on standardised ward round proforma commenced
- Developing, and seeking new ways of integrating, working relationships with community services

- Consistency of education, documentation and support are key
- Utilise every resource in any way possible
- Visible daily presence on every ward builds trust and working relationships
- Senior management support is essential
- Staff are motivated by success and positive feedback
- Everything has to repeated many times
- If we do what we are supposed to do… it really works!
- Keep going….never give up

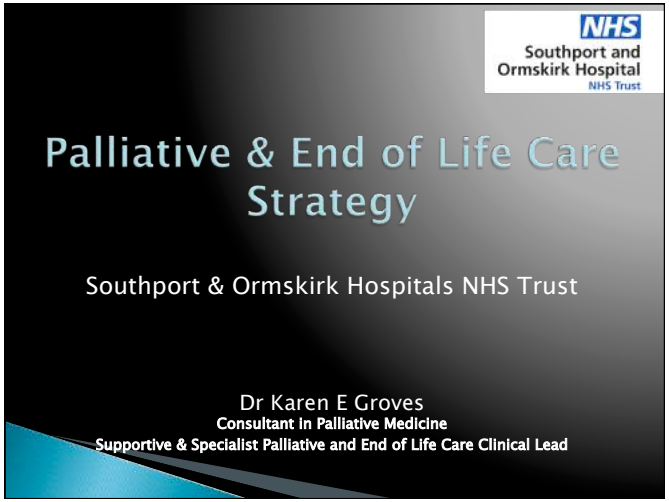
If *(Rudyard Kipling)*

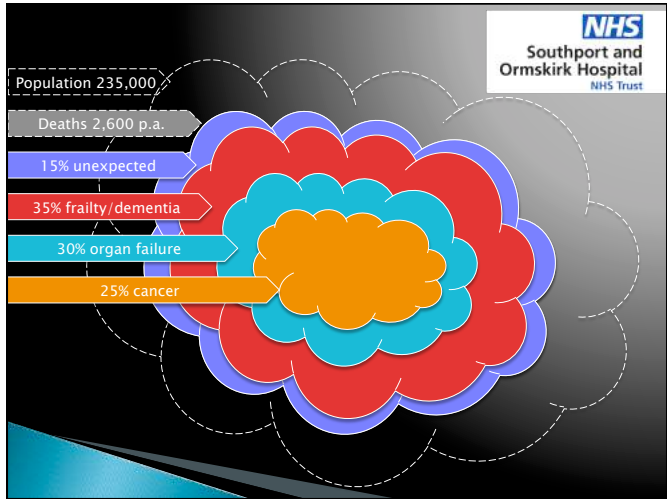
If you can keep your head when all about you
Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
But make allowance for their doubting too;
If you can wait and not be tired by waiting,
Or being lied about, don't deal in lies,
Or being hated, don't give way to hating,
And yet don't look too good, nor talk too wise:

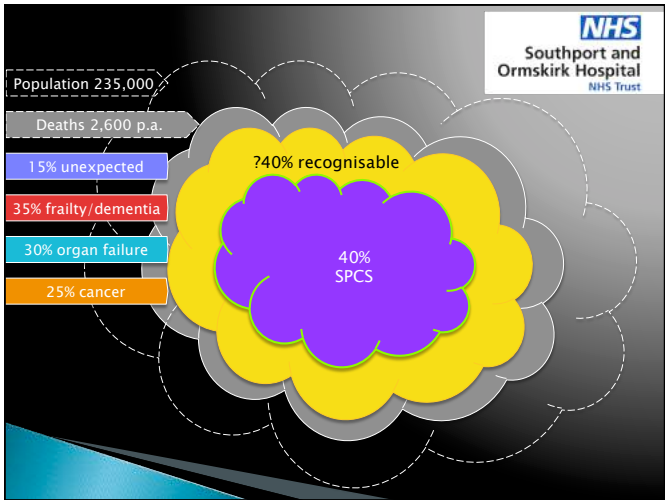
If you can dream—and not make dreams your master;
If you can think—and not make thoughts your aim;
If you can meet with Triumph and Disaster
And treat those two impostors just the same;
If you can bear to hear the truth you've spoken
Twisted by knaves to make a trap for fools,
Or watch the things you gave your life to, broken,
And stoop and build them up with worn-out tools:

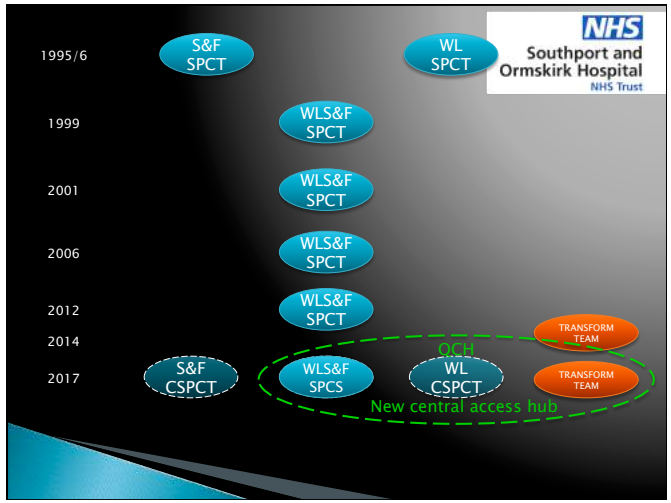
If you can make one heap of all your winnings
And risk it on one turn of pitch-and-toss,
And lose, and start again at your beginnings
And never breathe a word about your loss;
If you can force your heart and nerve and sinew
To serve your turn long after they are gone,
And so hold on when there is nothing in you
Except the will, which says to them: 'Hold on!'

If you can talk with crowds and keep your virtue,
Or walk with kings—nor lose the common touch,
If neither foes nor loving friends can hurt you,
If all men count with you, but none too much;
If you can fill the unforgiving minute
With sixty seconds' worth of distance run,
Yours is the earth and everything that's in it,
And—which is more—you'll be a man, my son!


NHS
Southport and Ormskirk Hospital
NHS Trust
Palliative & End of Life Care Strategy
Southport & Ormskirk Hospitals NHS Trust
Dr Karen E Groves
Consultant in Palliative Medicine
Supportive & Specialist Palliative and End of Life Care Clinical Lead


NHS
Southport and Ormskirk Hospital
NHS Trust
Population 235,000
Deaths 2,600 p.a.
15% unexpected
35% frailty/dementia
30% organ failure
25% cancer


NHS
Southport and Ormskirk Hospital
NHS Trust
Population 235,000
Deaths 2,600 p.a.
15% unexpected
35% frailty/dementia
30% organ failure
25% cancer
?40% recognisable
40% SPCS


NHS
Southport and Ormskirk Hospital
NHS Trust
1995/6
S&F SPCT
WL SPCT
1999
WLS&F SPCT
2001
WLS&F SPCT
2006
WLS&F SPCT
2012
WLS&F SPCT
2014
2017
S&F CSPCT
WLS&F SPCS
WL CSPCT
OCH
TRANSFORM TEAM
TRANSFORM TEAM
New central access hub

NHS Southport and Ormskirk Hospital NHS Trust

'BUILDING ON THE BEST' PROGRAMME

Building on the best

support : empower : educate

Karen Groves, Consultant Palliative Medicine
Louise Charnock, Transform Team Clinical Lead
April 2018

NATIONAL STATISTICS

- 1% of population dies each year
- 56% of deaths occur in hospital
- 60-70% people would choose to die at home
- $^1/_3$ of hospital inpatients will die within the next 12 months (Clarke et al, 2014)

Clark D, Armstrong M, Allan A, Graham F, et al (2014) Imminence of death amongst hospital inpatients: a prevalent cohort study **Palliative Medicine** Vol 28 (6) 474-479

LOCAL STATISTICS

- WL,S&F population 235,000
- 1.2% of local population die/year *(nationally 1%)*
- Higher than average elderly population
- Patient average age in hospital 80 *(Range 0-108 years)*
- 100 care homes in the local area *(3500 beds)*
- Hospital across 2 sites
- 497 beds

(455 General and acute, 27 Maternity and 15 Critical care)

S&O HOSPITAL DEATHS

- 12% hospital deaths are admitted from care home
- 44% WL,S&F deaths occurred in hospital 2016/17 (80% of these within S&O Hospital)
- 89% hospital deaths follow emergency admission

AIMS of TRANSFORM TEAM

Southport and Ormskirk Hospital NHS Trust

To
educate, empower and support
patients, families and health professionals
to
continually improve and deliver excellence
in palliative and end of life care
within
Southport and Ormskirk NHS Hospital

BUILDING on the BEST

Southport and Ormskirk Hospital NHS Trust

- 10 NHS UK Hospital Trusts selected
- Build upon Transforming Acute Hospitals End of Life Care (NHS, 2012)
- Two year programme March 2016/18
- Implemented by Hospice UK
- Based on up to 4 work streams of BotB programme
  - Cross boundary communication
  - Shared decision making
  - Outpatients
  - Pain and symptom management

EoL EDUCATION

Southport and Ormskirk Hospital NHS Trust

SUBJECT OF TEACHING	NUMBER OF STAFF IN HOSPITAL TAUGHT
Care of the dying	289
GSF	275
REoLT	246
Dealing with Uncertainty	91
Advance Care Planning	247
Genograms	172
Pain Management	132

IMPACT ON EoL KEY ENABLERS

Southport and Ormskirk Hospital NHS Trust

No. hospital patients	2015/16	2016/17	2017/18	overall
Hospital prompted GSF registration	302	425	764	↑153%
Documented REoLT conversation	417	350	410	=
Successful REoLT	80	99	114	↑43%
No. deaths in hospital	857	935	950	↑11%
Individual Plan for the Care of those thought likely to be Dying developed with patient & family	41%	49%	56%	↑15%
Hospital deaths who achieved PPC	37%	41%	64%	↑27%

GSF – Gold Standards Framework
REoLT – Rapid End of Life Transfer
PPC – Preferred Place of Care

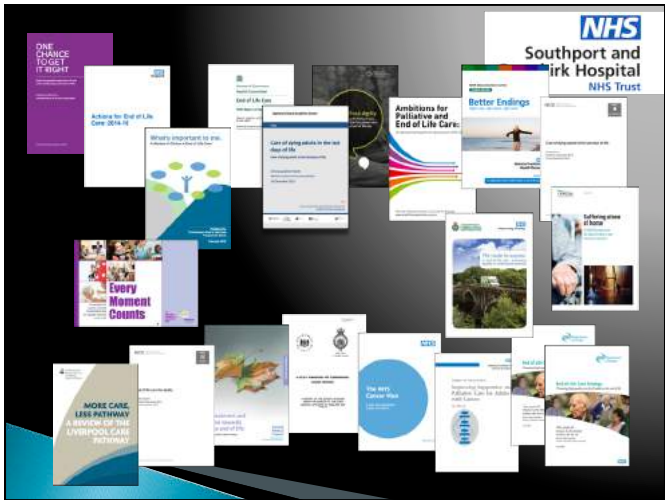
However!

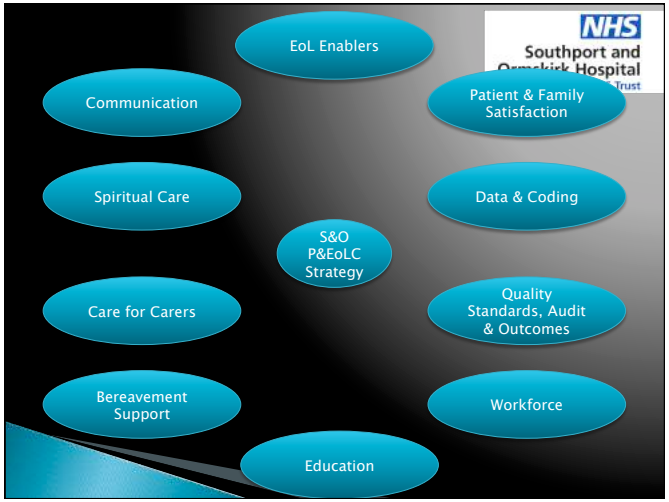
Southport and Ormskirk Hospital NHS Trust

- Increase in hospitals deaths
- Not all approaching end of life recognised
- Not all dying recognised as dying
- Not all patients wishes followed
- Increase in area deaths
- Lack of confidence in having conversations
- Communication & dealing with uncertainty
- Not all discussed and documented

Southport and Ormskirk Hospital NHS Trust

S&O P&EoLC Strategy




NHS
Southport and
Ormskirk Hospital
NHS Trust
EoL Enablers
Communication
Patient & Family Satisfaction
Spiritual Care
Data & Coding
S&O P&EoLC Strategy
Care for Carers
Quality Standards, Audit & Outcomes
Bereavement Support
Workforce
Education


NHS
Southport and
Ormskirk Hospital
NHS Trust
Issues


NHS
Southport and
Ormskirk Hospital
NHS Trust
End of Life Care …
… is everybody's business
We have only one chance …
… to get it right …
… for each individual & family

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6th June 2018

Agenda Item	**TB142/18**	**Report Title**	**Monthly Mortality Report**
Executive Lead	**Jugnu Mahajan,** Interim Medical Director		
Lead Officer	**Dr Chris Goddard,** Associate Medical Director of Patient Safety **Mike Lightfoot,** Head of Information **Rachel Flood-Jones,** Project Delivery Manager		
`Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information		☐ To Note ✓ To Receive

Executive Summary

The committee is asked to receive the report for assurance of the progress of the Reducing Avoidable Mortality Project, visibility of trust mortality data and analysis thereof alongside detail of associated quality improvement activity.

Contents:

Strategic Context – Learning from Deaths and Reducing Avoidable Mortality

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

Measuring Mortality

- The latest available Summary Hospital-level Mortality Indicator (SHMI) & Hospital Standardised Mortality Ratio (HSMR)
- Disease-Specific Mortality – December 2017
- Mortality Dashboard Highlights – March 2018

Reducing Avoidable Mortality (RAM)

Project Status Update

Strategic Objective(s) and Principal Risks(s)

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

Strategic Objective	Principal Risk
☐ **SO1** Agree with partners a long term acute services strategy	*Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards*
✓ **SO2** Improve clinical outcomes and patient safety	*Poor clinical outcomes and safety records*

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

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

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

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

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

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

Progress reporting will be provided in future Monthly Mortality Reports detailing key risks and milestones. Mortality data including mortality ratios and trajectories will be supported with insight into causality and linked to quality improvement activity.

Previously Presented at:

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

Monthly Mortality Report
May 2018

1.0 Executive Summary

Section		Summary
3.0	**Background (Strategic Context)**	The adoption of the Royal College of Physician's Structured Judgement Review method will drive a 'Learning from Deaths' culture to increase patient safety and reduce mortality. As part of the 'Reducing Avoidable Mortality' Project, robust processes are to be developed to link mortality reviews, serious incidents or complaints (where relevant) with mortality data in order to identify thematic trends and areas requiring quality improvement.
4.0	**Measuring Mortality**	**Mortality Ratios** Both the Summary Hospital-level Mortality Indicator SHMI and Hospital Standardised Mortality Ratio HSMR remain above expected levels. SHMI for the rolling 12 month period 1st October 2016 to 30th September 2017 is reported at 117.39 and HSMR at 114.4 for the 12 month rolling period up to November 2017.
5.0	**Reducing Avoidable Mortality Project**	A detailed update is provided for all key activity and all six work streams of the project.
Appendices		
1	**Mortality Dashboard Summary**	An overview of the monthly in-house Mortality Dashboard Report is included as Appendix 1. Highlights from the full report are detailed as narrative in item '3.0 Measuring Mortality'. The full report is presented to the monthly Mortality Operational Group and is available on request.

2.0 Strategic Context

Mortality is a key priority for the Trust, with improvement work driven by the 'Reducing Avoidable Mortality' (RAM) Project which has the overriding aim of reducing avoidable mortality by April 2019. The project will drive improvement in safety and quality, in collaboration with the Advancing Quality Alliance (AQuA) and the North West Innovation Agency. It will also embed activity to drive a culture of 'Learning from Deaths' in line with national guidance.[1]

[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).'

The Royal College of Physician's Structured Judgement Review Tool (RCP SJR Tool) is currently being rolled out across the Trust with the go live date of 3rd July 2018, (subject to IT updates by the system provider, Datix).

Trusts which have already adopted the SJR method have done so with the use of the free Datix RCP SJR Tool. Southport and Ormskirk Hospital Trust has instead purchased an upgrade to Datix IQ Cloud, which includes the SJR module as a bolt on to its existing Datix incident and complaints management system. The new functionality will link mortality screening and Structured Judgement Reviews into incidents and investigations where relevant. There has been a delay to the upgrade to Datix IQ Cloud (and access to the SJR tool) due to a requirement for IT fixes for the purposes of data protection, data storage and system security.

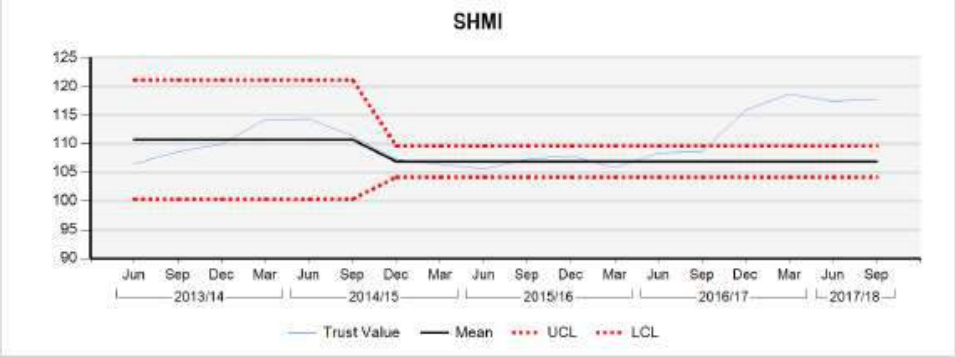
As part of the 'Reducing Avoidable Mortality' Project, robust processes are to be developed to link mortality reviews, serious incidents or complaints (where relevant) with mortality data in order to identify issues for quality improvement.

3.0 Measuring Mortality

3.1 SHMI & HSMR

3.1.1 Summary Hospital-level Mortality Indicator (SHMI):

The latest available reportable period for SHMI, (rolling 12 month period reported quarterly) is for 1st October 2016 to 30th September 2017 for which the Trust was reported to be at a ratio of 117.39.(This was representative of 1,356 actual deaths over an expected figure of 1,152 deaths).[2] These figures were published by NHS Digital on 22nd March with the next available on 21st June 2018.



3.1.2 Hospital Standardised Mortality Ratio (HSMR):

The HSMR is provided nationally by 'Dr Foster' and applies to in-hospital mortality (excluding palliative care). The latest available data for December 2017 shows the Trust's rolling 12 month mortality ratio at 114.4 with an in month position of 109.1.

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

These figures show a decline from November 2017 when the rolling 12 month position had been 113.2 with an in-month position 90.1. The in-month figure for the same month the previous year, December 2016 had been 99.69.

3.2 Disease-Specific Mortality – December 2017

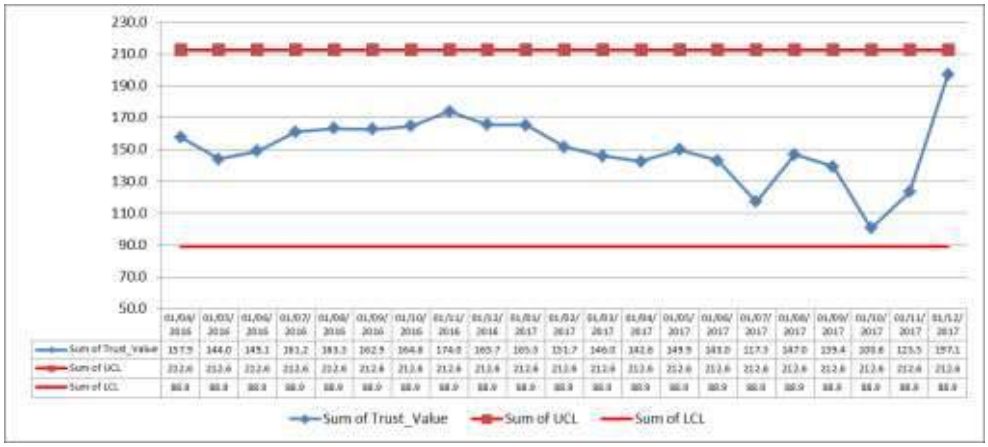
3.2.1 Lower Respiratory Tract Infection, Acute Bronchitis & Pneumonia

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

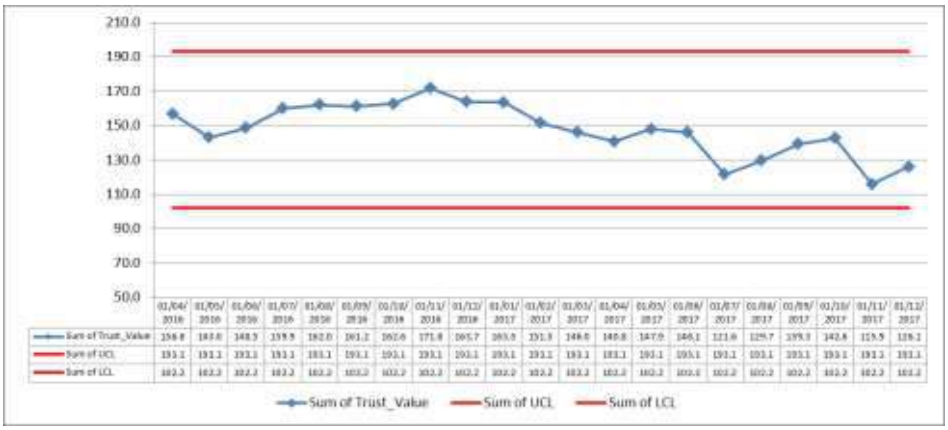
- Lower Respiratory Tract Infection (LRTI) jumped from 115.9 in November to 197.1 in December.
- Acute Bronchitis increased from 114.6 in November to 126.1 in December.
- Pneumonia barely changed between 125.2 in November to 125.7 in December.

The jump in the number of LRTI and bronchitis deaths is likely to be attributable to both the expected seasonal variation and the diagnostic accuracy checking exercise undertaken by Dr Chris McManus, Consultant in Respiratory Medicine. The exercise, focusing on diagnostic and coding accuracy has resulted in the reduction of reported Pneumonia deaths from September 2017. The seasonal rise in figures for respiratory related deaths is therefore being seen in an increase to both LRTI and bronchitis ratios.

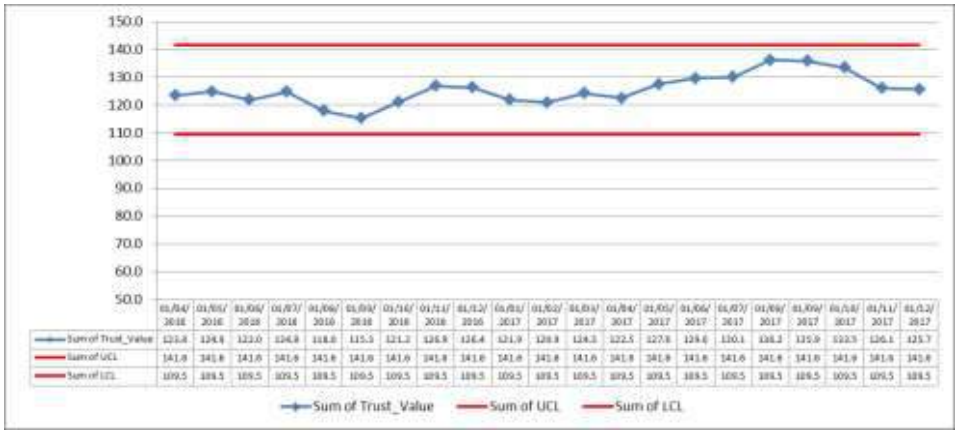
An External Mortality Review has been commissioned to look at LRTI, Acute Bronchitis, Pneumonia and Stroke deaths over the period of May 2017 to April 2018. This will take place in June with the report available before the end of August.



Lower Respiratory Tract Infection



Acute Bronchitis

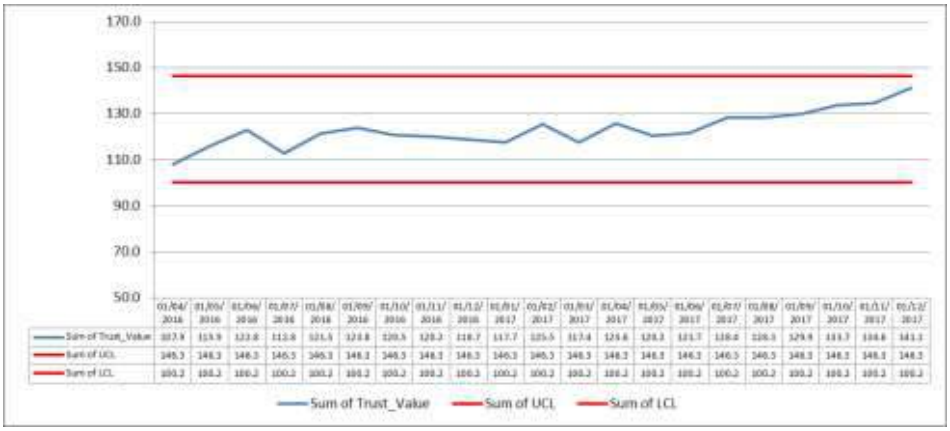


Pneumonia

3.2.2 Stroke

Stroke has the second highest rolling 12 month SMR for December 2017 of 141.1 up from 133.7 in November 2017.

As noted in the April report the Sentinel Stroke National Audit Programme (SSNAP) reported a ratio of 100 for the trust for November 2017; their calculations take into account specific indicators of poor stroke outcome (for example stroke severity).

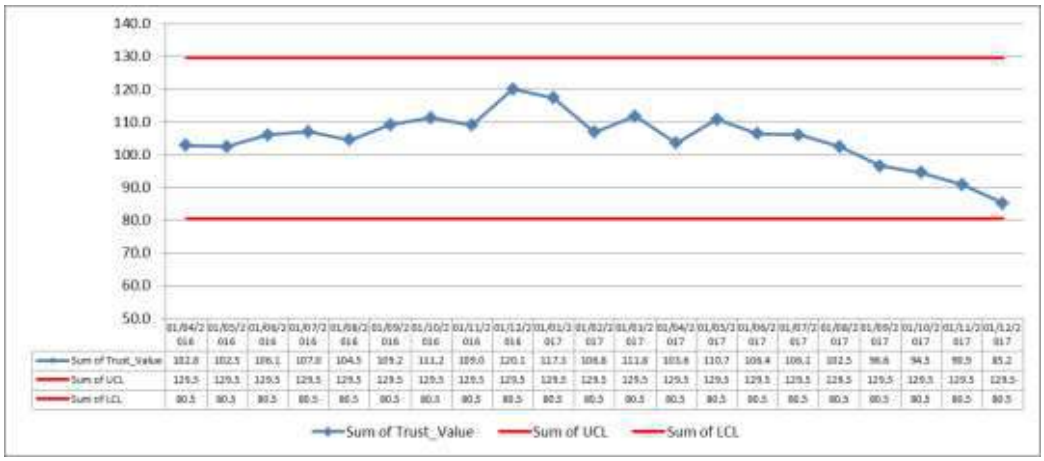


Stroke

3.2.3 Septicemia (Except in Labour)

The rolling 12 month SMR for septicemia continues on a trajectory of improvement to a reported 85.2 in December from 89.4 in November 2017, holding the ratio below the target of 100. Raised awareness of septicaemia in A&E and an increased focus on appropriate treatment has contributed to this great improvement from a ratio of 120 in December 2016.

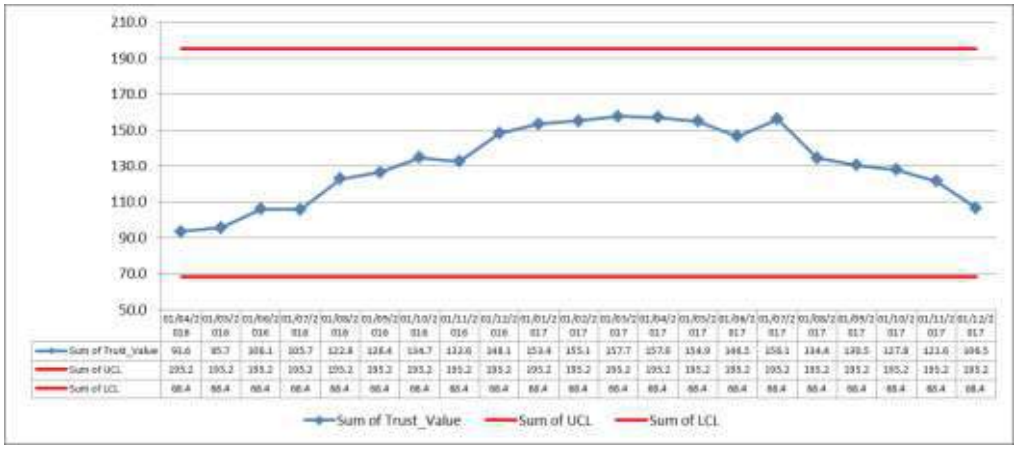
Patients being admitted through A&E with sepsis are being reported, however there is a problem in that patients who are deteriorating due to sepsis on wards are not being picked up and coded accordingly. A business case for an enhanced Outreach Team with a Clinical Support Worker is in progress to provide required support.



Septicemia

3.2.4 Urinary Tract Infection

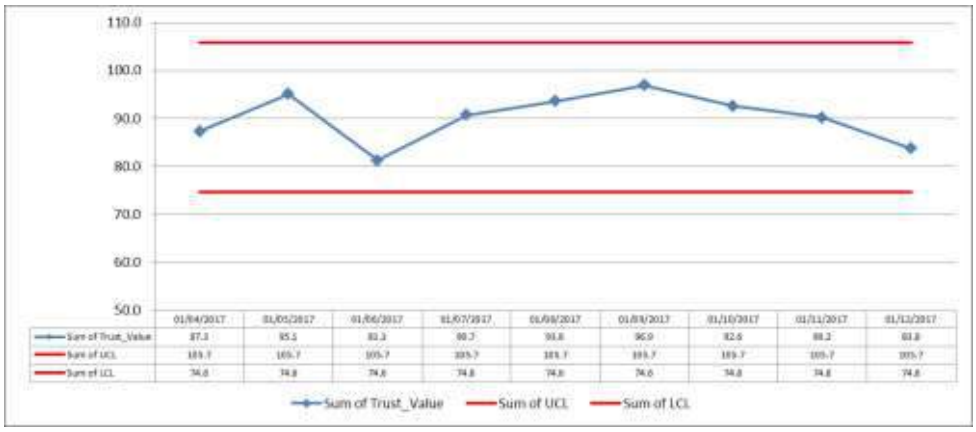
The rolling 12 month SMR for Urinary Tract Infection for December 2017 was 106.5, down from 118.5 in November 2017. This is continues a downward trajectory following a high of 156.14 in July 2017. This indicator was last below 100 in May 2016.



Urinary Tract Infection

3.2.5 Acute Kidney Injury

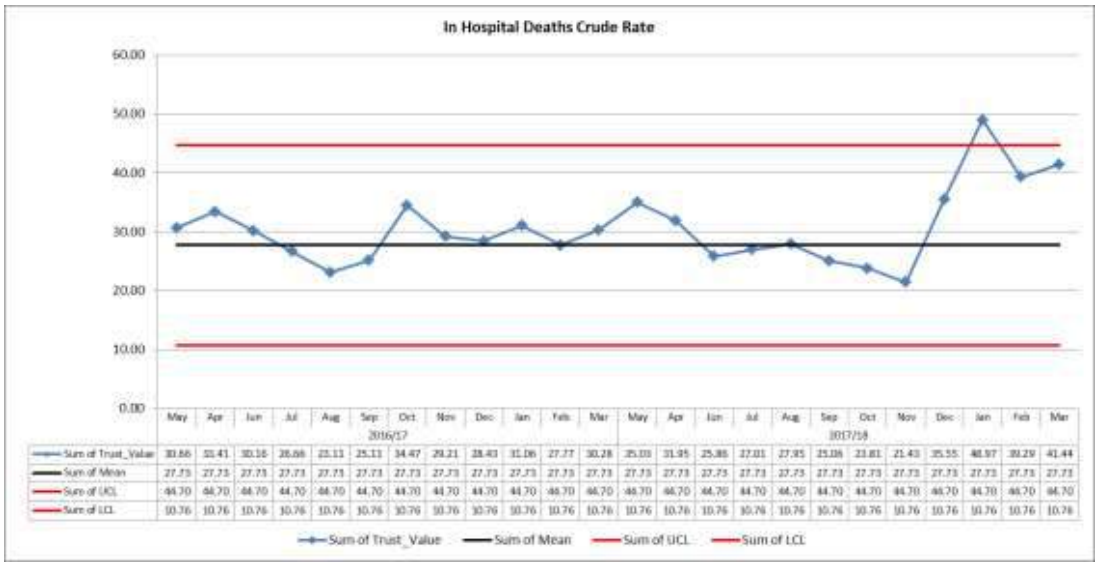
The 12 month rolling SMR for December 2017 dropped to 83.8 from 118.5 in November. The new clinical pathway for Acute Kidney Injury is to be submitted to the Clinical Effectiveness Committee this month for approval, ahead of roll out across the trust.



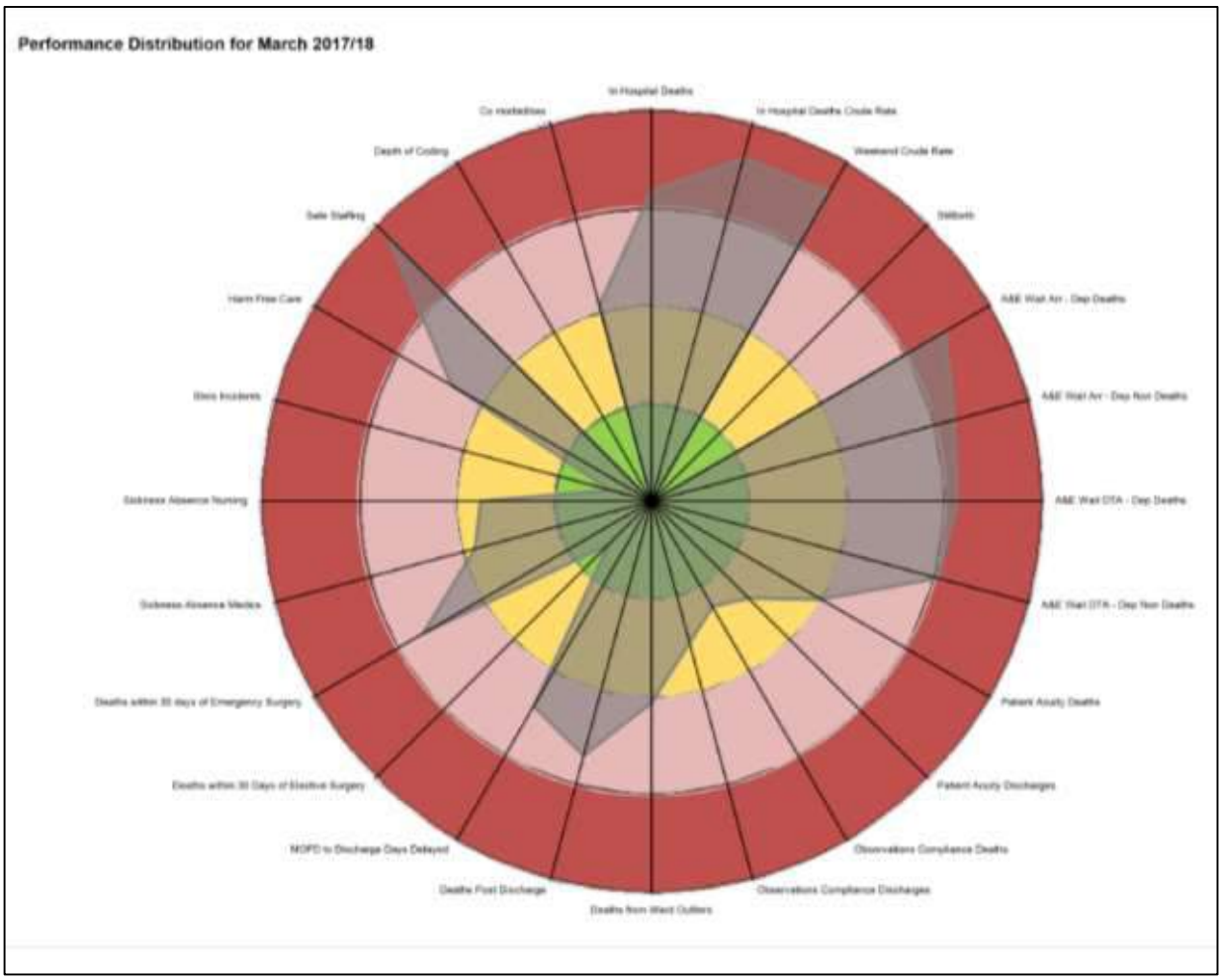
Acute Kidney Injury

3.3 Crude Mortality:

The Trust's Crude Mortality rate (the number of crude deaths per 1000 discharges) for March was 41.4 against a target of 31.0 (Planned Care 29.9 and Urgent Care 78.5). Whilst it is recognised that this is particularly high for the month of March, it is believed that this is reflective of the national picture; this will be subject to further scrutiny as more information is available.



3.4 Mortality Dashboard Highlights – March 2018



The radar graph, taken from the monthly Trust Mortality Dashboard shows the relative distribution of key mortality related measurements, highlighting areas of poor performance.

4.1 No preventable deaths were reported in March 2018.

4.2 97% of patients received harm free care.

4.3 There have been 7 deaths this year to date of Patients with Learning Difficulties. Best practice for quality improvement for patients with learning difficulties is being looked into in association with the Learning from Deaths national initiative.

4.4 28% of all in-hospital deaths were attributable to patients who had been in the hospital for less than 1 day.

4.5 65 deaths were within 30 days post-discharge, of these 33 were on the Gold Standard Framework[3] (GSF) at the time of discharge and of these, 15 had been on the GSF on admission.

As part of the 'Reducing Avoidable Mortality' project, a more robust process is being designed to identify those who are End of Life with alternatives to admission; giving

[3] The Gold Standard Framework is the scheme for those requiring End of Life Care.

patients the right care that they need in their own home. This will reduce overall admissions, hospital deaths and deaths within 20 days post-discharge.

4.6 The average Length of stay for patients who died within 30 days of discharge was 15.2 days.

4.7 The Average number of days between discharge and death for patients who died within 30 days of discharge was 13.5 days.

4.8 The total number of days between those identified as being Medically Fit for Discharge (MOFD) and the point of discharge for patients who subsequently died within 30 days of discharge, who had a GSF alert was 203 against a Trust target of 162, (48 for Planned Care and 155 for Urgent Care).

4.9 The percentage of deaths within 30 Days of Surgery was 0.13% for Elective Surgery and 10.55% for Emergency Surgery.

4.10 The Sickness Absence Rate for Medical Staff for March was 1.60% (0.48% for Planned Care and 2.31% for Urgent Care) while the Sickness Absence Rate for Nursing & Midwifery Staff was 6.28% (6.6% for Planned Care and 7.28% for Urgent Care).

4.11 The Safe Staffing ratio (between the proposed number of nursing staff to ensure a safe staffing level and the actual number of nurses working those shifts) was 84.59% (79.66% for Planned Care and 88.95% for Urgent Care).

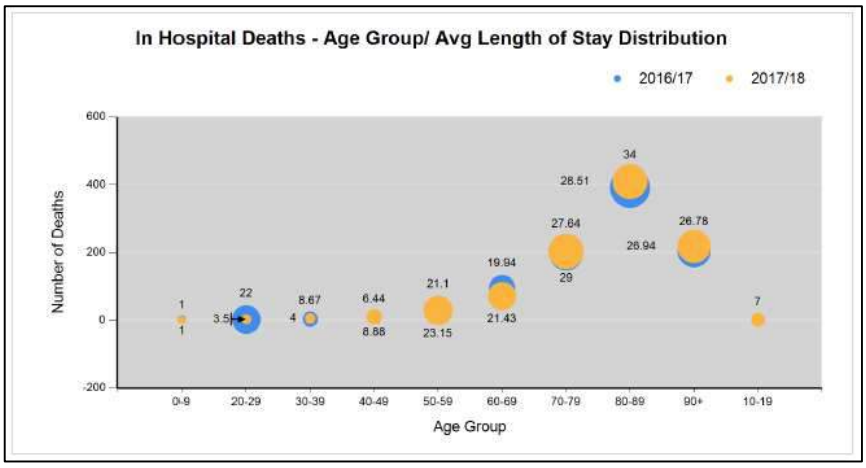
4.12 19.81% of deaths had been allocated a Z515 Palliative Care Code[4] however it is believed that this number should be closer to 28%. An investigation is currently underway under the umbrella of the RAM project to identify deaths which should have been coded accordingly and to identify best practice for compliance. There is an implication to the HSMR ratio in that those coded as Z515 are are deducted as expected deaths.

4.13 The average time that patients waited in A&E (arrival to departure) for patients who then died was 10.5 hours, the average time that patients waited in A&E (decision to admit to departure) again for patients who then died was 6.4 hours.

4.14 The average time that patients waited in A&E (arrival to departure) for patients who did not die was 7.3 hours, the average time that patients waited in A&E (decision to admit to departure) again for patients who did not die was 5.4 hours.

4.15 The chart below shows the distribution of in-hospital stays by age group in 2016/17 to 2017/18. (The relative size of the bubble represents the average length of stage of the spell). We can see that the greatest number of deaths occurred amongst the 80-89 age group. This group also had on average the longest hospital stays; the average length of stay was greater in 2016/17 (34 days) than in 2017/18 (28.51 days).

[4] The Z515 code is applied when assessment and care is provided by a member of the Transform Team (the Trust's specialist palliative care services team). As per the Trust policy, the code cannot be applied in cases where care is given by a nurse or medic who is palliative care trained outside of the Transform Team.



5.3 Reducing Avoidable Mortality Project (RAM)

The Reducing Avoidable Mortality Project continues to drive the work that was undertaken by the Deteriorating Patient Project.

All six work streams are live, with activity driven through weekly Project Group Meetings and from July onwards through bimonthly Steering Group Meetings. The project is currently in the Development Phase, (as illustrated in the Project Phasing Timeline below). Quality improvement and change activity are key aspects of this phase, ahead of the Project Execution Phase which will focus on embedding new processes and behaviours.

Both the Project Timeline and the Project Highlight report included below give detail on key activity and progress.

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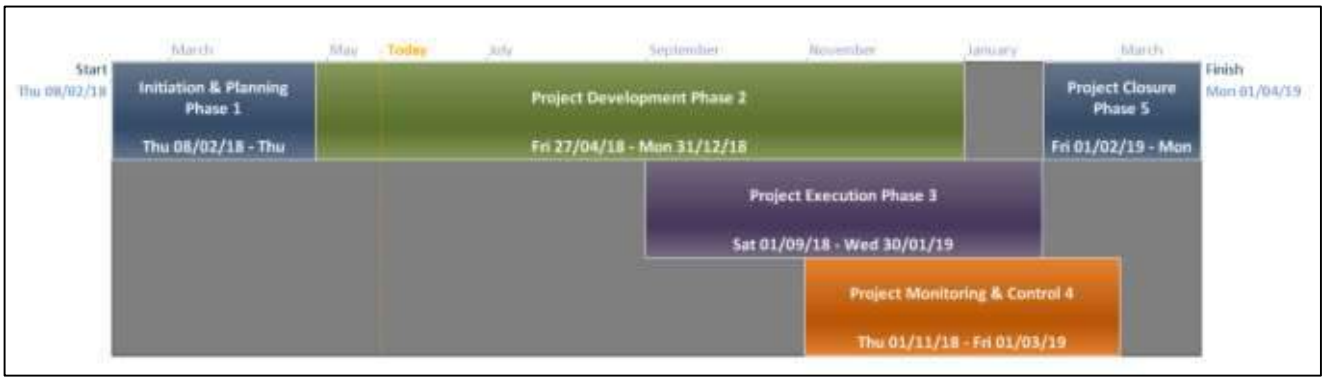
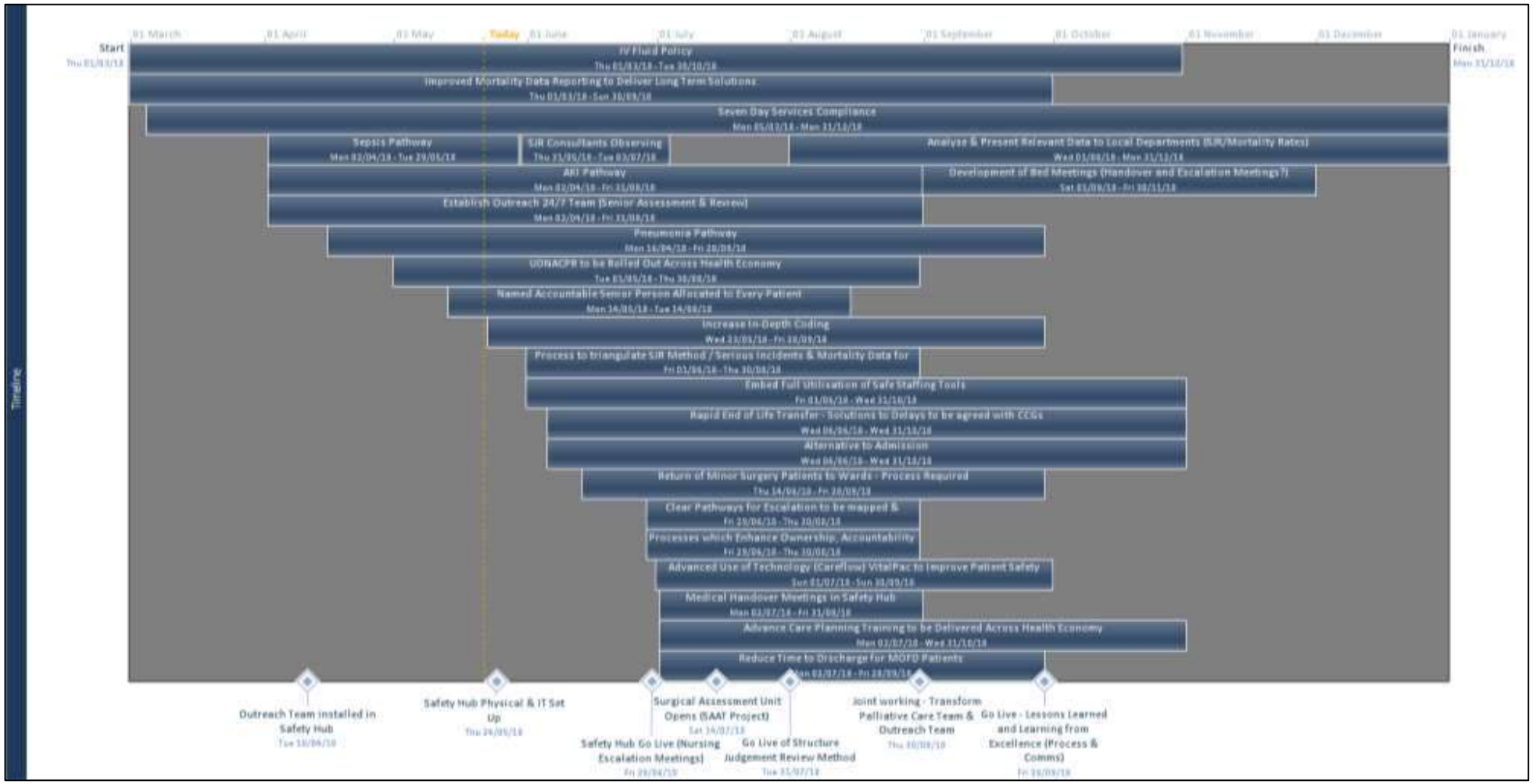


Reducing Avoidable Mortality - Project Phasing Timeline

Reducing Avoidable Mortality – Project Plan Timeline by Activity



Project Highlight Report

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

Project Manager	Rachel Flood-Jones
Quality Portfolio Lead	Jo Simpson
Project Reports to	Mortality Operational Group & Quality & Safety Committee
Report Date	14th May 2018
Reported to	Quality and Safety Commmittee

Key	
Blue	Activity yet to commence
Red	Activity is behind schedule
Amber	Activity has commenced / activity is still required / Project is on
Green	Required activity has been undertaken

Project Objectives

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	**Comments**		**Status Update**	**Status**	**% Completion**
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.	**Sepsis Pathway**		Paperwork has been finalised - roll out to now take place on wards.	G	100
	Community Sepsis Pathway: created and approved by South Sefton CCG for SOHT, NWAS & SSCCG (to be presented to WLCCG for potential adoption).		A new action will superseded this to present to West Lancashire CCG for their consideration for adoption.	G	100
	AKI Pathway: to be signed off at Clinical Effectiveness Committee 24/05.		After sign off; pathway to be designed and rolled out.	A	30
	IV Fluid Therapy Policy: has been written and is being driven as part of the Implementation Meetings for the same.		Stages of roll out to be confirmed.	A	20
	External Mortality Review: 'Developing Trust Capacity & Approach to Learning from Deaths' to review Pneumonia & Stroke deaths May 2017 to April 2018.		Review to take place in June, report to be available in August 2018.	B	NA
	Upper GI Bleed: Trust discussing the option of a formal SLA with Aintree.		Awaiting meeting confirmation.	A	10
	VitalPac: Upgrade to VITALPAC 3.5 required.		On track for end June 2018.	A	90
	NEWS 2: To be rolled out once VitalPac 3.6 has in place - aim April '19		VitalPac Team are sighted on this.	B	NA
	Timely Emergency Surgery: Surgical Assessment Unit (SAU) scheduled to open mid July 2018.		Going ahead	A	90
	Timely Emergency Surgery: Process for minor injuries patients to return to parent ward after surgery		Discussions are underway	A	10
COMMUNICATION: Drive the implementation of a robust Safety Hub and ICT Infrastructure through the SAAT Project in place for both sites by June 2018	**Safety Hub:** Physical set up and IT functionality		Completed	G	100
	Safety Hub: 'Go Live' of Nursing Escalation Meetings and relevant reporting on screens		Go live 18th June 2018	A	90
	Bed Meetings & Medical Handover Meetings to run through the Safety Hub		Bed Meetings to move in after Escalation Meetings - June 2018	B	NA
	Named accountable person allocated against every patient.		In progress	A	10
	Pathways for escalation to be designed and rolled out.		To commence 2nd July 2018.	B	NA
	Policy for the management of outliers		In progress on agenda for Mortality Operational Group in June 2018	A	30
	Ensure **optimum use of Careflow / VitalPac** to improve patient safety.		Specific work to commence 2nd July 2018.	B	NA
	Joint working between **Transform Palliative Care Team and the Outreach Team.**		Specific work to commence 2nd July 2018.	B	NA

SMART (Specific-Measurable-Attainable-Relevant-Time bound)	Comments		Status Update	Status	% Completion
LEARNING CULTURE: Implement and embed a learning culture with regard to learning from deaths across the organisation by September 2018.	In-house **Mortality Screening Tool** designed and tested (trigger for SJR method)		Completed	G	100
	Training of consultants in SJR Method		All specialities will be trained by the end of June 2018	A	80
	SJR Tool in DATIX IQ Cloud Go Live.		Dependent upon successful IT fixes from DATIX - This is a risk.	A	80
	Preparation for **External Mortality Review**		Completed. Review Lead in Trust on 24th May.	G	100
	Consultants to sit with External Mortality Review Team for **best practice use of SJR Tool.**		31st May to 3rd July 2018	B	NA
	Alternative process in place if **DATIX IQ Cloud** cannot be delivered by 3rd July 2018 (to use RCP SJR tool in the interim).		Process to be formalised and stand by communications to be finalised.	A	30
	SJR Mortality Reviews to be factored into job planning.		July 2018	B	NA
	Link Risk and Mortality Data: Formal process for triangulation of SJR method, Serious Incidents and Mortality Data		Work to commence June 2018.	B	NA
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	**The Unified 'Do Not Attempt Cardio Resuscitation Order'**		Has been agreed for use within and outside the hospital - training and roll out now required.	A	30
	Anticipatory Clinical Management Planning		Model is in place on the Frail and Elderly Short Stay Unit	A	20
	Advance Care Planning: training and awareness is to rolled out across the Trust.		Work to commence July 2018	B	NA
	Alternatives to admission: to be developed as part of a second stage of project: to involve Clinical Commissioning Group partners.		Work to commence July 2018	B	NA
	Rapid End of Life Transfer		Has already been implemented but to be reviewed and improved upon.	A	80
	Reduce time to discharge for patients Medically Fit for Discharge for patients already on the Gold Standard Framework (GSF) Registered.		Process scoping required to acheive this.	B	NA
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	**Mortality Dashboard** to be reviewed and updated.		Report has been reviewed and revised. March and April 2018	G	100
	Understand and Communicate Mortality Data: Mortality Reporting to QSC and Trust Board to be reviewed and updated		The report is still being reviewed on a monthly basis	A	85
	Understand and Communicate Mortality Data: Learning from Deaths activity and mortality data to be added to the Trust Website		Links to mortality data,Learning from Deaths Policy, Support for mortality and bereavement issues all on dedicated web pages on Trust site. Bereavement booklet and letters to be finalised and added.	A	90
	Increase depth of coding		Meeting to review the use of Z515 Palliative Care Coding (23rd May). Discussions are underway to change method of coding ambulatory care patients in order to improve our co-morbidity index. Work ongoing to review other areas.	A	50
	Analyse and pressent **data to local departments (SJR / Mortality rates and findings).**		To commence once the SJR method is being used in the Trust. July2018	B	0
WORKFORCE: Establish the proposed workforce model to deliver agreed clinical outcomes which will include a tangible 24/7 Outreach Team by September 2018	**Establish a 24/7 Outreach Team**		Business Case has been submitted. 24/7 Outreach Team essential to the success of the project to drive down mortality.	A	20
	Embed Full Utilisation of Safe Staffing Tools		Activity started in March and will continue as the function of the Safety Hub evolves.	A	20
	Increase Access to & Prioritisation of Skills Training		Strategy to be developed with Training and Development and key stakeholders for access to training to support and inform a strategy to ensure managerial prioritisation and release of staff for training.	B	NA
	Workforce to Deliver Seven Day Service Provision		Seven Day Services Project is in the scoping phase. Current activity is designed to establish current requirements to meet the National Standards. Best practice adopted by similarly configured Trusts is to be considered for suitability.	A	10

Key Milestones	Start date	End date	RAG	Comments
Safety Hub Set Up		10th March 2018	G	The Safety Hub has been set up with required IT equipment and the current Outreach Team is installed.
Safety Hub Go Live		30th June 2018	A	Escalation Nursing Meetings to run from the Hub (with updated reporting on screens) from 30th June with Medical Handover and Bed Meetings to follow.
Surgical Assessment Unit Opens (SAAT Project)	14th July 2018	14th July 2018	A	Part of the Safe At All Times Project. The opening has been pushed back but the opening date is now set for 14th July 2018. This will support 'Timely Emergency Surgery' activity within the Care Pathways workstream.
Go Live of Structured Judgement Review Method		3rd July 2018	A	Back up plan in place in the event that the DATIX IQ Cloud Tool is not ready for Go Live on 3rd July. Free RCP SJR Tool to be used.
Triangulation of Risk and Mortality Data	1st June 2018	30th August 2018	B	Process planning, PDSA approach and Comms Plan to roll out.
Go Live Lessons Learned and Learning from Excellence		29th September 2018	B	Process planning, PDSA approach and Comms Plan to roll out.
Joint Working Transform Palliative Care and Outreach Team	2nd July 2018	30th August 2018	B	Joint working to aid escalation decisions.
24/7 Outreach Team	1st March 2018	30th September 2018	A	An update is being sought on the Business Case that has been submitted for this requirement which is essential for the successful delivery of the remit of the project

Top Risks and issues to achieving programme objectives

Risk	RAG	Mitigation Activity	RAG After Mitigation	Comments
If DATIX IQ Cloud is not ready for use from the 24th June (due to required IT fixes). Impacting on the Go Live of the Structured Judgement Review Method from 3rd July 2018	R	Interim plan to use the free RCP Tool in place of DATIX IQ scoped so method will go live on 3rd July.	A	We are preparing for both eventualities.
If the Business Case for the 24/7 Outreach Team then this poses a significant risk to the successful delivery of the project's aim: to reduce mortality by April 2019.	R	There is a day time Outreach Team during the week. The Business Case is to extend the Team to provide full 24/7 cover. An update is required on the business plan. If the full requirement cannot be fulfilled a wider discussion will be needed to understand alternatives with which to deliver the required cover.	A	Awaiting an update on the business plan and the way forward.
If clinical staff cannot be released for training then pathway education will not be embedded and objectives will not be achieved.	R	Meeting required with T&D to discuss a strategy to deliver training.	A	Training funding is also an issue which is to be addressed in the same forum.
Funding resource for the CareFlow System	A	On IM&T Annual Funding Plan	A	Project group representation is on the IM&T Committee from which updates are fedback

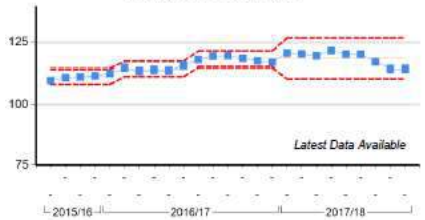
Appendix 1

Southport & Ormskirk NHS Trust Mortality Dashboard May 2018

Southport & Ormskirk Hospital NHS

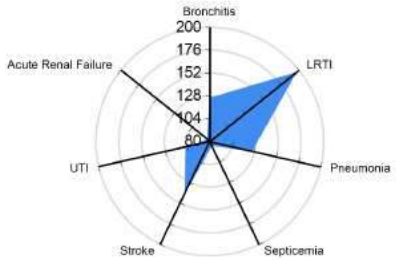
Dr Foster National Mortality Statistics

Rolling 12 Month HSMR

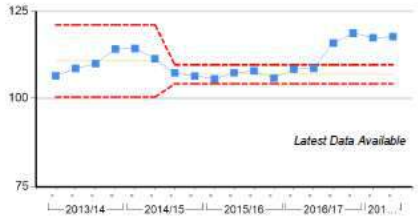


UCL and LCL are reset when 6 consecutive periods are above or belowthe mean.

Local HSMR December 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: 7

0.73% ▼

YTD Deaths of Patients with GSF Alert: 130

13.6% ▼

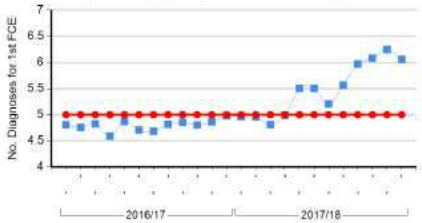
Deaths Post Discharge

Avg Spell LOS whilst admitted: **21.7**

Avg Days to death post discharge: **13.3**

YTD Deaths of Patients with GSF Alert: 155 — **24.6%** ▼

Depth of Coding - (compared to national average)



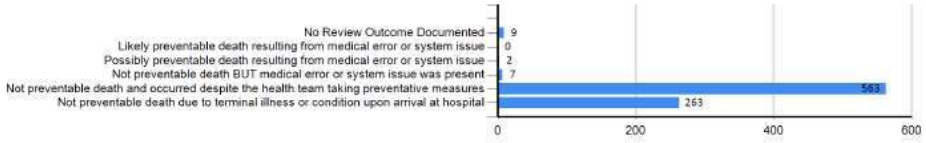
Top 5 Primary Diagnoses for Patients who die in hospital with comparison to last month

Primary Diagnosis Name	This Month	
Lobar pneumonia, unspecified	10	▶
Pneumonitis due to food and vomit	10	▼
Sepsis, unspecified	9	▲
Unspecified acute lower respiratory infection	8	▲
Chronic obstructive pulmonary disease with acute lower respiratory infection	7	▲

Mortality Reviews

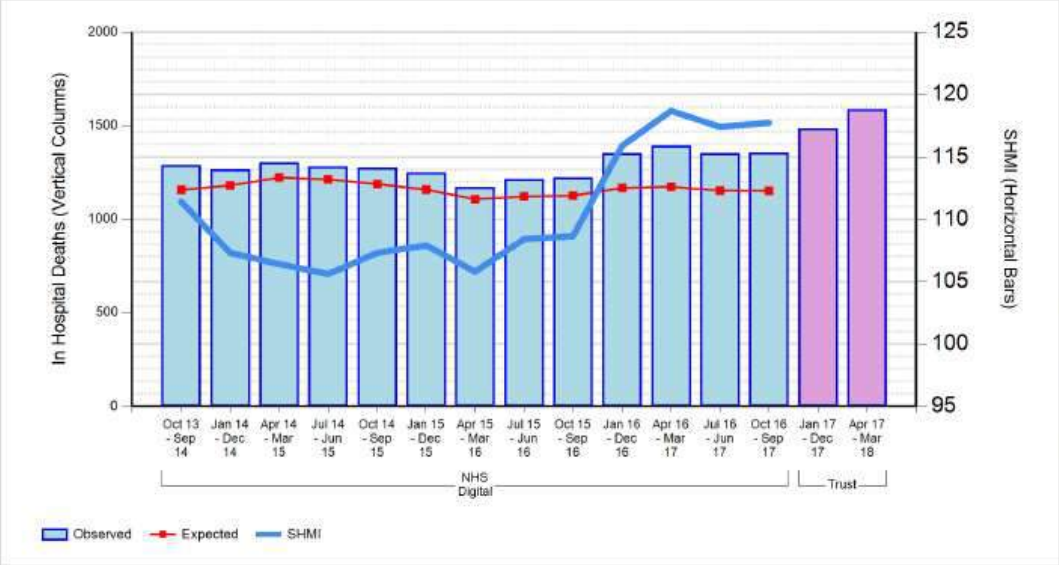
	2017/18											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Reviews Completed	66	123	72	53	77	71	53	64	80	108	77	
Reviews %	83.5%	132.3%	107.5%	77.9%	111.6%	110.9%	84.1%	118.5%	94.1%	89.3%	86.5%	0.0%

Mortality Review Outcomes - Last 12 Months



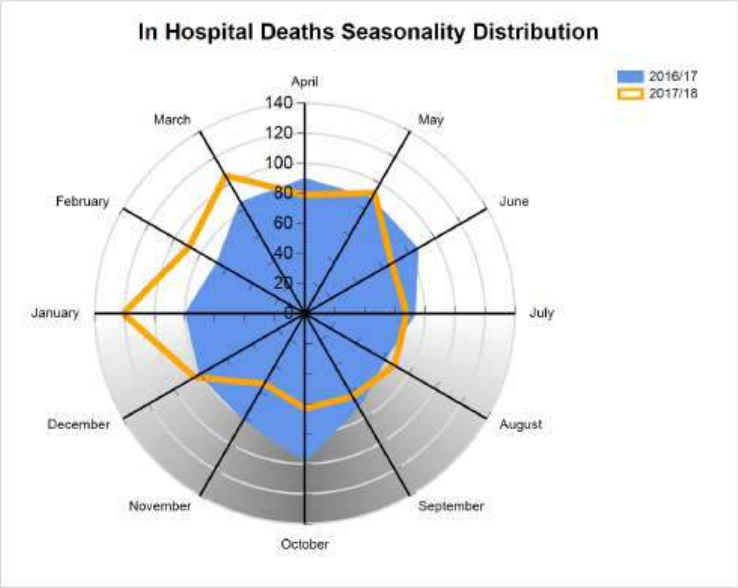
SHMI Breakdown

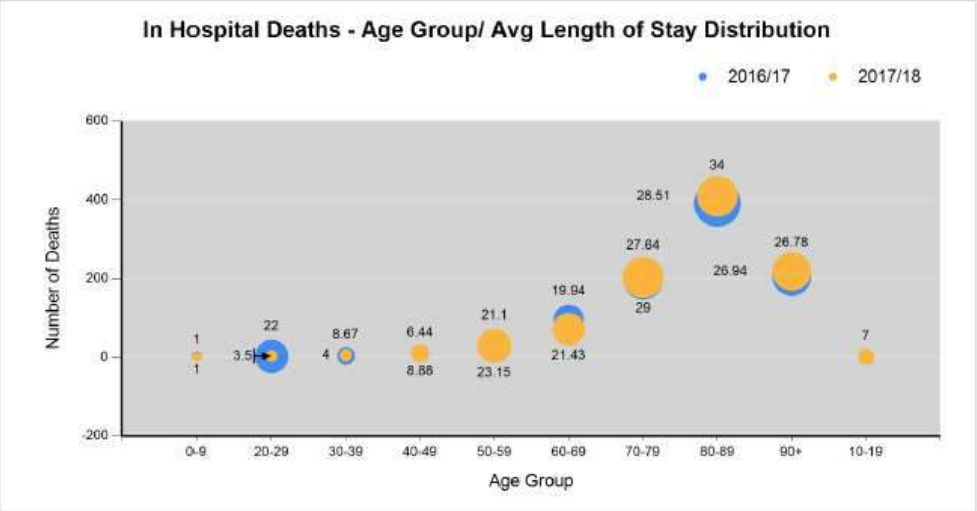
Southport & Ormskirk Hospital NHS



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

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





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.

Alert, Advise, Assure (AAA) Highlight Report

Committee/Group Meeting date:	Workforce Committee 24th May 2018
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

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

Sickness absence policy – this is still under dispute and Jane Royds and staff side are meeting asap to seek resolution.

Central Training Budget – the reduced awarded budget means we are relying on funds being awarded by HENNW. If these are not forthcoming, then CPD for nurses for example, is at risk. This is being added to the nursing risk register. There are some strategic decisions to make on where the budget is awarded in light of the mandatory training requirements.

Visibility of CBU training risks – there is not a forum where these are visible across the organisation for strategic decision making.

Operational/Management Board – Linked to above there is not an operational forum for cross trust debate/decision making on the people agenda which impacts the items brought to WFC – too many operational issues brought for discussion. PG running a session to define our behaviours at WFC as a High Performing Team.

PDR – Despite best efforts the PDR completion % is reducing. CBU's are actively focussed in their meetings on raising this with support from HR. A request for encouragement/challenge to take accountability to improve this in all areas (especially Corporate).

Safe Staffing – we cannot provide assurance on safe staffing. We can provide assurance on fill rates. There is a whole piece of work underway to review the reporting so that what is received is meaningful.

ADVISE

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

Staff survey action plan – The BU's have worked hard in an unrealistic turnaround time to produce plans. Ongoing work being monitored. The challenge is to become more future focussed rather than spending too much time trying to understand the result. Move towards setting a goal for the future and taking action to get there.

Sickness absence – Whilst showing a downward trend the actual at 5.1% is still too high against our target of 4%. Concern over anxiety and stress related illnesses.

HENNW – visit is due in June and after providing additional requested information we are ready for the visit. A lot of effort has gone into this which is recognised.

CQC Action plan. We cannot assure the Board that staff are competent to do the work they are employed to do – there is a piece of work underway to address but this is a large piece of work which has not been scoped yet

ASSURE	
(Detail here any areas of assurance that the committee has received)	
E-learning – we are pleased to report that we are way ahead of expectation on e-learning. **Policies** – there has been significant progress been made on shifting the out of date policies and aligning our people policies. **GDPR** – we are compliant as of the WFC with the latest version of requirements. **Navajo Chartermark** – some fantastic news – we have been awarded the LGBTIQ Chartermark Certificate – our thanks to everyone that has worked so hard to make this possible!	
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)	

Southport and Ormskirk Hospital NHS Trust

Board of Directors

6th June 2018

Agenda Item	**TB144/18**	**Report Title**	**Monthly Safer Staffing Report**
Executive Lead	Juliette Cosgrove Director of Nursing Midwifery Therapies and Governance		
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 April 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 April 2018 against the accepted national level of 90%:

- **Trust overall 86.61%**
- 77.02% Registered Nurses (RN) on days
- 83.17% Registered Nurses on nights
- 99.02% Care staff on days
- 100.78% Care staff on nights

- **Trust vacancy:**
- 12.10% (103.90wte) Registered Nurse vacancies at band 5 and above
- 9.35% (35.12wte) Healthcare assistant vacancies band 2 and above.

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

	Funded WTE	Contracted WTE
Registered	858.58	754.68
Non-registered	375.60	340.48
Total	1234.18	1095.16

The senior nursing leads and HealthRoster team are collaboratively working through E-Roster and SafeCare utilisation and reporting to ensure future reporting provides full assurance to the Trust Board on safe staffing. This includes a full review of available data and daily utilisation of the safer nursing care tool/e-roster to better understand the reporting against all inpatient wards areas.

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

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. 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 April 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 April 2018 submission indicates a trust fill rate for registered nurses on days 77.02 %, non –registered nurses days 99.02%. Fill rate of registered nurses nights 83.17% and 100.78% 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.

The senior nursing leads and HealthRoster team are collaboratively working through E-Roster and SafeCare utilisation and reporting to ensure future reporting provides

full assurance to the Trust Board on safe staffing. This includes a full review of available data and daily utilisation of the safer nursing care tool/e-roster to better understand the reporting against all inpatient wards areas.

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 were12.10% Registered nurse Vacancies (103.90WTE) and 9.35% non-registered nurse vacancies (35.12WTE) at the end of April 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. The Trust has engaged with the NHSI Retention programme with a plan being developed of the next 90 days, NHSI site visit at 60 days supporting finalisation of the Trusts improvement plan from August 2018.

The Trust is hosting its next local recruitment event for registered nurses on Tues 29th May 2018 at the Clinical Education Centre, Southport site.

Apprenticeship Levy:

- 57 current apprenticeships registered, 23/57 are within healthcare worker roles.
- 23 provisional expressions of interest**,** 11/23 are within healthcare worker roles.

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.

April 2018 recruitment:
Registered nurses - 13 new starters, 38% of which have worked shifts
Nonregistered nurses –8 new starters, 25% of which have worked shifts.

NHSP are collaboratively working with Urgent Clinical Business Unit to recruit paramedic colleagues to flexible working opportunities within Southport AED department.

4. Student Nurse Recruitment Update

The Trust will host the next local recruitment event on May 29th for adult nursing.

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.

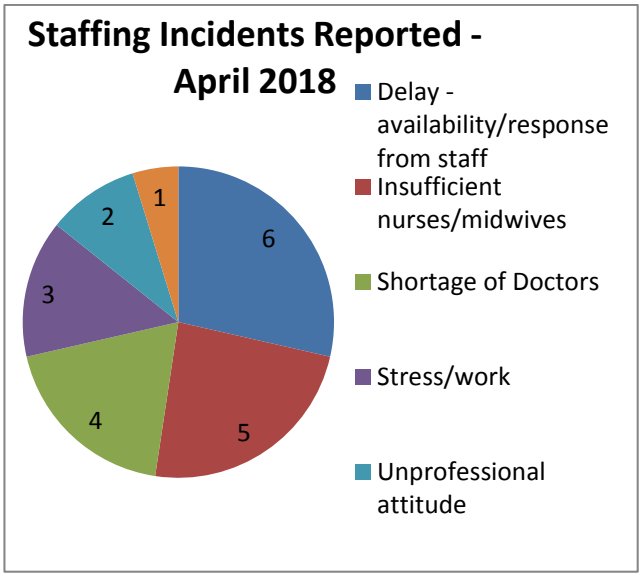
On-going Recruitment of Registered Nursing Staff

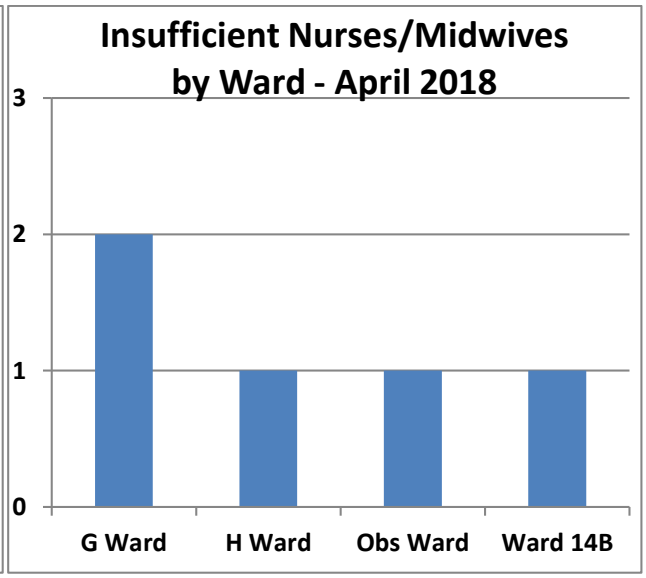
The Trusts Nursing Board on 25th April 2018 focused on nurse workforce planning.
This will align to the support work streams on recruitment, retention and roster management with NHSI.

The Trust remains engaged with the North of England Nursing Workforce Group will take 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 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



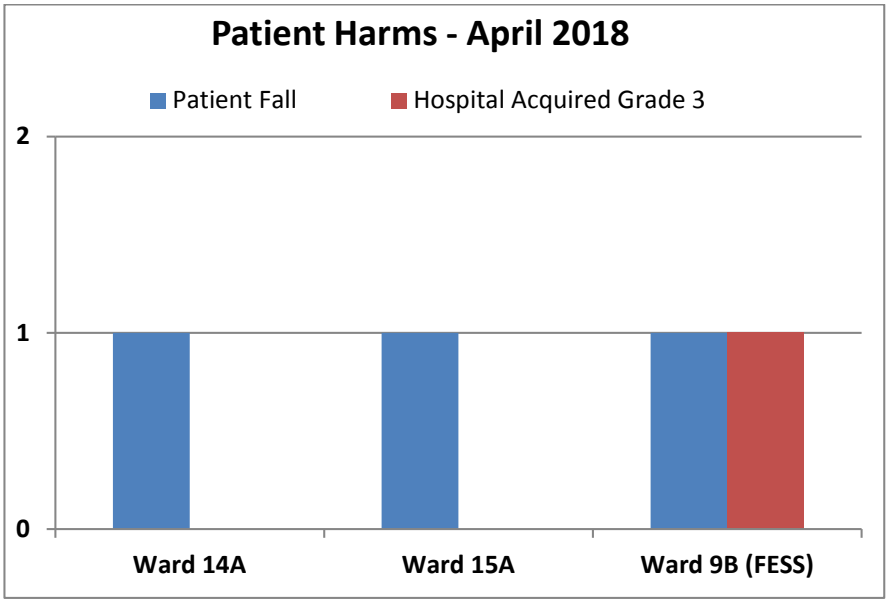


The number of staffing incidents reported has reduced from 43 reported in March 2018, to 21 in April 2018. This is due to a reduction in the number of incidents highlighting insufficient nurses/midwives in April 2018, with just 5 being reported, compared to 21 in March 2018. The locations of these incidents are shown in the bar chart above. 3/5 incidents were reported from the Ormskirk site. The 2 incidents reported on G Ward were both from the same shift, due to an RGN being transferred to Southport site to mitigate safe staffing risk.

Incidents continue 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 April 2018 reflected an average of 19.2 additional beds occupied, which further impacts on staffing capacity and capability.

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 utilization of flexible workers via NHSP and agency.

6. Inpatients experiencing moderate harm or above in April 2018



Three patient falls resulting in moderate harm were reported in April 2018. The breakdown by ward is shown in the bar chart above. In addition to a moderate harm fall, ward 9B (FESS) also reported a grade 3 Hospital Acquired Pressure Ulcer. This ward did not report any incidents highlighting insufficient nurses.

Incidents are not directly correlated to nurse staffing numbers alone.

7. NHS Improvement (NHSI) Safer Staffing Guidance

NHSI remain engaged with the Trust supporting workforce reviews inclusive of recruitment and retention programmes. Further visits/teleconference calls are planned over future months supporting 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 April 2018 and provided an update regarding on-going nursing and midwifery workforce recruitment activities to address vacancies.

Bi-annual nurse staffing reviews are completed within the Clinical Business Units with the Trust report to board in July 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.

The format and content of the Monthly Safer Staffing report is being updated with the support of the new Director of Nursing, Midwifery, Therapies and Governance in collaboration with NHSI national workforce leads in order to strengthen the report and clearly meet the recommendations within the NQB, NICE.

Carol Fowler
Assistant Director of Nursing - Workforce

Alert, Advise, Assure (AAA) Highlight Report

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

- At the end of April 2018 the Trust has a deficit of £2.6m against a deficit plan of £2.9m. This position is in line with the figures outlined in the 2018/19 Annual Plan that was discussed at the Board in May
- A review of the Trust's IT services suggests that further investment is needed to deliver the Trust's ambitious IT Plan. Consideration is being given to ways in which this can be achieved but it should be noted that the option of outsourcing has been discounted because it is a comparatively expensive solution

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 Trust is actively reviewing all ambulatory care pathways to ensure patients are appropriately streamed when attending A&E.
- NHSI has asked the Trust to appoint a Turnaround Director.
- Discussions are taking place with System C re support for the VitalPac system that is a key part of the Deteriorating Patient Project

ASSURE

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

- There is an ongoing financial improvement programme that includes assessment of productivity, ways of maximising income, identifying/delivering Cost Improvement targets, expenditure run rate control and the use of external assistance
- Further refinement has been undertaken of the Service Line Reporting/ Patient Level Costing System but the work is still subject to validation. It is hoped that by the end of July a version will be available that can be used as an integral part of reviews with CBUs and specialties.
- The Committee was given a helpful presentation from IQVIA on the work being undertaken to improve coding accuracy given the complexity of HRG4+. The output is supporting the Trust in securing payment at the appropriate tariff.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

It was felt that the operational risks overseen by the Committee were appropriately scored.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6th June 2018

Agenda Item	**TB146/18**	**Report Title**	**Emergency Care Performance Report - 4 Hour Standard Performance**
Executive Lead	Therese Patten, Director of Strategy		
Lead Officer	Jenny Farley		
Action Required *(Definitions below)*	☐ To Approve X To Assure X For Information		☐ To Note ☐ To Receive

Executive Summary

- An over view of the 4 hour contributory factors
- To enable the Committee to understand progress or deterioration in each of the components which impact the delivery of the Standard
- Continuing with a monthly report comparing each month with the previous and demonstrating the impact on improvement as part of the Patient Flow Improvement Programme
- Recommendation for the Trust Board to note

Strategic Objective(s) and Principal Risks(s)

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

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

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

Impact *(is there an impact arising from the report on any of the following?)*	
X Compliance ☐ Engagement and Communication ☐ Equality ☐ Finance	☐ Legal X Quality & Safety 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 and Leads following agreement by Board/Committee/Group)*
Add actions with milestones and Leads here

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

REVIEW OF 4 HOUR STANDARD PERFORMANCE APRIL 2018

1 Executive Summary

The report reflects the key elements which impact on the delivery of the 4 hour access target for April 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.

There was a marked improvement April and the overall Trust position was 85.79%.an improvement of 6.6% on the previous month. There were days in the month where the Trust achieved 95%.

Attendances remained the same as the previous month but there were 138 fewer attendances in the elderly between the ages of 70 and 90, possibly a reflection on the reduction in emergency admissions by 9.6%. Conversion Rates dropped by 0.11%. There were 620 fewer breaches, and although “no bed” remained the greatest cause of breaches there were almost 500 fewer than the previous month. Ambulance hand over times improved significantly in all categories. The 12 hour breach attributed to the Trust was following the Easter weekend when beds and side rooms in particular were at a premium.

This month delayed discharges and stranded patients are not included as it is recognised that the data is not wholly accurate. Work is going to cleanse the data and place new systems to ensure data is accurate and consistent at a given time. SAFER was put on hold as the focus for resources switched to the ED.

The overall improvement is difficult to pin down to one particular reason. Beds were available in a more timely manner, the department was congested less than the previous month, the clinical view is that acuity was lower and a super week in ED was piloted which focused on improving systems within the department; triaging to ambulatory care more effectively and Rapid Assessment and Treatment (RAT) model was introduced. The Clinical Decisions Unit was opened towards the end of the month which also supported flow and gave different areas to assess patients rather than in a cubicle in the department.

2 Overall Performance

Attendances remained the same as March therefore the performance improvement demonstrated that the Trust coped much better within its normal demand.

Table 1 below is the overall Trust performance and Table 2 is how it’s split over all sites.

Table 1

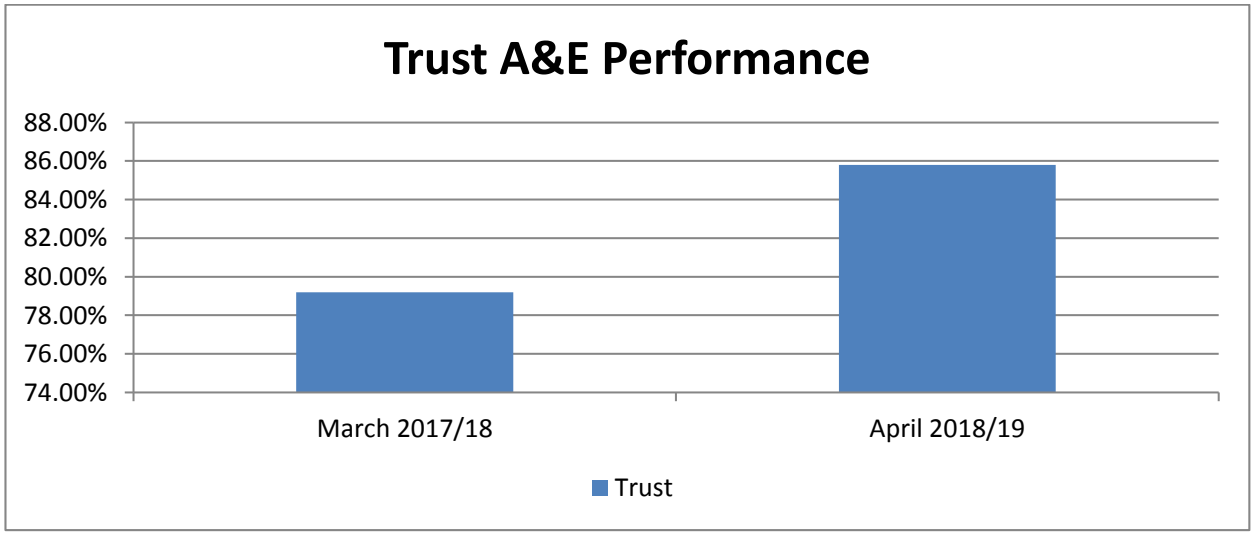
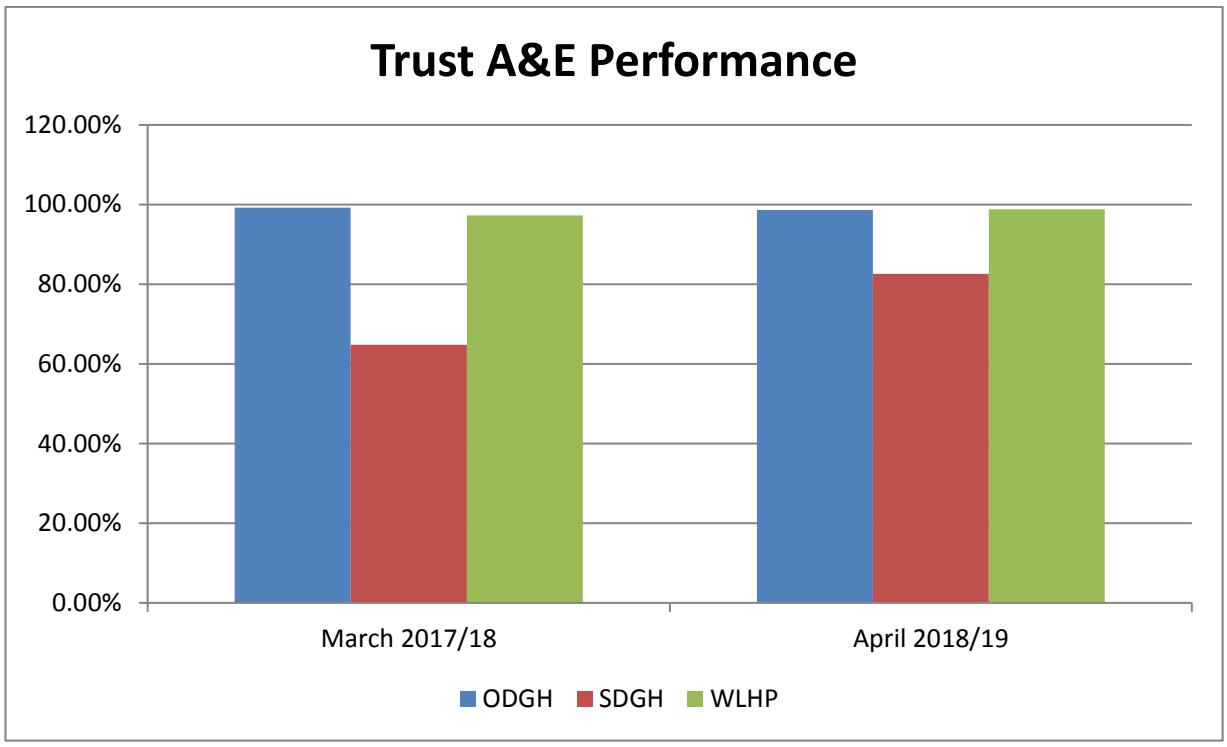


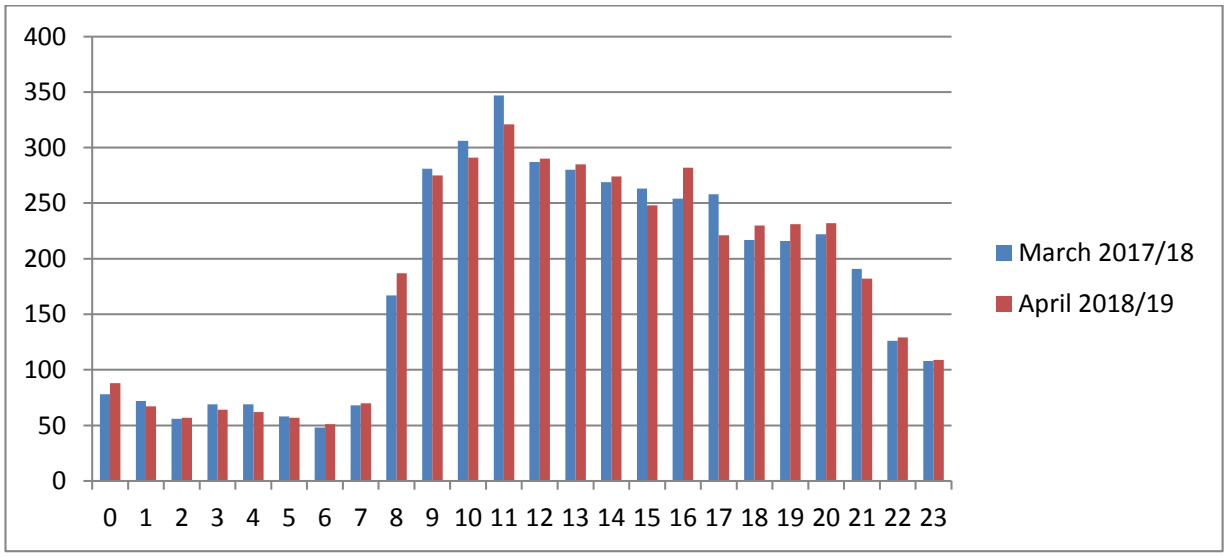
Table 1a Performance All Sites



Attendances

Total Attendances remained on par with March; 4310 & 4303 respectively. The age profile of attendances between 71 & 80 dropped by 9% as did the age group between 81 & 90 also by circa 9% compared to the previous month.

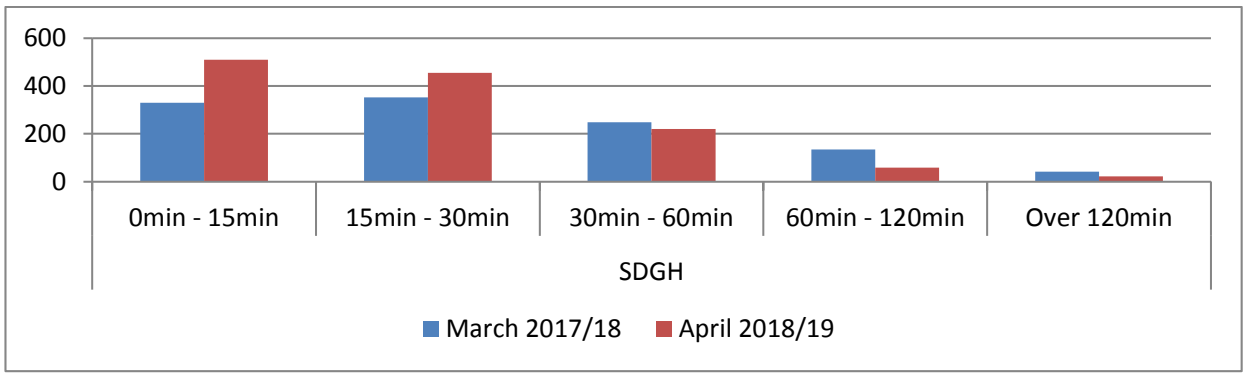
Table 2



3 Ambulance Handover Times

There was a marked improvement in ambulance handover times compared to the previous months, due to less congestion in the department, RAT and improved Triage processing straight to ambulatory care. In April 40% of patients were handed over within 15 minutes, compared to only 30% in March. For the longest wait category over 120 minutes; in April less than 2% of handovers took this long compared to 4% in March.

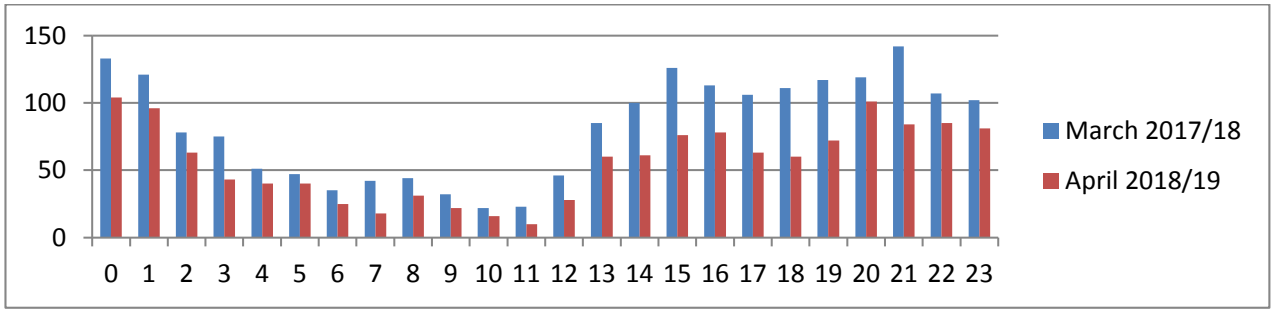
Table 3 Ambulance Handover Times



4 Breaches

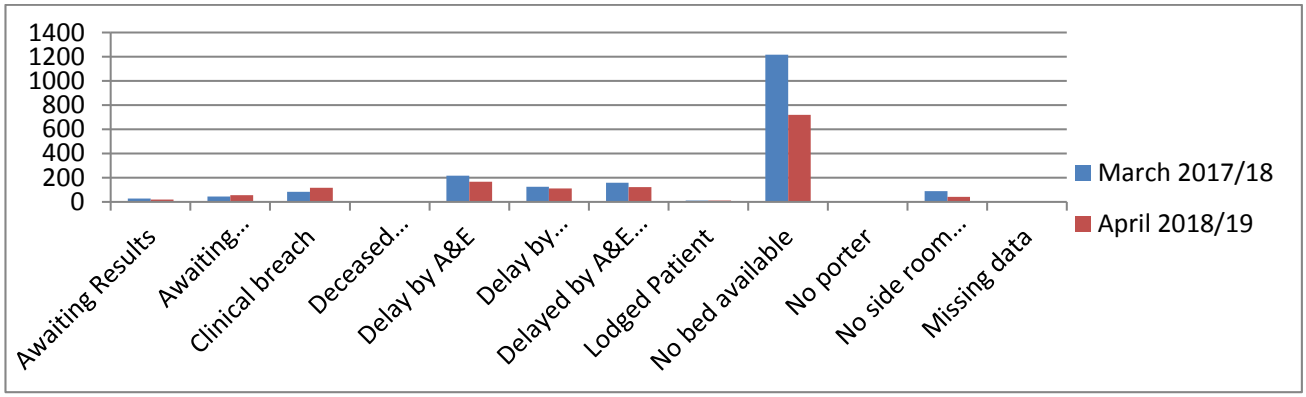
As would be expected given the improvement in performance the number of breaches dropped significantly; there were 620 fewer in April compared with March Table 4 below reflects a significant improvement in the ability of the ED to manage the department more effectively with every hour demonstrating fewer breaches compared to the previous month.

Table 4 Breaches



Although bed availability remains the greatest cause of breaches, there were 498 fewer breaches this month.

Table 5 Breach Reasons

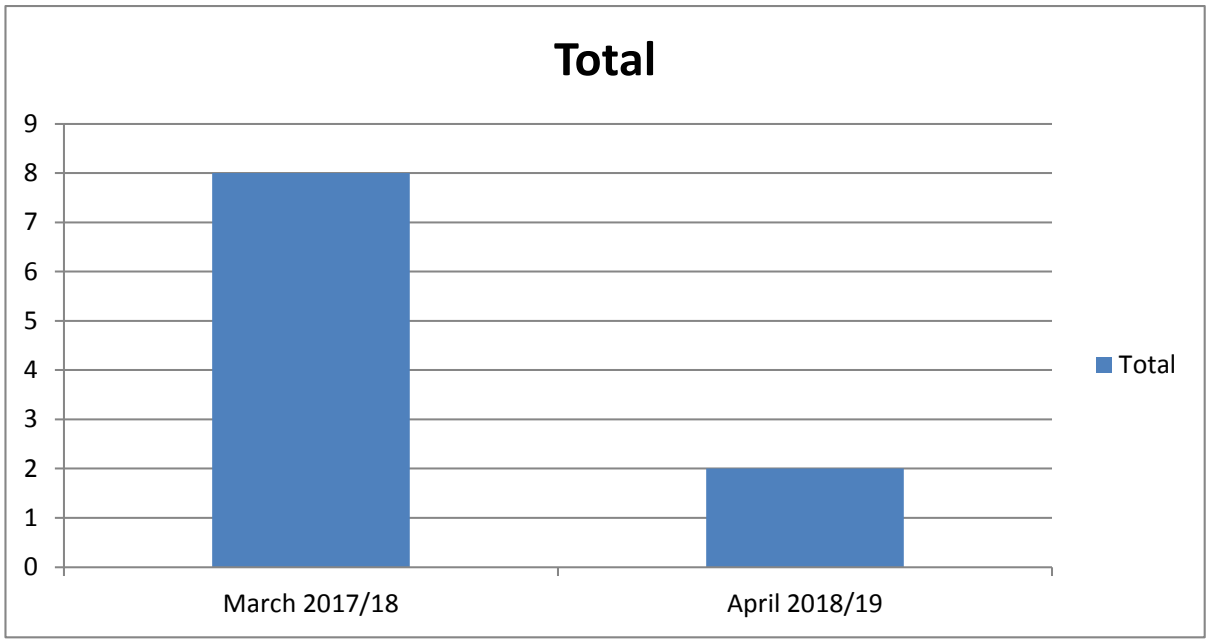


12 hour breaches

Disappointingly the Trust reported one 12 hour breach at the beginning of April previously it has been incorrectly reported that there were no 12 hour breaches in April (the other noted here was a mental health attributable breach).

This was during the bank holiday weekend where the Trust, like others, was under immense pressure, this particular patient was unwell and in addition was suspected of having flu and a side room was unable to be freed in a timely manner.

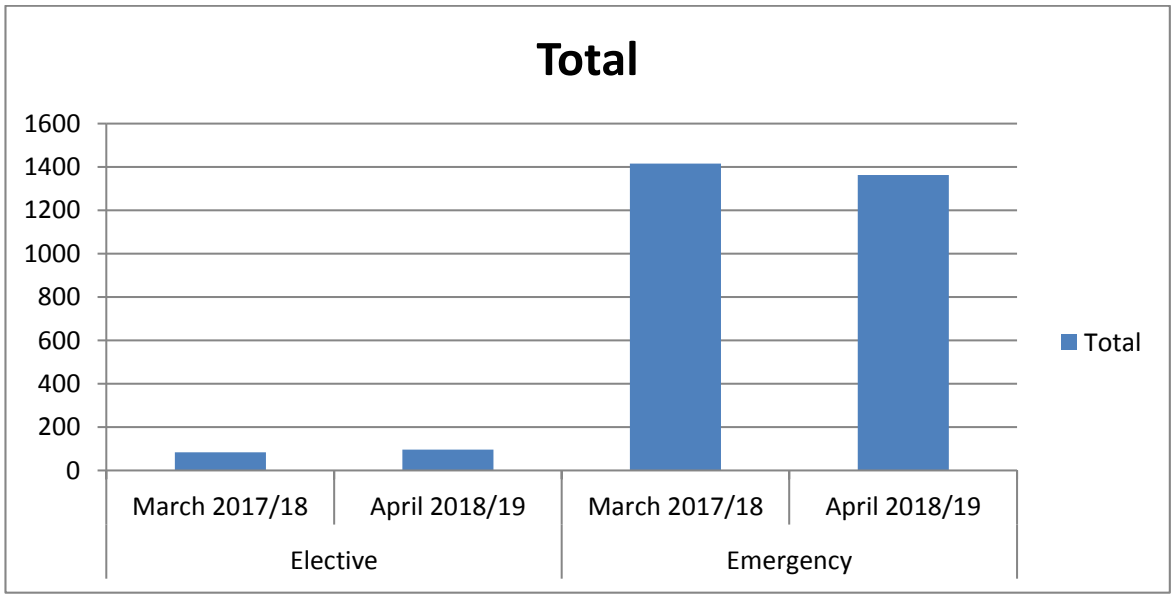
Table 6 12 Hour Breaches



5 Admissions

The number of emergency admissions also fell by 8.75% in April and the elective patients simultaneously increased by 9.6% possibly as a reflection of additional bed capacity on the Southport and Ormskirk sites with fewer outliers taking up beds.

Table 7

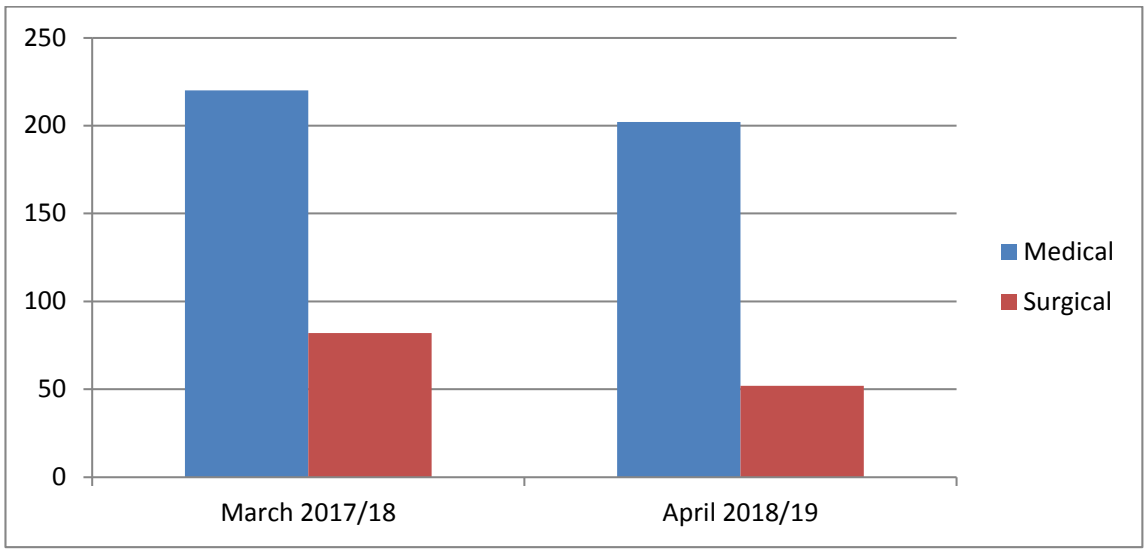


6 Outliers

Both medical and surgical outliers dipped in April; medicine by 9% and surgery by 6.3%, indicating that the reliance on additional capacity outside of specialty beds was reduced and those patients are more likely to be in an appropriate bed and specialty.

A programme of work looking at outliers has now been initiated by the Mortality Operations Group which reports to Quality and Safety Committee.

Table 8 Outliers

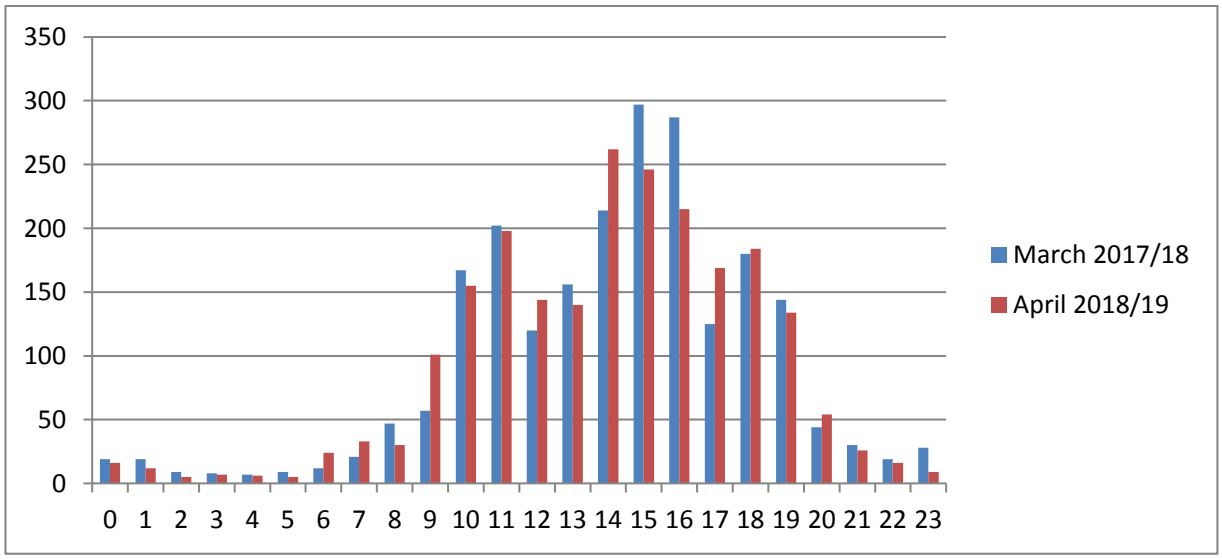


7 Hourly Discharges

The pattern of discharges per hour remains unchanged. March had seen a significant improvement in discharges in the early afternoon which was attributed to SAFER being piloted on certain wards. That improvement was not sustained in April. SAFER was suspended temporarily as the Trust took the decision to refocus the Flow Programme and improve the systems in ED particularly around ensuring patients not spending unnecessary periods on the ED corridor waiting for a cubicle.

It is anticipated the new Director of Nursing with additional Support from ECIP will relaunch this programme. The temporary solution for discharge lounge remains in place and was maximised throughout April with the permanent dedicated area due to open at the end of May.

Table 9 Hourly Discharges



Stranded & Super Stranded Patients Medically Fit and Delayed Transfers of Care.

Data for the above is not included in this month's report. As previously stated it is not accurate as it relies on timely updating predominantly by ward staff. Throughout April and May the Trust started a cleansing process. A snapshot of data was taken to compare actual figures (agreed by the Trust and Partners at twice weekly meetings) and identified that the Trust's Information system reported 57 patients more than the correct figure. In future this data will be cleansed and agreed in order that reporting can be accurate at the point in time.

A paper is being prepared for the A& E delivery board setting out the proposal for change following agreement there will be a process in place to report effectively.

8 Actions to Improve

The reset of the Programme for Improvement now includes a dedicated Programme Improvement Director (Jan Ross) and is gradually coming to fruition with a significant improvement in performance evident in April. Throughout May further work will continue focusing on the department with the aim of delivering at pace a dedicated discharge lounge and the required medical and surgical assessment space plus a focus on improving the function of the Ambulatory Care Unit.

The improvement in performance between March and April on the Southport Site was 17.75%. The work done focusing on the practices and procedures in the Department itself has been the greatest yield with the opening of the CDU, implementation of RAT and improved triaging straight to Ambulatory Care all supporting and improvement in performance and ultimately a better experience for patients.

The improvement dashboard shows:

- Overall SDGH performance is on an increasing trend and has stabilised over last 3 weeks
- % of patients DTA within 3hr 15 min is on an increasing trend and average time to DTA has reduced to 209mins
- % of patients admitted directly to base wards is on a reducing trend with only 17% patient admitted directly i.e. use of right admitted pathways
- Although total number of corridor patients has reduced slightly, the average time spent by corridor patients is on a decreasing trend and has stabilised
- Patients on average spend 2 hrs less on corridor than last month

ED Dashboard – Our performance to date

Southport and Ormskirk Hospital NHS
NHS Trust

Summary (Key points):

1) Overall SDGH performance is on an increasing trend and stablising over last 3 weeks.
2) % of patients DTA within 3hr 15 min is on an increasing trend & average time to DTA has reduced to 209mins.
3) % of patients admitted directly to base wards is on a reducing trend with only 17% patient admitted directly i.e. use of right admitted pathways.
4) Although total number of corridor patients has reduced slightly, the average time spent by Corridor patients is on a decreasing trend and stabilised. Patients on average spend 2 hrs less on corridor than last month.

SNo	Metric	Trend	Target	25.02.2018	04.03.2018	11.03.2018	18.03.2018	25.03.2018	01.04.2018	08.04.2018	15.04.2018	22.04.2018	29.04.2018	06.05.2018	13.05.2018
1	SDGH target A&E performance (Trajectory)		NA	55.20%	62.30%	62.30%	62.30%	62.3%	62.30%	77.00%	77.00%	77.00%	77.0%	81.0%	81.0%
2	Difference from Trajectory		0%	9.4%	-9.4%	-6.2%	-11.5%	-9.4%	-8.2%	-20.3%	-19.9%	-6.1%	7.5%	-6.1%	-4.3%
3	SDGH A&E Performance		89%	64.608%	52.941%	56.085%	50.849%	52.868%	54.141%	56.738%	57.113%	70.854%	84.484%	74.871%	76.712%
4	SDGH A&E Performance - Admitted		NA	31.765%	11.34%	20.382%	14.237%	19.094%	18.263%	13.559%	25.763%	48.802%	72.554%	57.92%	55.344%
5	SDGH A&E Performance - Non-Admitted		NA	81.029%	71.739%	73.851%	67.543%	68.923%	72.409%	75.145%	71.104%	81.997%	91.442%	87.956%	91.681%
7	SDGH A&E Triage Within 15 Minutes %		95%	10.392%	5.348%	33.545%	56.688%	60.375%	58.889%	58.156%	66.527%	62.211%	79.98%	68.692%	72.505%
8	SDGH A&E Average Time To DTA		195	253	301	251	283	270	283	270	235	217	195	206	209
9	SDGH A&E % DTA Within 3hrs 15mins		95%	44.565%	25.333%	38.158%	35.948%	34.42%	30.37%	33.66%	40.288%	45.854%	59.172%	52.34%	45.74%
10	SDGH A&E % Patients Seen Within 60mins		95%	45.431%	40.00%	35.591%	39.29%	32.891%	38.729%	37.601%	45.307%	32.381%	51.108%	45.825%	45.393%
11	SDGH A&E % Specialty Requests Within 120		95%	44.527%	37.129%	36.408%	44.068%	26.854%	40.594%	38.786%	37.265%	37.166%	55.068%	43.194%	43.048%
12	SDGH % Admitted Directly To Base Ward		0%	30.435%	33.559%	35.11%	32.441%	32.698%	35.294%	40.333%	27.09%	25.806%	21.809%	20.548%	17.299%
13	SDGH Discharges (Excluding MDU & EYE)		NA	378	303	363	329	368	358	320	365	400	442	474	433
14	SDGH Discharges Between 8am-12noon		NA	50	42	51	35	54	55	70	56	47	47	94	64
15	% Medically Fit Patients Weekly Snapshot		0%	16.923%	14.615%	13.59%	13.846%	12.308%	9.487%	14.615%	14.103%	16.154%	10.00%	9.231%	13.333%
16	Corridor Patients		0	265	278	316	378	403	427	380	352	367	354	370	368
17	Corridor Patients - Average Time Mins		0	227	308	169	221	168	201	196	147	81	56	80	73
18	ACU Activity		NA	139	143	122	129	112	108	127	142	140	126	155	116

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

6th June 2018

Agenda Item	TB147/18	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

Executive Summary

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

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

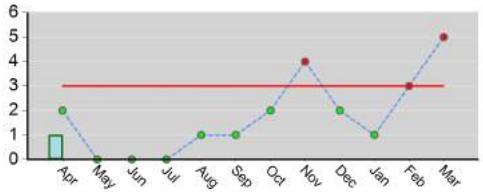
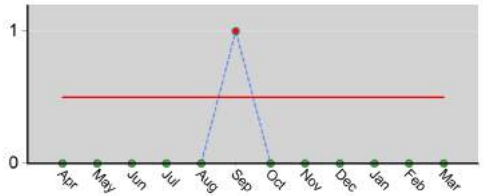
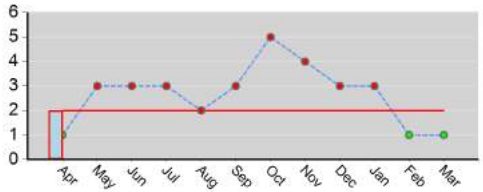
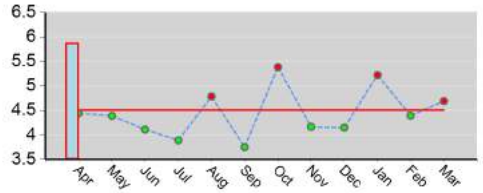
Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

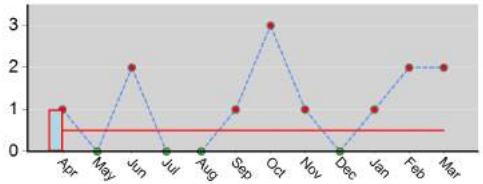
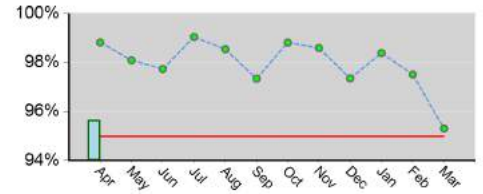
Safe (Page 1 of 3)

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	The Trust Finished 2017/18 with a total of 21 C diff cases; 5 of these cases were successfully appealed through the CCG appeals process and a further 6 cases are still pending appeal through the CCG. As the target was to have no more than 36 cases the Trust was well under trajectory. The Target for 2018/19 is to have no more than 35 cases, hence in discussion with the Executive Medical Director/Director of Infection Prevention & Control and the Infection Prevention & Control Assurance Group the Trust is to have an internal target of not exceeding 20 cases. In April there was one Trust attributable case which was a relapse of a patient who had acquired C diff when in another Trust and who had been transferred to NWRSIU. As the patient was in this Trust for more than 48 hours and the stool test from the previous Trust was more than 28 days ago the case was attributed to the Spinal Injuries Unit. This case won't be appealed as in addition to causation the analysis also takes into account the actions from the start of diarrhoea symptoms, hence due to the insufficiency of isolation rooms on the Spinal Injuries Unit the patient's isolation was delayed.	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	The last case of MRSA bacteraemia was in September 2017, hence in 2017/18 there was just the single case. There is a zero tolerance for MRSA bacteraemia; Southport & Ormskirk Hospital NHS Trust is recognised as a low incidence Trust even though there is a relatively high incidence in the community.	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	In April there were a total of 16 cases of E coli bacteraemia, but only 2 of these were hospital acquired with one case being on the Short Stay Unit and the other being on ward 15A. Both patients were male and frail octogenarians. The patients were carefully reviewed and treated by their clinicians in conjunction with the Consultant Microbiologist, however no specific source of infection has been identified. The Trust continues to work with the local CCGs and the CCGs and acute Trusts in the North Mersey health economy to monitor and fully understand the disease incidence and formulate actions to reduce gram negative blood stream infections.	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 75 falls were reported through DATIX in April'18. 73 of which occurred in clinical areas, 61 (84%) Urgent Care, 12 (16%) Planned Care. 43(60%) of falls were reported as no harm, 29 (40%) were reported as low harm. There were 3 reported falls at Level 3 or above. The revised falls risk assessment tool is now embedded into a risk assessment booklet which is completed in A +E for those patients who are identified as high risk, or are likely to be admitted. This has been developed as part of the new nursing documentation which went live on April 30th.	Quality & Safety Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

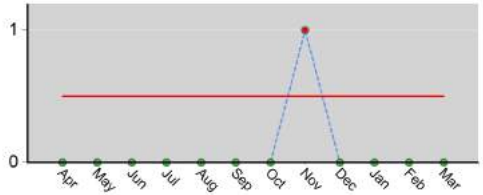
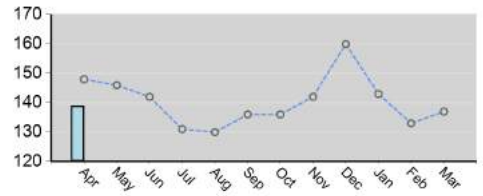
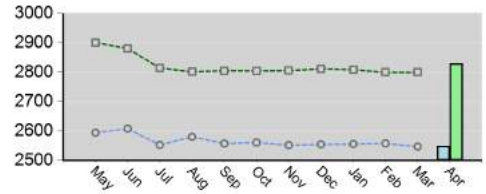
Safe (Page 2 of 3)

Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Hospital Pressure Sores	Number of reported Trust acquired pressure sores graded between 3 and 4. Threshold: 0. Collaborative goal: Elimination of grade 3 and 4 pressure ulcers plus 25% reduction overall. Line = Last Financial Year Bar = This Financial Year	There was 1 grade 3 pressure sore in April within Urgent Care. This incident is currently under investigation and RCA's have been requested from A&E & FESS ward over the incident.	Quality & Safety Committee	
Harm Free	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 95%. Higher is better. Line = Last Financial Year Bar = This Financial Year	National benchmark of 95% exceeded for month of April. On the day of census (n= 374) the Trust reported 7 patient harms which were made up of l x low harm fall (7a), 1 x Grade 2 pressure ulcer (14b) and 5 new UTI's across wards 10a, 11b and spinal rehab ward.	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 continues to be reviewed 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	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

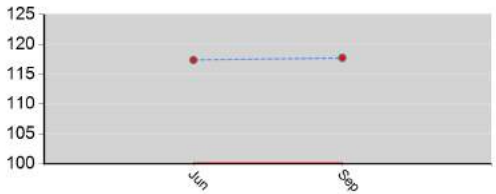
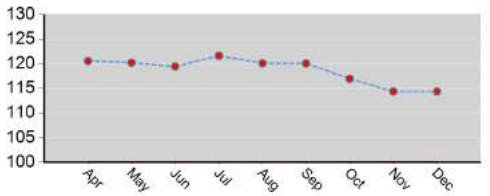
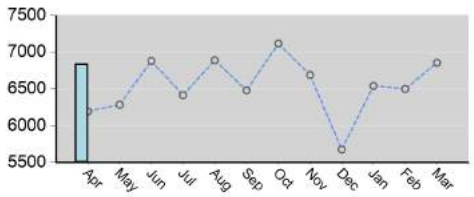
Safe (Page 3 of 3)

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 April.	Quality & Safety Committee	
Nursing vacancies	Number of nursing vacancies in month. Line = Last Financial Year Bar = This Financial Year	The number of nursing vacancies has increased to 139 in April 2018 this follows a 3 month trajectory of increases.	Finance, Performance & Investment Committee	
Establishment vs Actual	Number of WTE posts that are required to staff the Trust against the actual number of post employed substantively. Green = Funded, Blue = Contract Line = Last Financial Year, Bar = This Financial Year	The Trust's vacancy level is 9.9% (March 8.5%). Total vacancies in the Trust are 279 wte with 50% of all vacancies falling within nursing.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

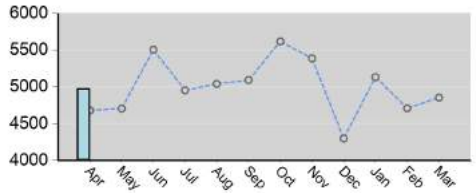
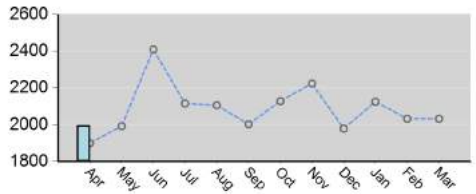
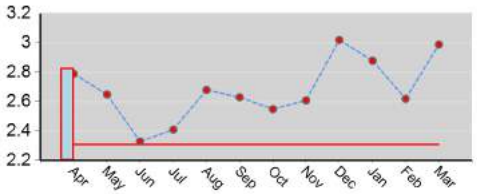
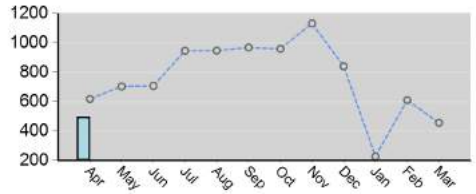
Effective (Page 1 of 3)

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	Performance in April was 60%. There has been a big push on this in the last 2 months since moving the stroke unit to 15B and getting our stroke therapy bay back in March. This has been in conjunction with the patient flow piece in the Trust. We have in April admitted 615 of our stroke patients within 4 hours to the stroke unit which is a massive improvement from < 25% and 78% to the stroke unit as their first ward which will impact on the 90% target. The main issues over the winter have been the Trust has been full to capacity with long waits in EDand lack of beds to move patients to plus the use of escalation beds in rehab.	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 latest available reportable period for SHMI, (rolling 12 month period reported quarterly) is for 1st October 2016 to 30th September 2017 for which the Trust was reported to be at a ratio of 117.39, this remains high and outside expected limits. The calculations are based on 1,356 actual deaths over an expected figure of 1,152 deaths. SHMI is published by NHS Digital on 22nd March with the next available on 21st June 2018. An External Mortality Review into Pneumonia, Lower Respiratory Infections, Bronchitis and Stroke is to be undertaken in June. The 'Reducing Avoidable Mortality' Project is currently delivering six work streams to improve quality and improve patient care to reduce mortality with a project end date of April 2019. Solutions for sustainable quality improvement are to be scoped with the Advancing Quality Alliance (AQuA) and the North West Innovation Agency; the first meeting for which is to take place on 30th May.	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 for December 2017 is 114.4 with an in month position of 109.1, which remains high and outside of expected limits. These figures show a very slight decline from November 2017 when the rolling 12 month position had been 113.2 with an in-month position 90.1. (The in-month figure for the same month the previous year, December 2016 had been significantly lower and within confidence intervals at 99.69). An External Mortality Review into Pneumonia and Stroke is to be undertaken in June. The 'Reducing Avoidable Mortality' Project is currently delivering six work streams to improve quality and improve patient care to reduce mortality with a project end date of April 2019. Opportunities for quality improvement are also being scoped with the Advancing Quality Alliance (AQuA) and the North West Innovation Agency, the first meeting for which will be on 30th May.	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	Referrals have remained static in April 2018 with only an increase of 13 from March 2018 with the number of referrals received was 6846. This is significantly higher than April 2017 (6197).	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

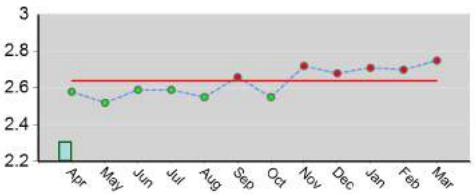
Effective (Page 2 of 3)

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 127 First Appointments in April 2018 taking us up to 4983. This is significantly higher than April 2017 (4682).	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	Treatments for April 2018 has decreased by 37 after remaining static in Feb 2018 and March 2018 at 2033. This is slightly higher than April 2017 (1933).	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 April reduced slightly on average. 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 there has been an increase in stranded patients the last week. Acute has now commissioned 12 additional beds within private sector as 28 day step down beds.	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 with an increase in MOFD in April. Daily ward/ board rounds are continuing identifying any avoidable delays, these are addressed or escalated. twice weekly MOFD and LOS meetings are being held with community partners and social services. Trust plans to roll out SAFER have been put on hold to support the Trust 're-set' programme. review has been undertaken and relaunched in May/June. business case for IDPT agreed for 12months. current acute DPT remain in seconded posts to support board rounds and identify delays.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

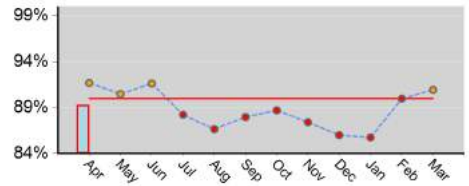
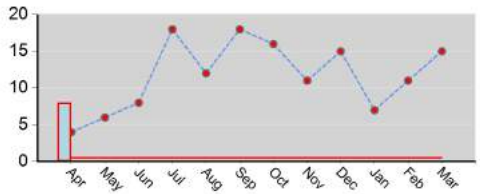
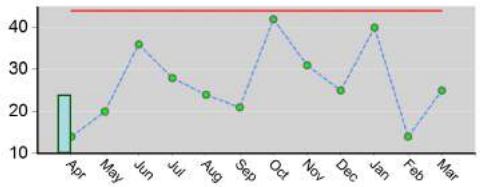
Effective (Page 3 of 3)

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% and remains within threshold in April 2018. This is significantly higher than April 2017 (6.7%).	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 2.31 and is within threshold.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

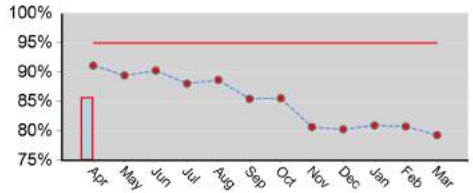
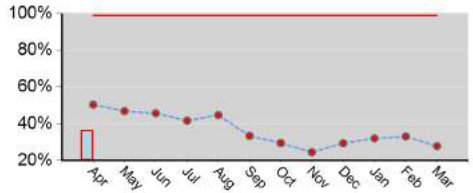
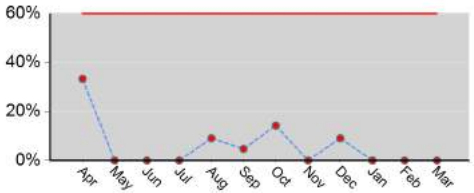
Caring (Page 1 of 1)

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 fell to 89.3% in May from 90.3% in April. This is against a Trust response rate of 6.1% which is 0.5% higher than March. For April CBU recommending percentages are Specialist 90.3%, Planned care 94% and Urgent Care 86.9%.	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 April there were 8 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 24 for the month of April, this is 1 less than the previous month . The complaints will be reported in the Quality and Safety reports for each Clinical Business Unit. The Clinical Business Units continue to work through the complaints within the required timescales, and the adherence to these timescales is monitored through the monthly Quality and Safety reports.	Quality & Safety Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

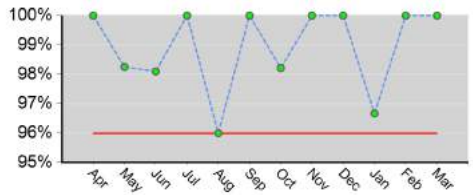
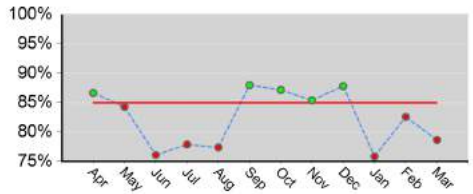
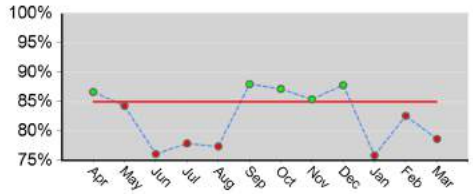
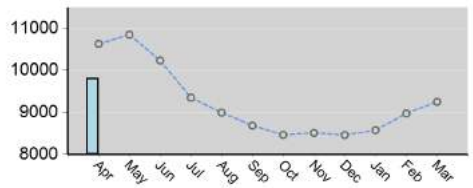
Responsive (Page 1 of 3)

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 saw some improvement in April but remains some way against the 95% standard (85.8% in April). Month-on-month last year, the department saw an increase in majors category (+2332 (9.4%) patients across the year), which put significant pressure on available cubicle capacity in ED, at the same time that LoS, a lack of a discharge lounge, and flow out of the Trust was challenged. April saw a 4.7% increase in majors capacity, indicating that last year's trend may well continue. CDU opened on 30/4/18 and saw over 130 patients within the 1st week of opening, which will support ED in releasing cubicles timely. a temporary discharge lounge was re-opened on 7B at the end of April, whilst work on the new lounge takes place.	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 times remained a challenge in April. The AED Delivery Board requested a workshop across all 3 acute Trusts to share best practice and understand further the difficulties in ensuring handovers are completed timely. It was acknowledged that all 3 EDs have and are in the process of 'creating additional space' when the scale of the problem lies with bed management flow and the knock on effect of delaying release of cubicle capacity within E.Ds. It was acknowledged by NWAS and the other 2 acute Trusts that patient demographics in Southport have made it extremely difficult to adopt 'fit to sit' principles that have worked successfully in the other Trusts. CDU opened on 30 April 2018; within 1 week over 130 patients had continued their pathway in CDU. The Trust starts phase 2 of the estate work in June 18, which will see an increase in triage clinical assessment space and creation of 4 cubicles for ambulances to offload into, which will further improve patient experience, privacy and dignity.	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	This continues to be an issue although it has not had any clinical impact. An audit will be undertaken with the TIA data to see if we are catching the data correctly as we haven't been counting patients in ED who get seen by stroke team as hitting the target. Only 40% of referrals are TIA or stroke but these patient can still be scored on the ABCD criteria.	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 recorded at 95.4% in March.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

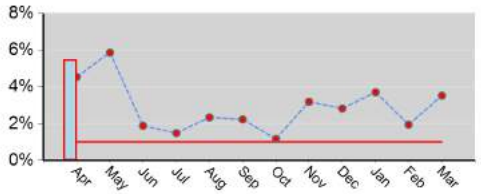
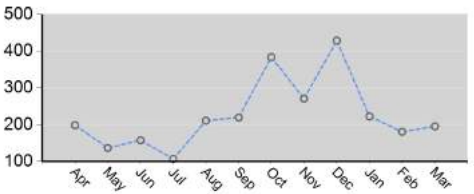
Responsive (Page 2 of 3)

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 recorded at 100% in March.	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 recorded at 78.7% in March. Breaches can be attributed to a number of reasons. 5 were complex pathways, 3 were due to delays in reporting radiology scans, 2 were administrative delays, 1 lack of capacity for tests, 2 were delays at HODs, 1 patient hadn't taken prep.	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	In March there were 13 patients who breached - 5 full and 8 half. The full breaches were in Colorectal, Gynaecology, Haematology (2), and Urology. The half breaches were in Gynaecology (2), Haematology, Head & Neck (2),Lung and Urology (2).	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 significantly in April 2018 by 560 patients taking us up to 9818. Numbers of RTT patients waiting has increased month on month since Oct 2017.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

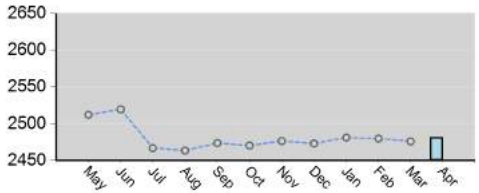
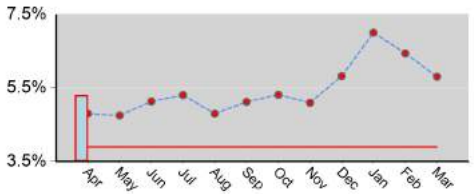
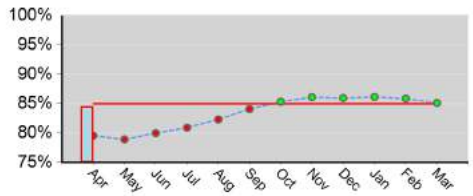
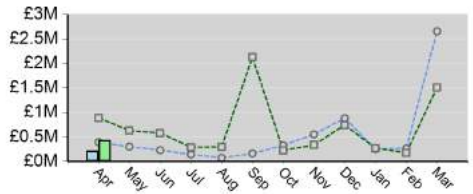
Responsive (Page 3 of 3)

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	Performance was recorded at 5.49% in April, an increase of 0.97% from March. Planned care specialties seen a increase in breaches last month due to a lack of additional activity agreement. Agreement reached regarding increased capacity via WLI/Backfill to further increase additional activity. Additional clinics arranged. – 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. There has also been the appointment of two locum consultant radiologists who will help with capacity problems.	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 April 18 which was recorded at 93.7%. 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. General Surgery 87.3% and T&O 83.5%.	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 March there were 196 delayed bed days due to delayed transfers of care. 145 bed days were due to patient/family choice, 12 due to awaiting care package in own home, 23 due to awaiting a place within a Nursing Home, 7 due to awaiting further non-acute NHS care and 9 due to awaiting community equipment/adaptations.	Quality & Safety Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

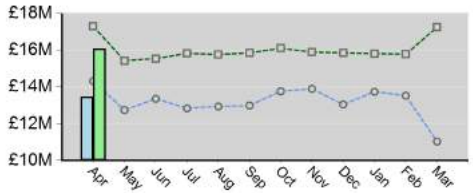
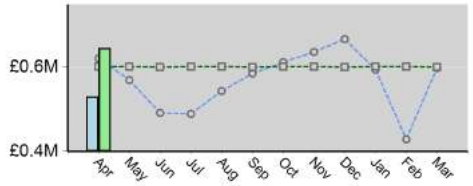
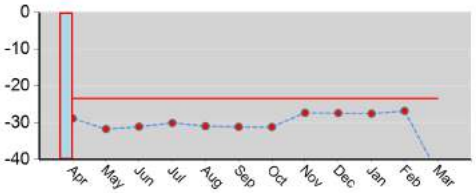
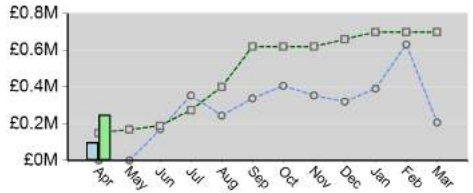
Well-Led (Page 1 of 3)

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.	Consultant PDR compliance remains above target and is nearly 100% compliance which is excellent.	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 this follows a 4 month trajectory in reducing sickness absence, however the levels are still high and the Trust is not near attaining it's target of 4%. 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 with a cross section of stake holders took place on 30/04/18. A revised policy will be going to JNC on 31/05/18 for discussion and approval.	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	Throughout April, a project was undertaken to scrutinise the accuracy of the overall data reporting. The work identified 70 ESR profiles which were not showing in previous reports, these have now been added which has an impact on the overall compliance. A consecutive piece of work was undertaken to fully review resuscitation training at all levels. This included a training needs analysis by the Resuscitation Officer who included a further 600 positions to basic resuscitation (annually), this dropped basic resuscitation from 68.14% (Dec 2017) to 52.34% (April 2018). At the same time, theoretical training was moved to eLearning prior to practical training, this has kept the figures low but slowing rising. There remains an ongoing issue with the volume of training required, especially for resuscitation and moving and handling, as the Trust only has one trainer per subject and limited space to deliver training. This will continue to impact on the ability of the Trust to meet the Trust overall target. The MyESR project continues to roll out and the Trust now has over 80% of staff registered.	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 capital programme has underspent in month (actual £222k against a plan of £435k). The reason for the underspend relates to the profiling of IT spend on the wireless network and telephony system. These will now impact later in the year. This metric is rates as green as the Trust has a number of controls in place such as a Board approved capital plan, monthly monitoring of spend and commitments and a monthly Capital Investment Group meeting.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

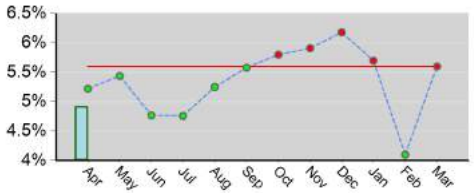
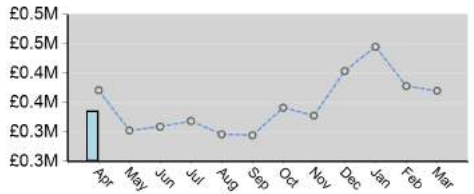
Well-Led (Page 2 of 3)

Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Income & Expenditure	This indicator looks at the relationship between Trust income and Trust expenditure at monthly intervals. Green = Expenditure, Blue = Income Line = Last Financial Year, Bar = This Financial Year	The Trust deficit in month 1 is £2.62M against a plan of £2.88M. Income is largely within plan but expenditure has underspent, across both pay and non-pay.	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 agency target for April within the NHSI plan is £647k. The actual spend in April is £531k. However, NHSI have set an agency cap of £5.6M for the full year. Furthermore, NHSI have informed the Trust that the cap will be further to reduced by circa £700k to reflect the loss of community services (in May 2017). This will result in an agency cap of circa £4.9M which equates to a monthly average of £408k. This target is extremely challenging and will necessitate a significant reduction in medical and nursing agency spend in future months.	Finance, Performance & Investment Committee	
Liquidity	Liquidity (days) Liquidity indicates whether the provider can meet its operational cash obligations. Threshold: -23.4	The cause of the deterioration of the liquidity rating is the re-classification of a DH loan as a current liability as opposed to non-current. A £4.22M loan is due for repayment in February 2019. However, DH have indicated that the loan will be extended. Once official confirmation has been received the loan can be re-classified back to non-current and this will improve the liquidity rating.	Finance, Performance & Investment Committee	
CIP (Cost Improvement Programme) delivery	Actual delivery in financial terms vs. the plan for delivery over the same period. Line = Last Financial Year, Bar = This Financial Year Green = Plan, Blue = Actual	The Trust's financial plan is dependent on delivering a CIP of £7M current year effect (CYE). The profile of CIP delivery for the first quarter is fairly low which is reflective of the work required to deliver some of the schemes from month four onwards. The plan was to deliver £208k in month 1; the actual CIP delivered was £100k. Schemes with a CYE of £4.64M have been identified (FYE £5.46M). The remainder of the £7M CIP (£2.36M) continues to be developed and monitored at the fortnightly scrutiny meetings.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - April 2018

Well-Led (Page 3 of 3)

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 decreased to 4.9% in April from 5.6% in March 18. 3% was accounted for Doctors,1.27% Nurses, 0.47% Admin staff, 0.12% AHP's and 0.06% Other.	Finance, Performance & Investment Committee	
Cost of staff sickness	In month based on staff sickness records. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.	The cost of sickness absence has decreased for the first time in 4 months to £0.3m.	Finance, Performance & Investment Committee	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

6 June 2018

Agenda Item	**TB148/18**	**Report Title**	**Director of Finance Report - April 2018**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☑To Approve ☐ To Assure ☐ For Information	☑To Note ☐ To Receive	

Executive Summary

Key messages:

- The Trust planned a deficit of £2.88m in month 1; the actual deficit was £2.62m, £254k less than planned.
- Income has delivered plan although assistance from 2017/18
- Expenditure is under plan despite CIP underachievement.
- Agency spend is below April's plan but unlikely to achieve NHSI target for the year unless major reductions in medical staff.

Recommendations:

The Board is asked to:

- Discuss and note the contents of the report

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

Add actions with milestones and Leads here

Previously Presented at:

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

1. Introduction

1.1. This report provides the Board with the financial position of the Trust for the financial period ending 30th April 2018.

1.2. The Trust has planned for a year end deficit of £28.8m (the control total of £6.9m was not accepted).

2. Month 1 Financial Performance

2.1. The Trust has performed as follows:

- **In month -** Deficit of £2.624m against a £2.878m deficit plan delivering a favourable variance of £254k.

2.2. The financial statements at the end of this report show the performance against this plan in more detail.

2.3. The table below is the I&E statement for April:

I&E (including R&D)	Annual Budget £000	In Month		
		Budget £000	Actual £000	Variance £000
Operating Income				
Commissioning Income	148,943	12,359	12,321	(37)
PP, Overseas & RTA	1,378	115	211	97
Other Income	11,908	989	934	(55)
Total Income	**162,229**	**13,462**	**13,466**	**4**
Operating Expenditure				
Pay	(126,817)	(10,974)	(10,794)	180
Non-Pay	(53,045)	(4,438)	(4,365)	73
Total Expenditure	**(179,862)**	**(15,412)**	**(15,159)**	**253**
EBITDA	**(17,633)**	**(1,950)**	**(1,693)**	**257**
Non-Operating Expenditure	(11,217)	(933)	(938)	(5)
Retained Surplus/(Deficit)	**(28,850)**	**(2,883)**	**(2,631)**	**252**
Technical Adjustments	63	5	7	2
Break Even Surplus/(Deficit)	**(28,787)**	**(2,878)**	**(2,624)**	**254**

2.4. The Trust has achieved the total income budget for April although a pressure on commissioning income will materialise if the Trust does not get a satisfactory outcome regarding the recording and payment of ACU activity (following the Expert Determination ruling).

2.5. Total underlying expenditure levels (both pay and non pay) remain consistent compared to last year, with the increase in pay expenditure being attributed to the provision for the pay award within pay reserves.

3. Income

3.1. Commissioning Income

3.2. Commissioning income is largely within budget in April but there are a number of issues that have been accrued based on estimates:-

- The benefit for "flex to freeze" (£180k) which is the monthly average.
- Improvements resulting from the coding review (EPS £55k and internal coding £110k) which is being carried out retrospectively and is a monthly average.
- The ACU Expert Determination adverse impact on 2018/19 (£149k).

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

3.4. The budget has been set at 2017/18 levels although there has been a non recurrent benefit in April from RTA which could be negated in future months.

3.5. Other income

3.6. See attached appendices for details.

4. Expenditure

4.1. Pay Expenditure

4.2. Pay expenditure in April is consistent with previous month's performance. A 2% accrual of the pay budget (£200k) has been actioned against reserves rather than allocated across all pay lines. The 2018/19 pay award has not been finalised so a monthly accrual will continue to be made.

4.3. All pay budgets are underspent in month except for a marginal underspend within other medical staff.

4.4. CIP unachieved in month £35k which is explained further in a separate agenda item.

5. Agency spend

5.1. The Trust has spent £531k on agency staff in April (5% of the substantive payroll) which is below the plan submitted to NHSI. The plan reduces considerably in July and will be a challenge to achieve with the plan being based on filling medical and nursing vacancies with either bank or substantive staff.

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

5.3. Executive Directors have been tasked with developing plans to replace/stop agency spend.

5.4. Nurse Agency

5.5. Nurse agency spend is £137k in April and is consistent with previous months.

5.6. 67% of the monthly nurse agency spend is within A&E (£92k); with the remaining spend incurred in medical wards, ITU, spinal injuries and theatres. 77% of April's agency spend is within Urgent Care CBU.

5.7. Bank fill remains high and the focus continues to be recruiting to substantive posts.

5.8. Medical wards and A&E also have high bank usage; Planned Care (34%) and Urgent Care (54%) account for most of the nurse bank spend.

5.9. Consistent vacancy levels of 10-12% are preventing any further material improvements on nurse bank and agency spend.

5.10. The cost of providing cover for nurse sickness in April was £80k (bank £68k; agency £12k) based on the information provided by NHSP.

5.11. **Medical Agency**

5.12. The Trust introduced a medical staff bank using the TempRE platform in November 2017.

5.13. Initially this allowed the Trust to reduce agency spend and generated savings through lower rates and savings on VAT and commission.

5.14. It has become increasingly difficult to fill the shifts at the published rates and often there is little financial difference between agency staff and bank staff. Plans are being developed to appoint substantively or secure fixed term contracts on reduced rates.

5.15. The cost of providing cover for medical sickness in April was £14k based on the information provided by TempRE.

6. Cost Improvement Plan (CIP)

6.1. The Trust has planned an efficiency requirement for 2018/19 of £7m.

6.2. £100k was achieved in April against a plan of £208k. This is covered in more detail within a separate agenda item.

7. Cash

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

7.2 A rolling 13 week cash forecast is updated monthly and sent to NHS Improvement usually in the second working week of the month.

7.3 This forms the basis of any cash draw downs in the future month (April's cash flow was sent on 5th March); note that the maximum borrowing was based on the original 2018/19 plan which was submitted in early March.

7.4 The Trust has borrowed £2.739m in April; this was the maximum available facility and it was anticipated that there would be a high cash outflow with the impact of March's capital spend.

7.5 The Trust has not agreed its control total with NHS Improvement, there is a punitive interest rate charge of 3.5% (normally 1.5%).

7.6 Performance against the cash target in April was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,000	1,079	Brought forward balance.
Cash inflows	15,917	16,847	VAT refund higher than expected. CCG cash inflows healthier than expected.
Cash outflows	-15,917	-15,396	Higher than expected cash inflows in March meant that the Trust was able to pay suppliers earlier than expected providing a cushion into April. In addition pay and tax costs lower than planned.
Closing balance	**1,000**	**2,530**	

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

7.7 May's loan request of £2.178m was approved at Private Board on 2nd May.

7.8 A revised 2018/19 Financial Plan was sent into NHS Improvement on 30th April and showed a cash requirement of £32m in 2018/19 based on a deficit of £28.8m plus £3.2m additional cash to support 2017/18 issues i.e. penalties and the Expert Determination.

8. Capital

8.1 Actual spend for April is low at £222k against a plan of £435k; this relates to the profiling of IT spend for the wireless network and telephony.

8.2 The Board should note that the Trust has orders outstanding worth £347k and has committed a further £312k of spend.

8.2 The detailed capital plan now includes commitments; this provides a better model for decision-making purposes particularly as the medical equipment line is managed on a contingency basis.

9. Commissioning for Quality and Innovation payments (CQUINS)

9.1. The full 2.5% CQUIN income of £3.2M has been included in the 2018/19 Financial Plan. Most of the CQUIN targets are "national" targets and are a continuation of 2017/18. The quarter one performance will be reported in July's FPI Board. Full CQUIN delivery has been assumed in April's income.

10. Risks

10.1. No provision for contract penalties has been accrued into the April financial position.

10.2. Although the full impact of a reduced tariff for ACU follow ups has been provided for in April's position this could contribute adversely to future month's financial performance.

10.3. CIP delivery as highlighted in separate agenda item.

11. Recommendations

11.1. The Board is asked to discuss the contents of the report and in particular note:

- The Trust is £254,000 better than plan at month 1 despite underachieving the CIP.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

6 June 2018

Agenda Item	TB149/18	Report Title	Extreme Risk Register
Executive Lead	Juliette Cosgrove Director of Nursing, Midwifery, Therapies and Governance		
Lead Officer	Mandy power, Assistant Director Integrated Governance		
Action Required *(Definitions below)*	☐ To Approve ☐ To Assure X For Information	☐ To Note ☐ To Receive	

Executive Summary

Since the last meeting 2nd May 2018, no new risks have been added to the Risk Register.

2 Risks have been downgraded to high on the Risk Register, details as follows:

- 1664 - Inability to provide out -patient review appointments in the required timescales; this risk has been reduced to **high** due to the controls in places that have reduced waiting lists: external support sourced: risk stratification completed/ weekly telephone calls with NHSI/ NHSE continues
- 1815 - If the ability to egress out of A&E is compromised, then the department becomes overcrowded, resulting in risk to patient safety, patients waiting to be reviewed by medical staffing exceeding national safety standards (4 hour Quality Indicators). This risk has been reduced to **high** due to the introduction of an additional building – (modular building - Clinical Decision Unit CDU).

There remains 3 risks rated as extreme.

The Board is asked to:

- Review the Risk Register
- Approve the changes that have been made to the Risk Register

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

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

Add actions with milestones and Leads here

Previously Presented at:

☐ Audit Committee	X Quality & Safety Committee
☐ Charitable Funds Committee	☐ Remuneration & Nominations Committee
X Finance, Performance & Investment Committee	X 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 MEM 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 Trainee representation at MEC ensuring trainee voice and participation at committee level HEE NW Action Plan is a standing agenda item at MEC with clearly assigned leads to specified actions Paediatric department has developed processes and procedures to support improvement to trainee experience Recruitment to new Clinical Education Lead roles underway to support development of robust QAF and consistency of training experience Job Planning process underway - expected completion by June 2018 Junior Doctors Forum (monthly) - trainees able to raise concerns directly with the GOSW GOSW presents a monthly exception report to Board Quarterly online health check requesting trainee views- shared via summary report to specialty leads and trainees						**Gaps in Controls**	Trainees report inconsistencies in ability to complete WBPA dependent upon specialty area The Trust has failed to respond to the GMC Survey specifically its red outliers Lack of CBU ownership of action plan and its resolution Insufficient number of trainees to fill the Rota's safely Trainees failing to complete critical incident forms as they do not like the Datix system Trainees do not receive timely feedback following submission of Datix reporting No evidence to support that trainees are learning from critical incident reporting Service pressures adversely impact on trainees experience and stop trainees attending local and regional teaching Lack of evidence of effective supervision in clinics and constructive feedback Trainees being asked to work without supervision or working outside of their level of competence Trainer disengagement - not responding to GMC Survey or completing/returning Specialty lead quarterly/annual reports The Trust does not have safe and compliant Rota's to allow for a good trainee experience 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	21/05/2018	15/06/2018
Assurance	Medical Education Committee minutes of meetings						**Gaps in Assurance**		

	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				
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 Rota's 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 Rota's. The Trust must ensure that service pressures do not impact adversely on the training experience of medical trainees and that trainees are able to gain sufficient experience to meet the requirements of their curriculum. The Trust must ensure all trainees at both sites are able to access formal regional and local teaching. The Trust must continue to improve its internal quality control process including systematic collation of information from departments, to evidence that postgraduate medical education is being delivered effectively. This must include a process for ensuring that actions are taken to address negative outliers that may result from the GMC NTS with measures put in place to identify improvements. The Trust must ensure that all trainees at both sites are able to access formal regional and local teaching The Trust must present HEE with comprehensive evidence of how trainees input into educational governance with examples of improvements being made, by the beginning of March 2018 The Trust must present HEE with comprehensive evidence of how the senior team has addressed a lack of trainer engagement by the beginning of March 2018 The Trust must review their governance structures to ensure they are fit for purpose in relation to education matters. The Trust must present HEE with comprehensive evidence of Board engagement and examples of how the structures are working by the beginning of March 2018. The Trust produce comprehensive evidence which shows how it has resolved the issue of the impact of the transfer of the education and training department on the administration of education by the beginning of March 2018. The Trust must present HEE with comprehensive evidence on how trainees are learning from critical incidents following its new process by the beginning of March 2018. The Trust must present HEE with comprehensive evidence that shows the job planning process is	**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 29/06/2018 21/06/2018	**Action Plan Rating**	Completed Completed Completed Actions Almost Completed Actions Almost Completed Completed Actions Almost Completed Moderate Progress Made Completed Moderate Progress Made Actions Almost Completed Actions Almost Completed Completed Completed Completed Actions Almost Completed Actions Almost Completed Moderate Progress Made

	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 SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team					Link to BAF	BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).				
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, and high turnover.							
Controls	Leadership Master Classes Annual 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 ongoing.						**Gaps in Controls**	lack of OD resource within organisation
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	11/05/2018	29/06/2018
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 its current form.								
Controls	Long term financial model and an estate solution based on the sustainability report completed by the Deloitte in 2015. The Care for You programme built on the Deloitte findings. This has now been supported by the Northern 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 working with KPMG (funded by STP) to develop costed clinical options						**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	22/05/2018	21/06/2018
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

PRIVATE TRUST BOARD

6th June 2018

Agenda Item	**PB081/18**	**Report Title**	**Uncommitted revenue support loan**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	✓ To Approve ☐ To Assure ☐ For Information	☐ To Note ☐ To Receive	

Executive Summary

Key messages:

- A loan of £2.479m is required in June.
- Revised 2018/19 plan submitted at the end of April 2018 setting out a total borrowing requirement of £32m.
- This is split £28.8m to fund the planned 2018/19 deficit plus £3.2m to settle prior year issues in cash i.e. penalties and Expert Determination.
- For June and cumulatively to June the Trust is borrowing less than the maximum borrowing capacity.
- A £4.22m loan due for repayment in February 2019 is likely to be extended.

Recommendations:

- The Board is recommended to approve the loan of £2.479m for June and authorise the Director of Finance to execute and manage the loan agreement.

Strategic Objective(s) and Principal Risks(s)

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

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

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

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

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

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

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

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

DH to send final loan documentation. Trust Director of Finance to sign and return with utilisation request and copy of the Board minute.

Previously Presented at:

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

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

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

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

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

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

For Information: Literally, to inform the Board

1 Introduction

1.1 As the Trust continues in deficit, there is an ongoing requirement for additional cash support. This support is given as a 3 year repayable, interest bearing loan (currently 3.5% as the Trust has not agreed its control total). Note half-yearly interest payments are taken over 3 years and it is only at the end of the term that the loan is required to be repaid in full.

1.2 In order to access this cash support, NHS Improvement (NHSI) require the Trust to submit a rolling 13 week cash flow forecast which will include the monthly additional cash support required.

1.3 The cash flow is analysed and then sent by NHSI to the Department of Health (DH) for final approval. Once approved DH then send the Trust the loan documentation for Trust approval.

1.4 This loan request is for a draw down on 11th June 2018 and is for the amount of £2,479,000 (see calculation in section 3 and appendix 2).

2 Authorisation

2.1 To access this essential cash funding, the following Board resolution is required:

- Approving the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party.
- Authorising a specified person or persons to execute the Finance Documents to which it is a party on its behalf.
- Authorising a specified person or persons, on its behalf, to sign and/or despatch all documents and notices (including, if relevant, any Utilisation Request and) to be signed and/or despatched by it under or in connection with the Finance Documents to which it is a party.
- Confirming the Borrower's undertaking to comply with the Additional Terms and Conditions

2.2 The nominated officer to execute and manage the agreement should be the Director of Finance.

2.3 The Board should note the following additional information:

- Interest rate is 3.5%. The normal rate is 1.5% but until the Trust agrees its control total a punitive charge of 3.5% is levied which applies to the whole loan term.
- Repayment date will be June 2021.
- The additional terms and conditions in schedule 8 (appendix 1).

3 Calculation

3.1 A 13 week cash flow forecast covering the period June 18 to September 18 was submitted to NHSI on 9th May. This identified a cash requirement of £2.479m in June.

3.2 The Trust re-submitted its 2018/19 plans on 30th April 2018 with a net deficit of £28.8m.

3.3 On the cash side though an additional £3.2m has been built in to enable the settlement of outstanding issues from 2017/18 – penalties and the Expert Determination.

3.4 Total cash requirement for 2018/19 is £32m.

3.5 The table below represents the maximum borrowing capacity based on the in-month deficit and the predicted settlement of 2017/18 issues.

	Deficit	2017/18 balance	Total
Month	**£'000s**	**£'000s**	**£'000s**
Apr-18	2,880		2,880
May-18	2,802		2,802
Jun-18	2,961		2,961
Jul-18	2,261		2,261
Aug-18	2,385		2,385
Sep-18	2,511		2,511
Oct-18	1,755	3,182	4,937
Nov-18	1,906		1,906
Dec-18	2,697		2,697
Jan-19	1,960		1,960
Feb-19	2,550		2,550
Mar-19	2,150		2,150
	28,818	**3,182**	**32,000**

3.6 Note for June, the Trust requires a loan below the maximum borrowing available.

3.7 The annual plan is reliant on the Trust achieving a £7m cost improvement programme.

3.8 The Board should also note that the first principle payment of a maturing revenue support loan is due in February 2019, value of £4.22m. This has not been built into the plans as the Trust was not generating resources to afford the repayment.

3.9 An update from NHSI on 3rd May 2018 suggests that the Department of Health will extend this loan and that the Trust will continue to pay interest at the existing rate.

4 Loan summary

4.1 The total value of loans including June's request is set out below:

Revenue support loans

	£'000s
15/16 loans	19,331
16/17 loans	20,700
17/18 loans	30,804
Total	**70,835**

New uncommitted revenue support loan 18/19

Apr 18 draw down	2,739
May 18 draw down	2,178
Jun 18 draw down	2,479
Total	**7,396**

Capital loans

	£'000s
Balance at Jun 18	1,600
Total value of loans	**79,831**

5 Conclusion

5.1 In order to continue to operate the Trust requires a cash injection of £2.479m in June.

6 Recommendation

6.1 It is recommended that the Board passes the resolution to agree to the terms and conditions of an uncommitted revenue support loan and appoint the Director of Finance to execute and manage the loan agreement.

APPENDIX 1 - SCHEDULE 8: ADDITIONAL TERMS AND CONDITIONS

1. Surplus/Deficit and Capital Limits

   1.1. The Lender has set a Surplus/Deficit Limit and/or a Capital Limit for the Borrower in consultation with the relevant Supervisory Body.

   1.2. The Borrower understands and accepts these Limits in the recognition that any net expenditure in excess of the relevant Limit(s) cannot be funded by the Lender based upon the assumptions made by the Lender at the date of this Agreement.

   1.3. The Borrower undertakes not to put forward any Utilisation Requests on this or any other Facility with the Lender that would result in Limits being exceeded by the Borrower without the explicit agreement of the Lender.

   1.4. In the event that a utilisation is likely to lead to a Limit being exceeded, the Borrower shall inform the Lender two calendar months before any such utilisation may be submitted.

   1.5. The Borrower will make no assumptions in any financial planning in relation to any financial support from the Lender beyond financing previously agreed to support the relevant Limit(s).

   1.6. Limits may be adjusted by the Lender from time to time in consultation with the relevant Supervisory Body.

   1.7. Performance against Limits will be monitored by the relevant Supervisory Body.

2. Nursing agency expenditure:

   2.1. The Borrower undertakes to comply with nursing agency spending rules as set out in the letter of 1 September 2015 from David Bennett and Robert Alexander to NHS Foundation Trust and Trust Chief Executives as may be updated from time to time. In particular, the Borrower undertakes to:

      2.1.1. Procure all nursing agency staff through approved frameworks unless such action is otherwise authorised by the relevant Supervisory Body.

      2.1.2. Implement an annual maximum limit for agency nursing expenditure as a percentage of the total nursing staff budget as set out in the letter of 01 September 2015 or as otherwise notified by the relevant Supervisory Body.

      2.1.3. Implement any additional controls as may be required by the relevant Supervisory Body in relation to the planned introduction of price caps.

   2.2. The Borrower additionally undertakes to Implement the NHS Employers Five High Impact Actions

3. Professional Services Consultancy Spend

   3.1. The Borrower will not enter into any contract for the procurement of professional consultancy services with a value in excess of £50,000 without the prior approval of the relevant Supervisory Body. The value of multiple contracts issued in respect similar Terms of Reference will be aggregated, as though a single contract had been issued, in respect of the application of this clause.

4. VSM Pay Costs

4.1. Where the borrower is authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the views of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.2. Where the borrower is not authorised as an NHS Foundation Trust, the Borrower will, via the Lender, seek the approval of the appropriate Health Minister before making appointments to Boards/Executive Boards where the proposed annual salary exceeds £142,500.

4.3. The Borrower undertakes to implement the requirements in respect of the treatment of "off - payroll" workers included in the letter from David Nicholson to Chairs and Chief Executives of 20th August 2012, or any subsequent guidance issued by the Lender.

4.4. The Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England to all newly appointed VSMs except where existing statutory terms take precedence. In addition the Borrower shall apply the most recently updated version of standard redundancy terms for NHS staff in England for existing VSMs where Section 16 is referenced in their contracts of employment.

5. Estate Costs

5.1. The Borrower undertakes to examine the overall running costs of Estates and Facilities against a benchmark group of similar NHS Trusts within 3 months from the date of this Agreement. Where higher than average costs are identified, and there is no valid reason for this, the Borrower will put in place an action plan to reduce these costs to match the agreed benchmark level. DH will need to satisfy itself that the benchmark is reasonable and plan is deliverable.

6. Surplus Land

6.1. The Borrower shall ensure that it has in place an up to date estates strategy covering a period at least 3 years from the date of this Agreement. The estates strategy should be informed by discussions with commissioners about clinical service requirements and consider options for rationalising the estate and releasing surplus land.

6.2. The report required in clause 6.1 shall identify surplus land and potentially surplus land to be released during the period from the date of this Agreement date to 31 March 2020.

6.3. The Borrower shall provide the Lender with a copy of its estate strategy within 6 weeks of the date of this Agreement or at a date otherwise agreed with the Lender. The Lender will need satisfy itself that the strategy is complete and deliverable for this condition to be satisfied.

7. Procure21

7.1. The Borrower will use the P21+ Procurement Framework for all publicly funded capital works, unless otherwise agreed with the relevant Supervisory Body.

7.2. Where the Borrower proposes to use an alternative procurement route, the Borrower will submit a business case to the relevant Supervisory Body for approval demonstrating that an alternative procurement route offers better Value for Money than the P21+ Procurement Framework.

8. Finance and Accounting and Payroll

8.1. The Borrower undertakes to commission NHS Shared Business Services to complete a baseline assessment of the Borrower’s finance and accounting and payroll services to assess the benefit of the use, or increased use, of an outsourced service provider. The

Borrower will provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

8.2. Where the assessment by NHS Shared Business Services supports the case for the use, or increased use, of an outsourced service provider, the Borrower will undertake an appropriate market testing exercise or use existing Government Framework Agreements to procure an outsourced service provider within a timescale to be agreed with the Lender.

9. Bank Staffing

9.1. The Borrower will undertake an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency to assess the benefit of the use, or increased use of an Outsourced Staff Bank provider. The Borrower commits to provide full details of the outcome of this assessment to the Lender within 6 Months of the date of this Agreement.

9.2. Where an assessment using the appropriate tool kit published on the NHS Centre for Procurement Efficiency supports the case for the use of Outsourced Staff Bank provider, the Borrower will undertake an appropriate market testing exercise or use an existing Government Framework Agreement to procure an Outsourced Staff Bank provider within a timescale to be agreed with the Lender.

10. Procurement

10.1. The Borrower shall provide third party non-pay spend to the lender in a format specified by the Lender, within 6 months of the date of this Agreement, and at least annually thereafter, on the request of the Lender,

10.2. The Borrower shall test the savings opportunities of increasing usage of the NHS Supply Chain and future editions and/or replacements of the NHS Catalogue within 6 months of the date of this Agreement and at least annually thereafter, on the request of the Lender,

10.3. Any savings identified through the process set out in 10.2 will be pursued by the Borrower. Any identified savings which the Borrower does not intend to pursue must be notified to the Lender along with the reasons for not doing so.

10.4. The Borrower will provide the Lender with current copies of its medical capital equipment asset register, medical equipment maintenance schedule, and capital medical equipment procurement plans within 6 months of the date of this Agreement, and at least annually thereafter on the request of the Lender.

11. Crown Commercial Services (“CCS”)

11.1. The Borrower undertakes to test the scope of savings opportunities from CCS within 6 months of the date of this Agreement, subject to appropriate CCS resources being available to support this undertaking. Any savings identified as part of this process which the Borrower does not intend to pursue must be notified to the Lender with the reasons for not doing so.

11.2. The Borrower additionally undertakes to provide details of its relevant requirements in support of all future collaborative procurements including e-auctions.

12. EEA and non-EEA Patient Costs Reporting

12.1. The Borrower undertakes to:

12.1.1. Become a member of the EEA portal and actively report EHIC and S2 patient activity on the portal

12.1.2. Provide an overview of the patient identification, billing and costs recovery systems in place with any planned improvements (for EEA and non-EEA patients)

12.1.3. Participate and collaborate with local/national commissioners in the development of the new ""risk sharing"" model for non-EEA chargeable patients.

13. On request of the Lender, the Borrower agrees to provide timely information and enable appropriate access to parties acting on behalf of the Lender for the purposes of appropriate tracking and reporting of progress delivering the conditions set out within this Schedule.

Appendix 2 – June 2018 daily cash flow forecast

Date	Description	In £	Out £	Balance £
01/06/2018	Opening balance			1,000,000
01/06/2018	S&F CCG	5,339,500		6,339,500
01/06/2018	West Lancs CCG	3,776,942		10,116,442
01/06/2018	South Sefton CCG	527,744		10,644,186
01/06/2018	Other CCGs	90,000		10,734,186
01/06/2018	RFT run		1,000,000	9,734,186
07/06/2018	Stafflow		94,000	9,640,186
07/06/2018	BACS and cheque payment run		965,000	8,675,186
07/06/2018	Weekly RBS bankings	42,000		8,717,186
11/06/2018	Interim cash support	2,479,000		11,196,186
14/06/2018	Stafflow		94,000	11,102,186
14/06/2018	BACS and cheque payment run		500,000	10,602,186
14/06/2018	Weekly RBS bankings	42,000		10,644,186
15/06/2018	DH revenue loan interest (multiple loans)		147,552	10,496,634
15/06/2018	NHSLA direct debit		687,664	9,808,970
15/06/2018	RFT run		1,100,000	8,708,970
15/06/2018	Estimated further receipts	250,000		8,958,970
15/06/2018	Contract receipts	2,500,000		11,458,970
15/06/2018	SBS contract payment		30,000	11,428,970
15/06/2018	Stafflow monthly disbursement		105,000	11,323,970
21/06/2018	BACS and cheque payment run		600,000	10,723,970
21/06/2018	Stafflow		94,000	10,629,970
21/06/2018	Weekly RBS bankings	42,000		10,671,970
21/06/2018	Tax, NI & superannuation		3,855,600	6,816,370
27/06/2018	Payroll		5,444,273	1,372,097
28/06/2018	VAT recovery	250,000		1,622,097
28/06/2018	Estimated further receipts	200,000		1,822,097
28/06/2018	BACS and cheque payment run		650,000	1,172,097
28/06/2018	Stafflow		94,000	1,078,097
28/06/2018	Weekly RBS bankings	42,000		1,120,097
29/06/2018	Alliance Healthcare payment		120,000	1,000,097
		15,581,186	15,581,089	

IRWCF 40 day limit

	£'000s
30 days utilised in 2015/16	15,111
April draw down	1,122
May draw down	875
June draw down	2,111
Jul 16 draw down	930
40 day limit reached	**20,149**

Term loans

	£'000s
Mar 16 draw down	4,220

Uncommitted revenue support loan (£5.4m facility)

Jul 16 draw down	1,470	
Aug 16 draw down	2,418	
Sep 16 draw down	1,512	
	5,400	

New uncommitted revenue support loan

Oct 16 to Mar 17	10,262	
Apr 17 to Mar 18	30,804	
Apr 18 request	2,739	
May 18 request	2,178	
Jun 18 request	2,479	**7,396**

Capital loans

	£'000s
Balance at Apr 18	1,600

Deficit funding (based on 30th April revised plan)

	£'000s	
Apr-18 deficit	2,880	
May-18 deficit	2,802	
Jun-18 deficit	2,961	
		8,643